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From Hostels to Hotels

An Empirical Study of Brisbane's Innovative Homelessness Response

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Research Summary

Why was the research done?

The COVID-19 pandemic has been an impetus for government and community organisations to significantly re-think how they respond to homelessness. In the second quarter of 2020, the Queensland Government closed Brisbane's main transitional housing and congregate-style homelessness facilities. In their place, an innovative homelessness accommodation response was established, which provides short-term supported accommodation in the form of self-contained hotel rooms at The Park Hotel (the Park). This research empirically and conceptually examines the Park as an innovative homelessness response.

What were the key findings?

We identify three key findings. First, despite the challenges of working within an environment that was not purpose-built, the Park service model was widely experienced as positive for facilitating practice and respecting the dignity and humanity of residents. Second, the residents living in the Park had extensive and complex homelessness histories which, in conjunction with the current lack of social and affordable housing, meant moving out of the Park within a short time-frame was not a feasible expectation. Third, residents wanted to be supported on their own terms to address their self-identified needs and achieve their own housing goals. However, limitations in the administrative data (particularly related to 'duration of need' and 'reasons for exit') impeded our ability to capture the realities faced by residents once they had exited the Park, including whether they were successful in achieving their housing goals.

What does this mean for policy and practice?

Our findings foreground the need for continued advocacy for the Queensland Government to increase their investment in social housing, as a lack of social housing is the critical determiner of whether Park residents can achieve positive exits and housing outcomes. In addition, it is critical for the Queensland Government to improve the mandatory data that is collected at the Park, alongside making unidentifiable Queensland Government data available to capture residents' pathways after their stay at the Park.

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1. Introduction

The COVID-19 pandemic has been an impetus for government and community organisations to significantly re-think how they respond to homelessness—including long-term homelessness experienced by single adults with no dependent children in their care. The experience with COVID-19 has demonstrated that shelter-based homeless accommodation is inadequate to enable people to socially distance and practice the hygiene and self-care that is required to maintain positive health and prevent the spread of communicable diseases. In the second quarter of 2020, the Queensland Government closed one transitional housing facility and Brisbane's three main congregate-style homelessness shelters in response to the health concerns raised by COVID-19.

One of the largest Brisbane congregational shelters that closed during COVID-19 was the South Brisbane Men's Hostel also known as 'Peel Street'. The closure of the Peel Street homelessness accommodation led to piloting an accommodation model that utilised unoccupied student accommodation. At the conclusion of the student accommodation pilot in January 2021, the Queensland Government leased the Park Hotel (the Park), a hotel in inner city Brisbane, as a new model of homelessness crisis accommodation. Run by the St Vincent de Paul Society Queensland (the Society), the Park is an experimental model that aims to facilitate sustainable access to housing and improve life outcomes for people experiencing homelessness in Brisbane.

The Park is considered an innovative approach to homelessness. The innovation lies in the provision of self-contained homelessness accommodation with independent amenity (bathrooms, etc.). In addition to better opportunities to contain the spread of infectious diseases like COVID-19, self-contained accommodation is also intended to enhance the capacity of support workers to engage with people who are homeless and meet their needs, for instance to access health care. Similarly, the self-contained accommodation and new modes of working with people who are homeless are intended to create the conditions to facilitate sustainable housing and life outcomes for people when they exit the Park. The model is also innovative because of partnership agreements involving multiple stakeholders who retain a shared interest in its success; that is the Department of Housing taking on the head lease of the property, the hotel owner remaining involved actively involved including in staffing to maintain the asset and sharing service delivery, the Society social service practitioners and coordinating the provision of multiple other contracted support service providers.

2. The Park service model

The Park departs from many other crisis accommodation models in the provision of private rooms through a repurposed commercial hospitality space. While residents are accommodated for their 'duration of need', the anticipated duration of stay for any resident is around 3 months. This makes the Park a short to mid-term facility. The provision of accommodation is complemented by support services delivered in collaboration with partners of the Society, including in-reach primary and mental health care, drug and alcohol support, and disability employment services operating onsite multiple days a week. Rooms receive laundry servicing, and residents are provided one meal per day. Residents do not have access to cooking facilities in their rooms, but they can use communal microwaves and sandwich presses. The hotel provides a coffee shop on site that sells espresso coffee, snacks and readymade meals such as two-minute noodles.

The residents' stays are regulated via rooming agreements that outline expectations they must meet. These expectations include adherence to the Park's harm minimisation approach, engagement in case management towards a housing outcome, compliance with regular room inspections and building safety rules. While there is no curfew, there is 24/7 security onsite, and during the research floors were segregated by gender. Residents were not supposed to be in each other's rooms and residents were not allowed to have visitors outside of support services. The rooming agreement is enforced through a system of breaches that allows residents to address issues of concern. With residents who repeatedly breach, the "focus period" would be initiated where residents are required to engage with Client Outcome Facilitators (COF) and achieve established tasks. Residents can be exited from the Park if they do not comply with the rooming agreement, engage in case management or are seen to be a danger to staff or other residents.

3. Research aims

This research seeks to empirically and conceptually examine the Park approach to homelessness service delivery utilising a mixed-methods design. Specifically, this research aims to:

1. Identify and formulate the theory of change for the model of service provision implemented by the Society at the Park.
2. Examine the practices of service provision at the Park, both by Society staff and non-Society stakeholders.
3. Quantitatively identify the demographics of people residing at the Park, including their durations of homelessness and health, housing, and other support needs.

4. Understand the experiences of living and being supported at the Park, including how people use or avoid Society services, and how they benefit from them.
5. Provide recommendations to the Society for what the Park model represents for homelessness and housing provision and their social justice mandate.

This research is conducted by independent investigators who are working in close partnership with the Society to feed the results back into practice.

4. Methods

This research draws on a mixed-methods approach to data collection and analysis, including both quantitative and qualitative data. We draw on quantitative data provided by the Society in the form of individual-level administrative data on the Park accommodation and residents' use of supported accommodation services. The Society collects this data at multiple timepoints, including on intake and exit from the Park to identify and track support needs, services provided as well as individual-level demographic data. This data is stored on the Specialist Homelessness Information Platform (SHIP), which enabled us to extract de-identified data for residents who had an active support period at the Park between 1 May 2021 (when the Park opened) and 9 June 2022.

We draw on qualitative data in the form of interviews with current or former residents (n=20), service practitioners (both Society staff and external providers) (n=16), and hospitality staff (n=8) at the Park (total n=44). Some service providers and hotel staff were interviewed more than once for a total of 47 interviews. In addition to qualitative interviews, members of the research team conducted weekly onsite observations of daily service practices and resident experiences. These onsite observations were conducted across nine months between February 2022 and November 2022.

These interviews and observations aimed to understand how residents experience the new approach to accommodation and service provision, what resident-led practice means to them, and if, and how, the model facilitates housing and other outcomes. From a service provider perspective, the interviews and observations also aimed to understand how the accommodation model and service delivery play out in practice, and identify what changes are being made—and could be made—to progress the development of the experimental model.

Throughout this paper all participants are referred to as either a 'resident', 'service practitioner', or 'hospitality staff'. To ensure participant anonymity, we do not specify whether residents are current or former residents, nor do we provide the specific job titles of service practitioners or hospitality staff. Service practitioners include Team Leaders, Client Outcome

Facilitators (COF) and external partners delivering services onsite. The research team is conscious of the very real practical challenges that COVID-19, flooding, and the resultant staff shortages have meant to the Park, and these are recognised as external disruptors that are time and context specific. Further, when focusing on the model of the Park, this should be understood in the context of the profoundly complex practice environment. People often present to the Park in extreme need when most other mainstream institutions in society have failed them. The practices that underpin the model are thus conducted in an environment that is both stressful and requires immediate responses to meet significant human need.

5. Findings

5.1 The service delivery model

5.1.1 An experimental theory of change

A theory of change is a description of the strategies, actions, and resources that facilitate change and achieve desired outcome/s. Having a well-articulated theory of change can formalise evidence-based practice and tacit knowledge and experiences, as well as provide a shared vision. Importantly, the nature—and, indeed, the worth—of the experimental model can only be understood by augmenting the perspectives of service practitioners with the experiences of the Park residents, which we do in later sections. Among service practitioners, however, the experimental approach led to multiple understandings of what the model should achieve and how it should be put into practice.

Our findings suggest that, despite the Park being a broadly experimental model, only some service practitioners identified the Park as an opportunity to experiment with innovative daily practices. For these practitioners, the Park model represented a resident-led practice model that focuses on facilitating residents' next steps in their housing journey. These practitioners articulated how the 'resident-led principle' underpinned their daily support practices and interactions with residents. As one practitioner described:

> *You're working alongside that person. One of my managers told me, she gave this analogy, you are driving in the car with your resident and you're sitting next to them. You're the GPS, you're helping them, but they're telling you where they want to go (Service practitioner 3).*

This approach was also referred to as "mature, contemporary practice" (Service practitioner 1), which was based on facilitating conversations around options, feelings, and pathways rather than controlling a resident's behaviours. The resident-led and facilitatory approach aimed to encourage autonomy and independence and this was contrasted to other models that may 'disable' residents:

There's a risk with support that's 24/7 on a site that you disable people via the support, that they then become reliant on the support that's actually in place and don't feel that they can disconnect from that or that they can stand on their own two feet (Service practitioner 1).

Together, the self-contained rooms and the resident-led practices enabled, as a service practitioner observed, "something that's a lot more individual and a little bit more dignified to start their journey" (Service practitioner 6).

There was also recognition that the resident-led approach was difficult to uphold in day-to-day engagements with residents. This was particularly the case when the Park needed to enforce a policy around breaches. The management explicitly stated they were trying not to take a 'hard line' with breaches and exiting residents as a consequence, as was the practice in previous models. On occasions where a resident was exited due to multiple breaches, the staff still tried to engage in an "mature, contemporary" way by keeping conversations open:

But even in delivering that [exit], we try not to get the police involved. I asked him to go offsite and cool off for a few hours and come back when we can have a sensible conversation where you're prepared to give me the respect and listen to the things that I have to say, and I will give you the same respect as well. So again, allowing that communication to happen a little bit more effectively (Service practitioner 6).

Some service practitioners, however, emphasised the innovation of the Park model in terms of the provision of self-contained hotel rooms, which represent a radical divergence from the congregate-style shelters that were until recently the norm. Indeed, when asked what they thought was different about the Park, some of the more recently recruited COFs would note the single self-contained rooms but did not clearly articulate the expectation that there would be a change in daily practices with residents. Similarly, one practitioner suggested that their daily work practices were just like their previous employment in a homelessness service organisation, asserting:

It's crisis accommodation. It's essentially what I was doing at [provider] (Service practitioner 3).

The key difference for this service practitioner was that the Park provided fewer meals and "you're just giving people their own space".

As the Park model is in its early stages, it is reasonable to find divergent ideas about what constitutes the model. Our findings suggest that while some participants saw the experimental component of the Park model as enabling critical resident-led practice, others viewed this

experimentation as primarily relating to the built environment of the accommodation provided. Below we articulate how the changes to the built environment can indeed facilitate changes to practice. Changes to practice, however, do not automatically follow changes to the physical environment, rather they need to be embedded within a clear framework that service practitioners can engage with, including the provision of training to foster the conditions for changed practice.

5.1.2 The impact of the built environment on daily practices

An innovative component of the Park is the move away from shared amenities and the improved facilities of self-contained, four-star hotel rooms. The rooms available and the policy to determine availability changed throughout this research. Initially, the Park had 64 rooms available for residents, with a further 15 rooms reserved by the Queensland Government for government-determined emergencies. A further four rooms were allocated as staff office and meeting spaces. In an Evidence Note published early in the research (Stambe et al., 2022), we recommended that the 15 rooms reserved for the Queensland Government should be made available to the Society to use to meet demand. Subsequent to our recommendation, the Queensland Government made the 15 rooms reserved for emergency response, as well as the four rooms being used as staff office and meeting spaces, available to be allocated to residents to meet demand. Thus, the capacity of the Park went from 64 rooms to 83 rooms.

Having a self-contained room (not having to share bathroom) was identified by service providers as significant for maintaining dignity, respect, and privacy. As one service practitioner remarked:

> *Eight times out of 10, when I bring them to their room, there's a tear. Yeah, they get quite teary. Because it is showing respect in a nice room. And they come in, it's beautifully made up and there's a little toiletry pack there. They weren't expecting something like that (Service practitioner 7).*

The provision of single and self-contained rooms creates a space that is conducive to a harm minimisation approach to alcohol use. In the Park model, the single rooms were seen as giving residents more autonomy over their space and scope to exercise choice. This approach was anticipated to encourage a sense of control, but within the boundaries of what service practitioners deemed to be acceptable behaviour. The space and sense of safety so facilitated, service practitioners hoped, could then be leveraged by residents to plan their next steps:

> *Working from, I think, a perspective of giving them a safe environment and putting boundaries up and having your boundaries and stuff with the workers and whatnot, and what is allowed and acceptable, it gives them a thing to*

take a look at themselves a bit more and identify what it is that they really want, need, how they want their life to be (Service practitioner 4).

The language we're using now is all about, this is your safe space, this is home, this is what you make it (Service practitioner 2).

In this way, the provision of single rooms positively influenced practice by establishing a framework where practitioners respect the residents and value their privacy. Here, a resident-led approach and the built environment are mutually reinforcing. Indeed, this also illustrates how the perception of the resident – a person of worth with the capacity to make autonomous decisions – fits hand in glove with the space (single rooms) and practices (resident-led) that underpin the model.

Alongside the positive view of self-contained rooms and the model that they sit within, some service practitioners identified three key drawbacks related to delivering a service in a building that was not purpose-built. The first drawback identified was the challenge involved in engaging residents. Service practitioners noted that the design of the front entry enables residents to slip through their gaze:

We miss them all the time. They're in, gone, out. You're chasing your tail, trying to catch them all the time, and it's frustrating (Service practitioner 8).

During observations, we also observed that it was hard to hear and see residents moving through the front foyer:

[Service practitioner] noticed [resident] was about to leave and do something else (the resident had a woollies bag under her arm) instead of coming to the appointment about her lack of engagement. They nearly missed her. [Another service practitioner] literally had to jump up and run after her in the driveway and call her back (Fieldnotes, 21 February 2022).

Although most service practitioners recognised this difficulty, some still managed to find ways to engage with residents by being flexible about where support conversations occurred:

They don't hang around... so it's just chat with them in the elevator, talk to them out the front in the gutter (Service practitioner 9).

The second drawback service practitioners raised was that the building space limited opportunities for residents to build a sense of community and engage with each other. For example:

> *[The building layout] doesn't allow for us to open up more spaces for people to use more freely. You know, common areas. People can come and go out of here as much as they like and use that space (Service practitioner 6).*

This relates to the final drawback, which was service practitioners' sense that they were unable to monitor interactions between residents and mitigate potential conflict. Some service practitioners felt like they were "flying blind" because they did not know what was going on in the individual rooms. Being unable to observe residents led some service practitioners to feel like they were providing services in a "reactive" capacity. This view was not universal, however. Indeed, one service practitioner precisely pointed to the resident-led approach requiring service practitioners to adapt:

> *You've got to release some of your previous controls… people now have their own room, have their own bathroom. And that's okay. It means you need to engage in a different way. It doesn't necessarily mean your risk has gone up because you can't enter a room all the time (Service practitioner 1).*

Thus, while the single rooms were generally perceived to be a positive development, the overall built environment was not deemed to be fit-for-purpose. The drawbacks created some difficulties for service practitioners to engage with residents and deliver services in ways they considered meaningful.

5.1.3 Developing trauma-informed practices

The Park delivery model was developing in-situ to become a facilitatory approach as mentioned above. The research identified the ongoing development of the Park service delivery model as a gradual shift towards a more explicit trauma-informed approach to working with people experiencing homelessness. This had implications for (1) the use of the built environment (2) engagement with residents and (3) the division of labour between the Society's staff and the Hotel staff.

The experimental nature of the Park model meant that some of the daily service delivery was being developed and refined. A notable point of change for the service delivery model and the assumptions that underpin practice was the shifting COF space in the foyer area.

The foyer area became a point of contestation that signalled a shifting focus of practice. When the fieldwork began in early 2022, the COF spaces was contained in the corner of the foyer area, behind two large pillars. The COFs could see outside into the driveway, but their line of sight for the foyer area was impacted by the pillars. At the beginning of the fieldwork a mobile whiteboard was also used to 'close in' the COF area.

The COF area was not seen as ideal. For some of the staff, the COF area created issues around observation, privacy, and safety. Some of these issues were partially addressed through creating an 'exit' pathway on one side of the desk area, using special screens to prohibit people reading the computer screens (except for the person directly in front of the screen). The whiteboard was eventually removed, and a lounge was put in the COF area. There were repeated concerns mentioned by lead COFs and management that the COFs were spending too much time in the COF space and not 'using the space' to engage with residents. Instead, they wanted to change the space so there was one COF 'floating' in the foyer space and another behind reception (Fieldnotes 19 September 2022). A key part of the argument was to use the space as idealised at the beginning of the fieldwork to:

> *A less controlled environment, better outcomes, adult to adult relationships (Service practitioner 1).*

By October 2022, the COF area in the foyer had been replaced with a resident space. All of the COF computers and other resources had been moved to the Offices on Level 1, and in their place was a computer, lounge and table and a couple of chairs. A COF was stationed at the end of the reception desk, and their role was to attend to minor requests or concerns from residents, but mostly to refer the resident to their usual case worker. Another COF staff member was also supposed support the COF behind reception. They had a small table on wheels that they could use for their tablet. The dynamic between residents and staff was supposed to change to facilitate autonomy by only helping with smaller tasks, and the majority of the foyer area was allocated to the residents. Other congregational models have adjusted the foyer area to facilitate autonomy and break down power dynamics between social workers and residences (Parsell et al., 2017). By moving the COFs to the reception area and having a floating COF on the floor, the Park was continuing this attempt to engage in innovative social work practices and adjust the built environment to influence the relations between COFs and residents.

The changes to how COFs and residents were to engage with one another signalled a more fundamental shift towards the facilitatory approach mentioned earlier, but also to engaging with residents through a trauma-informed lens. In the literature a 'trauma-informed' approach involves a four-pronged approach: a *realisation* of the impacts of trauma and recovery pathways, *recognition* of the signs of trauma, a *response* that incorporates this understanding into practices and effort to avoid *re-traumatisation* (Champine et al., 2019).

For the COFs this meant active team development around what it means to meet people where they are at, or:

Literally bringing your practice to where they are, not bringing them to you (Service practitioner 15).

For example, in team meetings staff would often share strategies of how to engage with different residents, and how to individualise their practices to help work with the residents. Such individually tailored service delivery included recognising that "nearly all of our clients come from horrendous trauma" (Service practitioner 15). Taking a more explicit trauma-informed approach also meant COFs had meetings about working on their language and being mindful of how they presented information to residents:

Being trauma-informed is being very present and is being very, not cautious, but present, pre-emptive, open to sensing where somebody is and how best to position myself so as they're going to engage with me in such a way that they're empowered and calm and feeling safe and all of those things. They're not feeling like there's any threat or any challenge (Service practitioner 16).

The change in how language was used and how they were trying to engage with residents also translated into altering the dynamic between the Society's staff and the hotel staff. For most of the fieldwork, the hotel staff and COFs would conduct the room checks on Tuesday, and then do a follow up with certain residents who had to clean their room on the Thursday of the same week. The objective from the hotel staff's perspective was to monitor the asset side of the rooms. As one hotel staff explained "[COFs] don't check the same things as we do". However, towards the end of fieldwork the room checks had shifted to be only the Society Team Leader doing room checks. This was again explained from a trauma-informed lens:

We sort of had to explain how somebody who's in a point of being in fight or flight mode isn't going to hear specifics about what time they need to have their laundry out (Service practitioner 16).

Instead, the new room checks would involve an examination of the space and people's ability to clean rooms. Maintaining routine is another opportunity to take a trauma-informed approach:

So we can be keeping a check on who needs extra assistance here and then start unpacking why are they needing assistance here (Service practitioner 16).

By adapting their daily practices in this way, the Society staff were moving towards providing opportunities to recognise signs of ongoing trauma and respond appropriately, including through the ongoing reflexive practices for staff. The explicit approach to trauma requires

tailored training for the COF and hotel staff to appropriately understand and realise how trauma can manifest in people's presentation and behaviour, and to adapt their practices to work alongside people to realise recovery pathways.

5.1.4 Daily challenges of balancing individual and collective needs

Service practitioners at the Park faced multiple challenges in their daily interactions with residents and other services. One key issue that most of the service practitioners described was how to balance the needs of individual residents with the needs of the collective of residents staying at the Park. For example, service practitioners were aware that drug and alcohol use, as well as trauma and mental health concerns, among residents made the environment unsuitable for those who were trying to stop their substance:

> *If you're someone struggling with that [drugs], it's only a matter of time before you just cave. So that, I would say, doesn't work, is that you are congregating a whole lot of people that have got similar stuff going on (Service practitioner 3).*

> *It's not a good environment be around… people that are coming in here are trying to get out of a cycle. But when there's a big group of people around, the energy, everyone's around that same energy, no one's able to get out of that cycle that they're wanting to get out of (Service practitioner 4).*

The key challenge for service practitioners was not just related to supporting individuals within a less-than-ideal environment for their journey out of homelessness compounded by complex health concerns. Practitioners also raised the issue of how an individual and their support needs could influence other residents:

> *That's something that often gets lost in this is, is how do you walk that very fine line between being able to give assistance and support to somebody in their hour of need, but, at the same time, recognise that there's people who are on their own journey who may be compromised severely by introducing someone like that (Service practitioner 2).*

In this way, the service practitioners perceived that part of their role was to take an explicit utilitarian approach and focus on supporting the needs of the majority as a way of balancing the tensions and issues that may arise from such situations. One strategy service practitioners relied on was to screen potential residents before welcoming them into the Park. As one service practitioner explained:

> *Once you can control your intake, then things settle down. It makes it much more comfortable for everybody... Nothing against anybody with mental*

health or any addictions. Nothing against them. It's just that we have to consider everybody. And if you've got too many, it's difficult (Service practitioner 7).

Controlling the intake was also about managing the workload of the staff, reducing the pressure of having many residents with high support needs, and having a proportion of residents that can be moved out of crisis accommodation within a reasonable timeframe:

> *Normally we just pick the next person off the list. But at the moment, because we've got such high needs with our residents, we were looking for people with less of a need and people that we could exit a little bit faster, get them off the street, and then look for housings (Service practitioner 7).*

A key concern here was mental health issues and behaviours of some residents. Service practitioners frequently noted that they had many residents with mental health issues and did not have the expertise to support them.

Controlling the mix of people in the Park necessarily also affected the processes of admitting residents as well as exiting them for breaching their rooming agreement, particularly in relation to drug use, drug dealing and aggressive behaviour towards other residents and/or staff. During one observation, the fieldnotes documented an incident where a resident who had previously been exited from the Park on the grounds of possessing drug-dealing paraphernalia and damaging property, returned to seek residence after being stabbed. The decision was made to allow the resident to move back, based on the "moral issue" of knowingly letting someone who had recently been stabbed stay on the street without income or support. This example demonstrates how, in some instances, a utilitarian approach may be sidelined to accommodate the urgent needs of an individual. This illustrates how service practitioners were constantly charged with making decisions involving weighing up harms for individuals and the collective, guided by moral principles and within an evolving service delivery model.

5.1.5 Working in "God's waiting room"

Without exception, service practitioners clearly articulated that their objective was to support residents into housing. As one service practitioner expressed:

> *So, if we really distil this down to its most basic element, everything is about housing. Everything is about this being a transitionary facility in which the client achieves a housing outcome. That's basically it (Service practitioner 2).*

Despite the clear objective to support residents to find housing, achieving a successful housing outcome was experienced as difficult. Across the interviews and participant observations, all

service practitioners noted the main barrier to achieving a housing outcome was a lack of housing supply:

> *Our biggest issue is finding people a place to live (Service practitioner 8).*
>
> *So even though they're here, can't afford anywhere else, they still have that requirement by Housing to try and find somewhere, which, as good as it is, it's pointless because they can't afford it … where do we put the people when there's not enough houses? (Service practitioner 9).*

In light of the shortage of affordable housing and the extended wait for social housing, for many residents the Park was experienced, not as a "transitionary facility" (Service practitioner 2), but as one service practitioners dubbed it, "God's waiting room":

> *Once people have got their [housing application] ID, they're linked in with all of that, it's like a waiting room here. They're waiting for the house… it's a waiting room. God's waiting room for people to take that next step (Service practitioner 3).*

The practitioners identified two key challenges relating to supporting residents while they waited for affordable housing. First, practitioners face contractual obligations to work with residents in a case management approach for their 'duration of need'. However, the support that practitioners can provide, or should provide, was ambiguous when a resident's only need was affordable housing:

> *We have people here that are ready to go, but there's just not the appropriate accommodation within the price bracket that they can afford… they're here as part of a duration of need, but you could also put that to, "Well yeah, there's nothing for me that I need" (Service practitioner 6).*

Indeed, enacting a resident-led approach in the context where a resident is "ready to go" but there is not enough affordable housing was experienced as a disjuncture by some service practitioners.

Second, service practitioners face challenges when balancing the need to keep residents engaged with the program with the respect owed to them as autonomous individuals exerting agency over their own lives. For both the 'ready' and 'not-so-ready' residents, service practitioners articulated that keeping them engaged and motivated to transition out was difficult because of the duration of their stay in "God's waiting room":

It makes it so much harder for the people at the Park who are working there because it's hard to get these customers to buy into their transition out when you can't guarantee them their transition out (Service practitioner 5).

The longer that the residents are here, the harder it gets. They start disengaging. They don't see anything happening, so why would they want to keep talking to us? (Service practitioner 4).

The problematic outcome of residents being in the Park too long and disengaging is that they risk being exited for failing to comply with the conditions of their stay:

One of my worst things, that I hate so much, I think it's really wrong, is that when we say to a resident, "You've been here too long and this is your move out date" (Service practitioner 7).

The long wait time expands the duration of need, and some practitioners found the wait time, disengagement, and the expectation that residents improve their housing readiness a point of contention:

Now we're in this really bizarre space where that duration of need is very, very much, I personally feel, a barrier to us really reinforcing that this is a program that has expectations. And if you're not willing to accept and participate in this, then it becomes quite difficult to sort of justify continual engagement and use of resourcing if you have no interest in alleviating your housing crisis or you're unwilling to move on (Service practitioner 2).

Here again the resident-led approach is challenged, this time by day-to-day practical realities, contractual expectations, and external factors such as housing supply. The description of the Park as a waiting room challenges the purpose of the model and raises important issues moving forward.

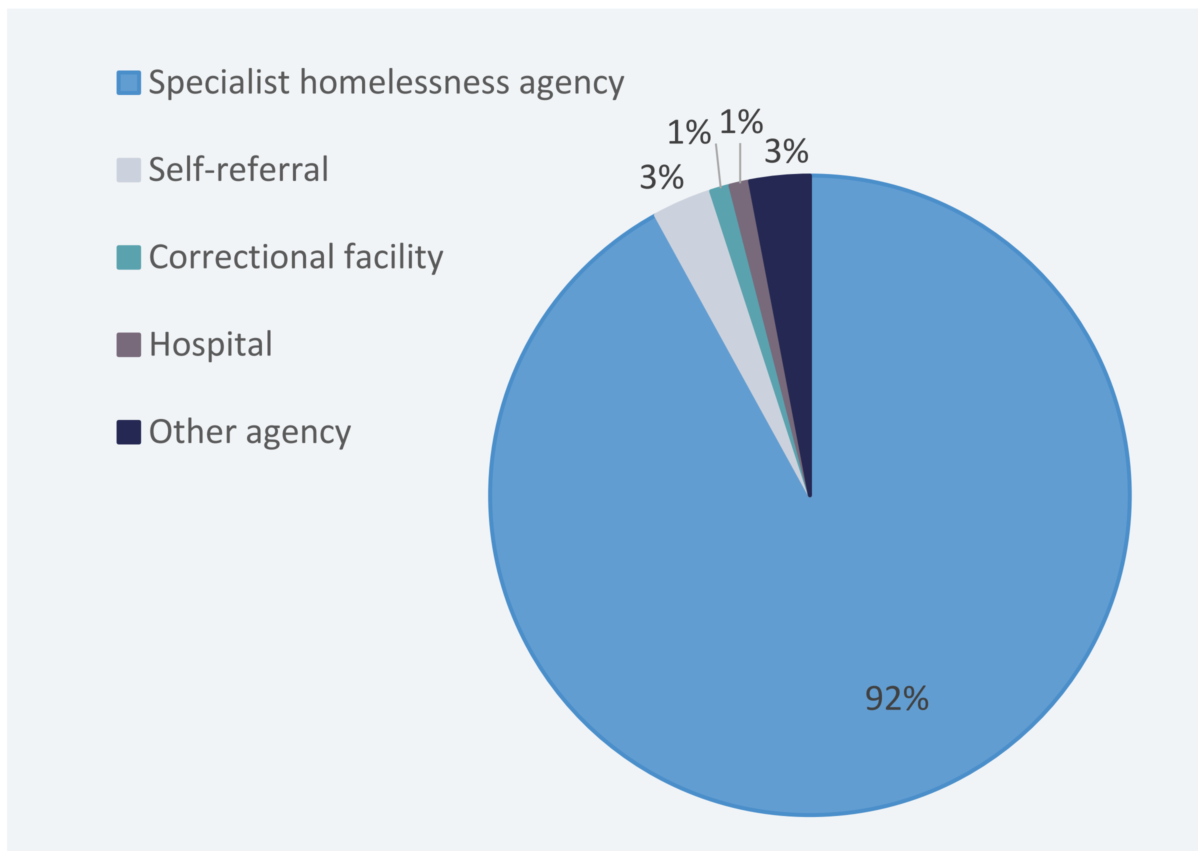
5.2 Getting to know the residents

5.2.1 Pathways to the Park

Of the 276 people who have stayed at the Park, 202 (73%) presented on one occasion, while 72 (26%) presented on more than one occasion. People enter the Park through a number of pathways (Figure 1). The vast majority (92%) were referred by other specialist homelessness agencies such as Micah Projects and Communify, as well as through internal transfers from the Society's previous accommodation at Peel Street in South Brisbane. In contrast, a much smaller proportion self-referred (3%) or were referred by other agencies not related to housing

(3%). A few (2%) entered the Park from a domestic and family violence refuge, a correctional facility, or a hospital.

Figure 1. Pathways to the Park



5.2.2 Resident profiles and systemic failures

Of the 276 people that the Park has accommodated:

- 202 (73%) are male, and 74 (27%) are female[1]
- 76 (28%) identify as Aboriginal or Torres Strait Islander, and 200 (72%) identify as non-Indigenous
- 226 (82%) were born in Australia, and 48 (18%) were born overseas (of whom 23 are from a non-English-speaking background)
- 51 (18%) are aged 25 to 34, 94 (34%) are aged 35 to 44, and 97 (35%) are aged 45 to 54.

[1] Qualitative fieldwork included three people who identify as transgender and two people who identify as gender-diverse. Because SHIP only distinguishes between males and females, the full spectrum of gender identities is not captured in the data.

- 200 (72%) were homeless[2] upon presenting, 26 (9%) were at-risk of being homeless, and 50 (18%) were unsure or did not report their previous dwelling
- 232 (84%) were living alone when they sought support, 27 (10%) were living with a group, and 17 (6%) had other living arrangements

For many residents, the lack of permanent and stable housing was an enduring experience. Of the 202 residents with available data, nearly half (49%) did not report a permanent address for up to a month prior to entering the Park, while 16% had been without a permanent home for at least 1 year. The day-to-day experience of long-term homelessness upon entering the Park is illustrated from the below quote from a male resident:

> *[Been sleeping rough for] more like six years. Yeah, with a few breaks on the odd lounge chair or lounge room of a friend's. But yeah, not too many. I'm usually just living rough around the city (Resident 7).*

Many residents at the Park share past and ongoing experiences of rough sleeping, including sleeping in open spaces in parks, on inner city footpaths, and trains. Another resident at the Park explained that prior to accessing the accommodation;

> *I was walking around all night and sleeping on trains (Resident 6).*

This person is not an outlier. Based on the SHIP data, nearly 6 out of 10 (56%) residents had been living in various public spaces prior to their entry at the Park. This is a significant proportion of the Park's residents, and it is critical to evaluate this in light of the existing evidence that demonstrates people who sleep rough are likely to experience other intersecting forms of health, social, and economic exclusion.

In addition to rough sleeping, a noteworthy number of people, 15%, entered the Park after leaving another emergency accommodation (15%). Meanwhile, only a minority (12%) had been living in a house or a flat, including those who had been couch-surfing with friends or relatives.

This data is significant to reflect on, as it demonstrates that people present to the Park after housing, family, and government support systems have not been able to prevent their homelessness. People's experiences of homelessness prior to entering the Park demonstrate

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[2] AIHW (2021) defines homelessness as living in: (i) a non-conventional accommodation or sleeping rough (such as living on the street); or (ii) short-term or emergency accommodation due to a lack of other options (such as living temporarily with friends and relatives).

several system failures. Being homeless exposes people to the public gaze, making their personal habits, recreational activities, addictions, or general needs more visible than when those same activities occur in private homes. Increased visibility therefore also exposed people to more interactions with services, particularly the criminal justice system. For example, residents described drug use or trying to find shelter while sleeping rough and the implications of being more detectable to police:

> *I racked up 17 charges in the 10 months I was on the street, and it wasn't normally me that would do that type of shit. It wasn't bad stuff, it was mainly just getting caught with drugs and that (Resident 2).*

> *We had to sleep over at the shelters next door and we got chased from there, the police chased us…They said, "If you don't move from here, we're going to throw youse in the watch house for trespassing" (Resident 12).*

Living in exposed and marginal spaces meant people were also living with the constant threat to their health and safety:

> *I've been down on the ground, in the gutter and kicked (Resident 12).*

People described strategies they used to try and keep safe, such as sleeping in groups:

> *You live in these camps and you live in these places where I'm sleeping on the ground, I've got a person next to me… It's a safety thing, yeah (Resident 9).*

People's health and safety was also under threat when living in boarding houses or backpacker hostels.

> *I used to sleep on the floor while a heroin addict's spilling coffee all over me, with my feet up against the door, because that would get kicked in every second night and you'd get robbed (Resident 9).*

When housing situations became unliveable, people described having few options but to return to the streets:

> *I just said, "I'm going," and I packed my bags up and I moved out. I went down the park [public space] (Resident 11).*

For women, such limited housing options made them even more vulnerable to violence when they were made homeless. In the example below, a resident was couch surfing when she had an argument with the man she was living with. She attempted to find another place to stay for

the night, but instead was met with brutal violence from another man living in the same complex:

He threw me out that evening, little did we both know what that door was opening up for me. I thought, "Well, where do I go?" I was raped that night, badly (Resident 8).

The quotes above highlight two interrelated system failures that underpin many of the resident's stories about their homelessness. First, people's homelessness exposes them to situations, and puts them in spaces, where they have little control over their environment, and which makes their activities and needs more visible to the public. Second, people's homelessness, and the danger and vulnerability that such a condition creates, is determined by lack of access to safe and affordable housing. This is devastatingly captured by Resident 8 when she was made vulnerable without any options for shelter, *"where do I go?"*. Residents' experiences of multiple harms and forms of exclusion prior to entering the Park provide a sober illustration of the critical need that the Park responds to and the challenges inherent in its responses.

The societal failure to provide housing for all is captured in the SHIP data analysis: an overwhelming majority – 84% of cases – are driven into the Park by two interrelated reasons: inadequate or inappropriate dwelling (58%), and housing affordability stress or housing crisis (26%). While residents expressed resignation about their lack of opportunity to find adequate and affordable housing, some residents articulated clear structural determinants that left them with few housing options:

There's some pretty bad policies, or no policies whatsoever, when it comes to long term housing policy and vision, how a lot of these social organisations work. And then some other key issues like rent assistance not being enough… So the go-to for single people is just to push them into boarding and share houses because that's the only thing that's affordable (Resident 4).

Boarding houses and hostels are seen as "shocking, nasty places" (Resident 4) but are nevertheless default options provided to people who are sleeping rough. Some residents spoke of their preference to sleep rough rather than go into a boarding house, for safety and health concerns:

Interviewer: But this time [the boarding house] wasn't an option for you? Rather be on the street?

> *Participant: Yeah. No, no, no. Yeah, there wasn't vacancy there and, yeah, no, it wasn't a good place. Not a lot of ventilation in the room, in the room I had (Resident 6).*

Even with these options, however, there is still a housing shortage and some residents described having to continue to sleep rough while support agencies and outreach teams send referrals to organisations like the Park:

> *[Outreach] asked us if we wanted to get off the street. If we wanted to get off the street, there might be a small waiting period… A couple of months, I think, I was on the street. Still on the street, at the park, waiting (Resident 7).*

Living on the streets, in boarding houses, or in backpacker hostels demonstrates systemic failures to provide sufficient affordable, safe, and sustainable living environments for society's most structurally disadvantaged. Importantly, the SHIP data reflects the general profile of Specialist Homelessness Services (SHS) residents in Australia on several domains. Aboriginal and Torres Strait Islander people are overrepresented at the Park, and according to 2020-21 data collected by the Australian Institute of Health and Welfare (AIHW, 2021), are also disproportionally represented in the homeless population in comparison to the general population. Likewise, a lack of employment and receipt of government income support are reflective of broader sectoral trends. The Park is thus functioning as a response to people who are failed by society in multiple ways.

5.2.3 Assessing residents' needs

Residents' entries to the Park are established by means of the intake interview. Intake interviews are a significant bridge between the life histories of people entering the Park and the capacity of the service to support people to meet their needs, including by providing safe and affordable housing. The intake interviews are undertaken by Team Leaders (TLs) and usually take place in a private space, like a meeting room where the intake is unlikely to be disturbed. The aim of intake is to introduce the new person to the Park, complete paperwork such as the Rooming Agreement and collection of rent via Centrelink, and to "set the standard of what's expected" (Service practitioner 7). As part of setting expectations, TLs outline the rules of the Park and establish the objectives of the program, namely finding housing:

> *And when I say the exit date and I put three months and I say, "This date, it could be a month before, it could be a month after. Just keep in mind that we want you to exit into [safe and affordable housing] - And it depends on how much you work with us and how much we work with you that's going to determine that exit date for you (Service practitioner 7).*

The intake interview is also an opportunity for TLs to "find out [a resident's] journey and how they're travelling" (Service practitioner 7). This part of the intake revolves around identifying the person's presenting issues and potential areas for support, which are then recorded in the SHIP database:

> *[TL] listened as [resident] outlined his transition from gaol into the boarding house. He appeared rather heightened, almost panicked as he detailed how navigating the outside world was giving him anxiety. [TL] let him talk for a little bit and then moved through the list of presenting concerns on the form. At times she would press for a little more detail, particularly around mental health (had counselling or on medication?) and substance and alcohol use. She mentioned the three things she is looking for – that Housing also look for – whether he can pay his rent, keep his room tidy and get along with his neighbours. She said she knew his room would be clean. When [resident] said he is an alcoholic, [TL] told him about their harm minimisation policy and asked if that would be a struggle for him. [TL] also mentioned they are there to support him around that (Fieldnotes, 27 July 2022).*

However, service practitioners also recognised that the intake process was not always the best time to elicit information from residents. Needs are likely to be under-reported during intake. This was acknowledged by TLs, who noted that many individuals were guarded:

> *It's difficult to do intake with somebody that is so wary. A lot are very willing to give their story, a lot are very closed (Service practitioner 7).*

Indeed, residents would describe the exhaustion on their first arrival at the Park:

> *I come up, and I was a wreck that day…And soon as I seen [TL], I was like a big - I just exhaled. I had to exhale. And then [TL] said, "You could go up to your room, have a good sleep." I slept for like four days (Resident 12).*

The intake interview is thus required to achieve the appropriate balance of obtaining and relaying information, but at the same time creating the conditions for the establishment of rapport and ensuring the person feels comfortable and safe.

Additionally, residents' experiences of being homeless—and these experiences being underpinned by systemic failures—meant the intake interview was an important first step to gather information but was also potentially a very emotional event. As demonstrated in the fieldnotes below, the intake of a resident who was sleeping rough became immediately a complex tale of several domestic and family violence situations, having children removed by

Child Safety, drug use, and underpinning all of these situations was the struggle to find adequate, safe and affordable accommodation for herself and her children:

> *As we sat down in the meeting room [resident] immediately started to cry. She talked about the fight she had with [ex-partner] – it seems he was sleeping under the same bridge and he didn't want her to get accommodation. [TL] said her name was on the list so she was entitled to it. It sounded like their relationship had not been a long one but was abusive. [TL] said to her that the Park will help her – they will "give you a hand if you want to take it". She explained the separate rooms and no visitation policy. [TL] framed it in a way to keep her safe. [TL] started with the paperwork. She went through Centrelink and sharing of information. Then she went through presenting reasons... [TL] asked about substance abuse and [resident] said it was "hard to have a bong on the streets". But with some probing admitted she occasionally uses meth to "actually have a good time and do naughty things with my friends". [TL] ticked DV [on the SHIP form] and probed her more about her DV and mapped the current situation on the back on the sheet. [TL] focused on her Child Safety issues and her children, one she had lost because her housing was deemed unsuitable and her mother [the child's grandmother] was intoxicated when the officers came over and the other was taken from her at birth because she was homeless … [Resident] would cry intermittently through the intake process and had trouble answering some questions. She described a history of violence – including her mother having DVOs against [resident]. [Resident] denied having any health problems or mental health problems when asked but gradually disclosed that she feels very anxious around new people and her foot may be broken from when [ex-partner] recently stamped on it (Fieldnotes 12 July 2022).*

The complexity of people's current struggles to find adequate housing and the intersecting structural disadvantages that frame their lives makes the intake interview only the first step for residents to describe and unpack their experiences. Residents sometimes admitted that they did not always fully disclose their concerns at intake. Consequently, staff may learn about a resident's circumstances through an altercation with another resident, or through routine room checks. This is illustrated by the case of a resident who described long-term drug use while sleeping rough but did not share this information during intake:

When they first found out about [my drug use], I think it was me first or second week of actually living here, they did a room inspection… there was actually an uncapped syringe on me floor (Resident 2).

As the first interaction, the intake interview is a key information gathering exercise for TLs to understand the resident's current situation, background, and support needs. Taken together with the analysis of the SHIP data, the qualitative research demonstrates that gathering accurate information at the point of intake is not always possible. Understanding the resident's support needs and encouraging requests for support, thus, relies on nurturing relationships and ongoing empathetic engagement from staff, who need to also be cognisant of the structural disadvantages and system failures faced by people experiencing homelessness. The complex experiences in people's lives prior to entering the Park are important to understand from a service provision perspective, but the complexity also means that the Society's staff conducting intake interviews are required to professionally and sensitively engage with people to build rapport and to minimise the chances of retraumatising people. At the Park, the intake process is more than a simple matter of eliciting information.

5.3 Living at and leaving the Park

5.3.1 The housing crisis

Residents' experiences at the Park are fundamentally tied to broader housing market dynamics. This includes the significant challenges that people who are homeless experience when accessing affordable housing, in both the social and private sectors. Our research found that we cannot decouple people's experiences of living at the Park from the failures of the housing market to provide people with affordable, safe, and secure housing. Residents recognised that the reason they were at the Park was due to a lack of appropriate housing:

From what I can tell, and I know there's not enough money, there's not enough housing, and there's certainly not enough disability housing (Resident 4).

While living at the Park, people told us they were waiting for social housing to become available. Indeed, and as demonstrated earlier, supporting people to access social housing is one of the core objectives that service practitioners at the Park are driven to pursue. However, for many residents, the wait for social housing was exhaustingly long. Residents described how their reliance on social security payments such as the Job Keeper payment, made it almost impossible for them to enter the private rental market. This was also particularly pertinent for residents who were underemployed and/or precariously employed. Earning some

extra income reduced residents' chances to receive social housing but they were also not earning enough to be competitive in the private rental market:

> *And looking at rentals all day, oh my god. It is exhausting when you're back to the start. You do it so many times, "Is it available?" blah, blah, blah. You don't get responses back. When you do, you go and visit it, it's not like the picture and it is - Wow, it's astronomical to live alone now (Resident 15).*

The lack of affordable housing options and difficulty finding sustainable work was a significant problem for residents who were non-citizens and therefore did not qualify for government support:

> *Whether it's Housing or Disability. I've been there too, and I don't qualify for anything…so I've got to do it for meself, and that's pretty hard (Resident 10).*

From our interviews and observations, residents' experiences of living at the Park were always in the context of struggling to find somewhere else to live. As demonstrated above, the limited housing supply meant residents were at the Park waiting, as one service practitioner described, "in God's waiting room". This raises questions about what constitutes the support program at the Park while people are waiting for housing options and how these supports are perceived by the people they are designed to help.

5.3.2 Living in 'God's waiting room'

Living at the Park is predicated on residents agreeing to a set of conditions laid out in their rooming agreement. Part of these conditions is agreeing to engage in the support program. The agreement is set at a 3-month period although residents' length of stay is determined by the 'duration of need'. Residents' experiences of living at the Park are inflected by these intersecting components of engagement, need, and support within the context of the housing crisis.

Overall, the residents spoke favourably about their experiences of living at the Park and the support they received from the Society's service practitioners. The residents explained that the workers were generous with their time and encouragement:

> *I saw that they're helping me a great deal. I don't know where I would've been or where I'd be today if it wasn't for them (Resident 17).*

Notably, none of the residents described feeling like they were being 'pressured' to find an alternative housing arrangement:

I thought that I was going to go good, bad, good, like go homeless, good here, and then homeless again. They said, "No, we've got you. Now you're here, we've got your support" (Resident 6).

This was important for the residents because it enabled them to feel like they were able to recuperate, reflect, and plan their next steps:

If I was still on the streets, I would have taken the first opportunity … At least here, you can actually [be] a little bit pick and choose-y, like what you want, which is good. Because usually when you're desperate, you make desperate decisions (Resident 19).

The residents who had previously stayed at one of the congregational style hostels, appreciated the relaxation of house rules and the flexibility this provided them:

I can relax and recuperate a bit. You don't have to be up. You're not woken up at seven o'clock in the morning to get out of the building and stuff (Resident 7).

Together with the self-contained rooms, flexible accommodation timeframe, and the space to take the next step, the manner in which residents described the approach of and support from the on-site staff is consistent with the Park model described above. This approach to practice was captured well by a service practitioner who described it as a "mature, contemporary practice" that is more faciliatory than directive.

As well as providing people with shelter, the space to plan their next steps and housing applications, residents described the extra support and encouragement they received to address other needs. This included support to link into other services, such as alcohol and other drugs, mental health, or general health requirements. The Park has various services visit the site to support the residents. Most of the residents had seen and spoke appreciatively of the general practitioner that works from the Park several days a week. Some residents engaged with the disability employment provider that also provided services on-site, as well as addiction support, Hepatitis C clinics, and less frequently, visitations from charity organisations to provide extra services such as clothing or haircuts.

Despite the consensus that the Park was a supportive environment, residents did identify some needs that they considered unmet. Notably, residents talked about the lack of specialist mental health support, particularly in terms of onsite support from an external professional or COFs:

> *They [COFs] don't seem to understand somebody that's got serious health problems, and I think that's one of the big cracks… I think, actually, it would probably be beneficial if they actually had qualified counsellors on staff here (Resident 1).*

It is important to consider that residents wanted to be supported on their own terms and in reference to the needs they self-identified. Consistent with trauma-informed care and mental health recovery, participants appreciated staff fostering a resident-led approach which respected their understanding of their own distress to facilitate autonomy and mental health. Alongside not enforcing a strict time limit on their stay, this approach can provide considerable care and support for self-determination. This is particularly important for residents who may have different cultural frameworks that should be considered alongside medical models of care:

> *[COF] advocated for checking in culturally before they explored an examination authority for the Aboriginal resident. [COF] said that she had spoken to Elders, and they suggested [resident] could have been mustered and it requires a smoking ceremony. The COF wasn't dismissing mental health intervention but wanted to support the resident through the resident's worldview first (Fieldnotes, 12 Oct 2022).*

Principles of facilitating autonomy and independence do need to be applied consistently across multifaceted and convoluted settings. Some residents felt there was miscommunication amongst staff, and between support staff and hotel staff that sent conflicting messages to the residents:

> *[Resident] is getting cockroaches in his room and he wanted to take "preventative action". However, he was told by hotel staff, and then again by Vinnies staff that he was not allowed to have fly spray or aerosol deodorant in his room. He said they cited "fire alarms" issues [i.e. the fly spray would trigger a fire alarm] but [resident] cried, "bullshit". He said he was frustrated that they always used the fire alarms as an "excuse" and he was annoyed with the contradictions in approaches – for some things they had to be assertive and act as agents of their own destiny – such as with buying their own bread and then at the same time the staff treat them as children who can't do certain things – for example with the fly spray (Fieldnotes, 1 Sept 2022).*

The residents did acknowledge when they felt the Park service practitioners had responded appropriately to concerns raised by residents. Of note is the change to the food provided by the Park chef. Some residents lamented what they considered the poor quality of the food, the lack of variety, and the overuse of carbohydrates (notably rice or pasta). For some residents, the poor food quality was a reflection of how residents were perceived, and interpreted this as an extension of the stigma that comes with the experience of homelessness:

> *It makes you feel like sub-human, because it's like, "Well, that shit's [food] good enough for you" (Resident 9).*

Once the menu had changed the residents were more positive:

> *The food's just improved immensely… More healthy, better for your bowels, better for just your body and your health in general (Resident 16).*

Being guided by the wants and needs as identified by the residents is consistent with how the Society is shifting their daily practice to support autonomy and treating people with respect and dignity. Residents did articulate some concerns with the program in terms of support provided, communication and food as noted above. However, outside of finding safe, affordable and appropriate housing options, their stay at the Park was mostly an improvement on their lives prior to entering the Park.

5.3.3 Aboriginal and Torres Strait Islander perspectives

As shown above, the analysis of the SHS database illustrates that 76 or 28% of residents identified as Aboriginal or Torres Strait Islander. People who identify as Aboriginal and Torres Strait Islander constitute 3.8% of the total Australian population, which highlights the disproportionate number of Aboriginal and Torres Strait Islanders living the Park. As mentioned earlier, the overrepresentation of Aboriginal and Torres Strait Islander people in the Park is consistent with broader data on homeless populations.

The Society supports the National Agreement on Closing the Gap and has made an explicit commitment to stand in solidarity with Australia's First Peoples to respect their human rights to live without economic, social and cultural oppression.

At the Park, there are multiple examples of how COFs have tried to adjust their practices to be culturally appropriate for Aboriginal and Torres Strait Islander residents. Early in the research, a cross service meeting was arranged with the Institute for Urban Indigenous Health (IUIH). IUIH staff were often at the Park Hotel supporting some of the residents. For example, one Aboriginal and Torres Strait Islander individual was having trouble with maintaining his room in accordance with the occupancy agreement along with some significant mental health concerns. To include culturally appropriate practice into the Park service provision model, an

IUHI staff member came to work with the resident on addressing these issues. This included taking him to a men's group and performing a smoking ceremony in the resident's room. Such collaboration required IUHI, the Society and the hotel to agree on adapting their practise and rules to accommodate the resident's cultural and health needs (Fieldnotes 27 September 2022).

In addition to explicit steps implemented to identify a culturally appropriate mode of practice, some residents who identify as Aboriginal and Torres Strait Islander spoke about their experience of being supported in culturally appropriate ways. As one example, one resident needed her art to be a part of her support, self and cultural expression, and healing while at the Park. The resident explained the importance of being able to do artwork for her emotionally, mentally and culturally:

> *Sometimes then people aren't around for you to talk. That's how you get through trauma, is talking. You know? Talking and art. Art, it's a lot of history, saying story time, story time. That's why. Now we know. It's not because story time, they're going to go make money from it. It's story time. You know what I mean?... Singing. That's their way of expressing, "Okay, this event happened, and this is how we dealt with it." … And this is where they went and did it, on land, on country, on home. So that's where I'm at. That's what I'm doing. This is my journey (Resident 18)*

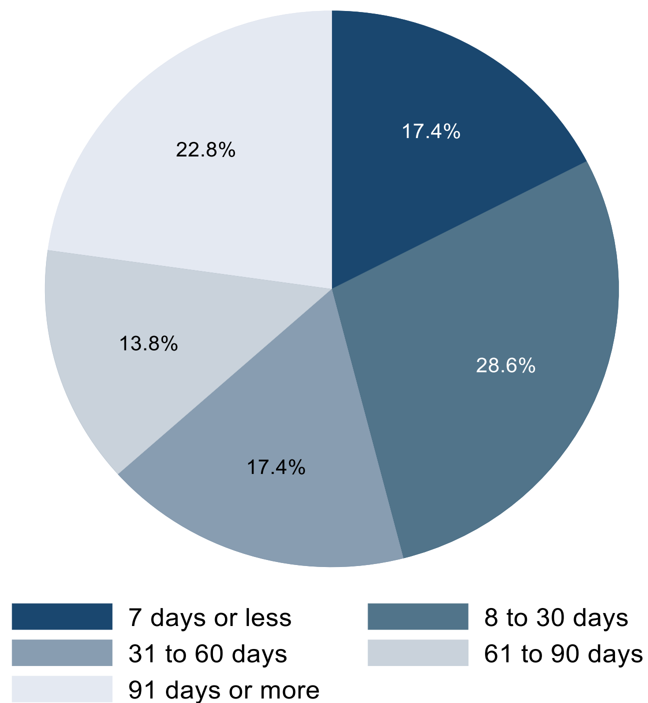
Additionally, some of the Society's staff acknowledged that there was more to be done at the Park to ensure they were providing a service that was appropriate for different Mobs residing at the Park. Service practitioner 3 for example, observed, "we need a diverse team who can interact with lots of people". This was important for two reasons. First, diversity in the staff, particularly hiring Aboriginal and Torres Strait Islander people, meant that the residents would have someone on staff that understood their worldview. In reference to a staff member who was part of a local Aboriginal community, it was noted that the COF has got "that in with the Aboriginal community. They respond really well" (Service practitioner 3). This was particularly important because other staff have noted that Aboriginal and Torres Strait Islander people may experience shame, meaning "that a lot of people who identify will not come to us for any support" (Service practitioner 7). Second, having professionals who identify as Aboriginal and Torres Strait Islander as a COF or an Aboriginal Liaison Officer will provide an education resource to other staff members. As noted by a staff member who identifies as Australian First Peoples, a key issue is lack of cultural knowledge, "It's just that cultural, people not knowing properly how our culture is. I find, since I've started here, I'm explaining things a lot" and this education was for both the Society staff and hotel staff. Having representation on staff at the

Park therefore provided cultural education and identification and support for Aboriginal and Torres Strat Islander residents.

5.3.4 Duration of need and exits

There was a subset of 213 residents out of the 276 that had completed one stay at the Park (had entered and exited). Among these 213 residents the average length of stay was 59 days (approximately 8 weeks). However, a closer look at the data indicates a high rate of short stays (Figure 2). Indeed, 17% of residents stayed for 7 days or less; 29% stayed for 8 to 30 days; and another 17% stayed from 31 to 60 days. In other words, nearly 1 in 2 residents (46%) stayed for only a month or less despite being given a 3-month rooming agreement.

Figure 2. Length of stay at the Park

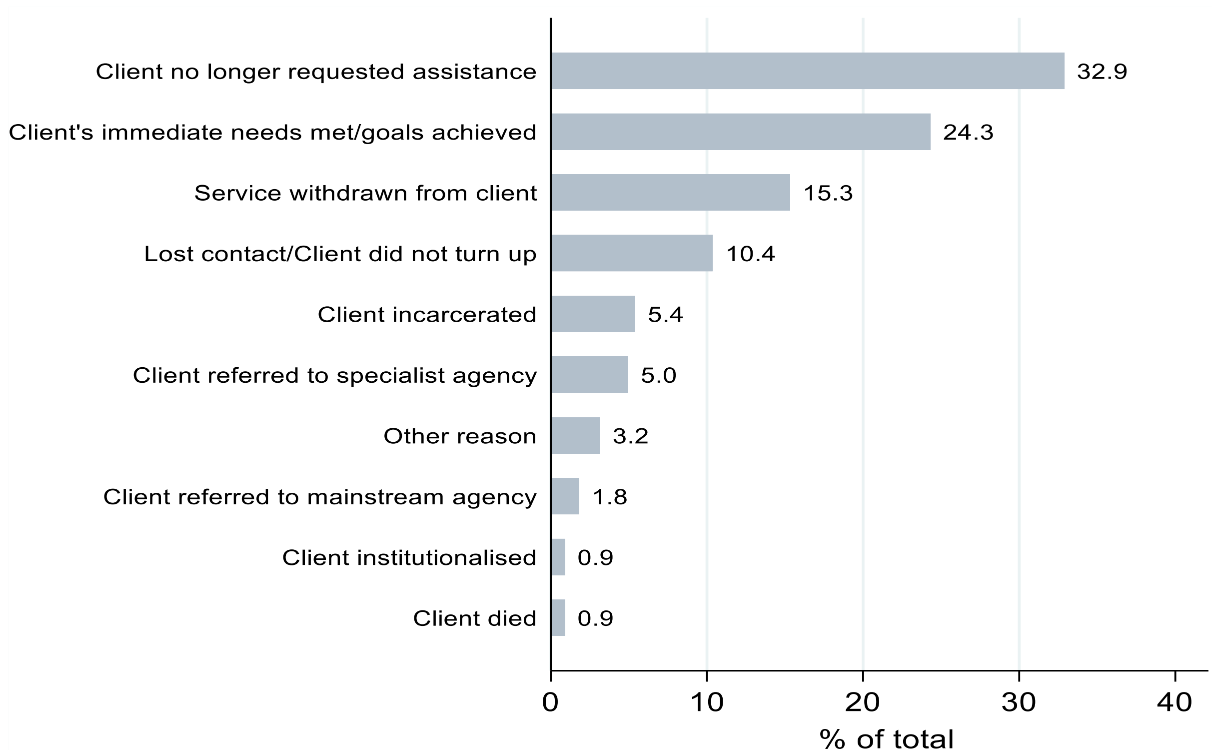


To better understand residents' duration of stay at the Park, we turn to the reasons for exit reported in the SHIP database. Ideally, residents should only exit the Park once they have achieved their stated goals, which may include obtaining access to safe, secure, and affordable housing.

There are many reasons that residents move out of the Park. For instance, some residents may no longer require assistance if they perceive their needs have been met or they no longer wish to continue receiving support. Accommodation will end if a resident vacates the Park without notice, or when service is withdrawn by the Park. The latter may occur if a resident violates the rules of their agreement (for example, through threats or acts of violence) or refuses to engage with service practitioners.

Figure 3 provides a breakdown of the different reasons residents exit the Park. Out of the 276 residents that had stayed at the Park, there were 222 instances where accommodation was provided and data on exit reasons is available[3].

Figure 3. Reasons for exiting the Park



Of these, 33% ended due to the resident no longer requesting assistance; 24% ended due to the resident's needs or goals being met; and 15% due to the service being withdrawn from the resident. Additionally, 10% of cases were closed due to loss of contact with the resident.

These patterns yield a valuable insight; there is a significant percentage of residents who exited the Park voluntarily, either because they no longer required assistance (33%) or because they left without notice (10%). It is impossible to know which of these residents left and went into safe and sustainable housing. Indeed, the choice to leave the Park could indicate a good outcome – into housing – or it could indicate less than ideal situations for people leaving the Park, such as exiting into other forms of homelessness. Unfortunately, the SHIP variables are ambiguous and difficult to interpret. More insightful conclusions on housing outcomes after exiting the Park, will require follow-up with residents at least once after their departure. Additionally, Queensland Government holds data that would illustrate the housing or accommodation outcomes experienced by many people who exit, such as those who move

[3] Some clients may have multiple accommodation records. This happens when they exit and re-enter the Park at a later date.

into social housing, or other private forms of accommodation that are supported by Queensland Government housing assistance.

From the qualitative data, we can identify several push and pull factors that may partially explain residents' length of stay and reasons for leaving. For instance, it may reflect the transient nature of this population or the challenges with engaging in the program for people with ongoing trauma and other complex concerns. Additionally, residents may not want to engage with the services provided at the Park but nevertheless need crisis accommodation. Residents also noted that they found it difficult living near other residents, especially around drug and alcohol use and that such lifestyle behaviours could risk eviction:

> *I call this, yeah, the devil's playground because it is. Just so much temptation. Somebody can get lost in a crowd and it could be jeopardising their accommodation. There was one part here where people were doing one thing wrong and then they're kicked out and it's like, "Hey, that's not fair" (Resident 12).*

One resident struggled to abstain from illicit substances while living at the Park. However, the support from the service practitioners meant despite several behaviours which could have resulted in breaches, the resident was not exited and instead was supported into social housing after roughly 12 months of living at the Park. Not all residents want to engage in the program, and this was often cited by service practitioners as a reason for residents leaving the Park within three months. For the Society, it is important to engage with residents where they are at, and that includes paying attention to the nuances of their situations and the ongoing impact of societal failures and trauma that contribute to their current struggles:

> *My life's pretty scrambled at the moment…I've been here for nine months, so I haven't really interacted that much. Only just recently. Because I've been a bit lost on my journey…I'll be honest with you, I have put a hole in the wall upstairs because of my anger issues and just being suppressed, more to the point. So, not being able to deal with stuff, of being held back and closed in (Resident 16).*

There was also a considerable percentage of residents who had been at the park longer than 91 days; 22% of residents stayed 91 days or more. Although the available SHIP data means we cannot dig deeper into this cohort, qualitative research with residents who have stayed for longer than three months at the Park demonstrates the difficulty people have in finding accommodation and moving out of the Park and the benefits—but also potential unintended consequences—of long-term stay in crisis accommodation. Despite the challenges residents faced prior to entering the Park, living at the Park, and in their lives more generally, people

still found a way to take care of themselves and others and orient themselves optimistically toward the future.

5.3.5 Taking care and hope for what comes next

The residents we interviewed all spoke about the challenges of living at the Park. There were two main issues that the residents identified. First, the residents found there were many drug and alcohol issues and mental health concerns:

> *Not one person in this building doesn't have a fucked up story (Resident 9).*

Second, there were many descriptions of violence and interpersonal conflict between residents:

> *The violence, because, end of the day, they're not going to be violent to you. They're violent to themselves more. Yeah. Unless you've got an argument with them. That's why I say the drugs and everything... There's a lot of drama here (Resident 19).*

Residents explained how they would try and take care of themselves in such a 'dramatic' environment: (1) limited contact (2) creative pursuits (3) health practices (4) meaningful activity (5) caring for others and (6) enacting agency.

One key strategy of self-care that most residents talked about was limiting their interaction with other residents, or being very selective about who they spent their time with:

> *I don't associate with the people. Because I know if I associate with the people, it's going to heighten my risk of using drugs and substances again. And no disrespect to these people, but they're not the kind of friends I want to have. You are who you surround yourself with (Resident 13).*

Many residents talked about keeping themselves in their bedrooms as a way of limiting these interactions. However, this presented new challenges for some residents, especially those who did not have a balcony. For some residents this meant they were forced to go downstairs to smoke, and thus chanced running into people, including staff. This meant residents sometimes felt like they had to perform lest they be seen to be vulnerable:

> *And a lot of the times, I felt the staff - If you get dressed up and walk through, "Oh, you look lovely today. You look lovely today." But when you look like shit they just assume that you're on drugs or something. You think, "Oh, okay. So I'll put on that front, please all," and inside I'm really fucked up, but that's okay (Resident 15).*

Being in the room to avoid others also meant they could feel:

…suffocated and panicked, can't breathe and claustrophobic (Resident 16).

This also limited their other self-care practices. Resident 16 for example loved to dance but found the lack of fresh air in her room dissuaded her from this self-care practice. Many other residents talked about using creative expressions to look after their own mental health, whether that be creating figurines, using electronic devices, singing, or drawing:

That's how you get through trauma, is talking. You know? Talking and art. Art, it's a lot of history, saying story time, story time (Resident 18).

Many residents talked about the importance of maintaining a health regime while living at the Park:

Every day I wake up, I take my antidepressant in the mornings, workout for two hours, I do my stretches because of my knee, my physio, and then I step out and be that person. But I'm usually pretty good. Yeah (Resident 6).

However, there was a limit on how much avoiding others, being creative or looking after their health could facilitate self-care. For the men in particular, the lack of employment was detrimental to their sense of self-worth. For example, some male residents wanted to engage more actively at the Park to give something back to the Society but to also find a way to meaningfully spend their time. They had attempted to contribute to the Park but were restricted by concerns around workplace health and safety. As clearly demonstrated in the literature (Parsell & Clarke, 2022), not being able to reciprocate can contribute to people's sense of shame at receiving charitable help and support. Moreover, while residents were appreciative of the change to the menu and being provided one meal a day, many also wanted to cook for themselves to look after their health and for enjoyment:

Whereas here, you can't even cook yourself food, like a meal. You can't even cook or anything. So you're just sitting there staring at the wall and then just your mind's ticking over and it does send you insane (Resident 9).

But see, if I could cook, it'd be different, but I can't. There's a microwave. And if I buy vegetables, it just destroys any vitamins in them, so it's pointless…I need that for my health (Resident 8).

Engaging in reciprocal behaviours was not just aimed at the Park but also occurred between residents. Situation-specific relationships could provide meaning for some residents and enable them to look after themselves by also showing care for others:

I look after people and they're not doing it down here, the girls that come in and crying…they come to mine, have a coffee, and a cone, and blah, blah, blah, and off you go (Resident 15).

The important elements of these findings are that residents find their own ways to take care of themselves, but also that the hotel facility and the crisis accommodation model did not provide residents with ample opportunity to care for themselves. The restricted access to some amenities, such as the pool, and limited resources such as a kitchenette would enable residents to engage in more self-care.

Being able to rest, plan their next steps, and engage in self-care coalesced with residents' sense of hopefulness about their future. This is important, as it speaks to residents' sense of autonomy and volition, as clearly demonstrated by this resident who, living through a lifetime of trauma and drug addiction, used his almost 12 months at the Park to make a plan for a different life that he desired. Indeed, he acknowledged the support from the staff at the Park, but also his agency:

I've been the one doing all the driving. I'm the one that's doing all the hard yards…Most of my life I've been on drugs. So I've gotten sick of it. I made myself a goal, to give up the gear, get myself clean… get myself a job, and get my life back on track, and to get back into contact with my mum and my brother (Resident 11).

Indeed, for many of the residents, stepping out of the Park was driven by a desire to reconnect with friends and family:

Just a key use of peace and just spend a bit of time with my grandchildren. They're my light. I don't want the dark. I've learnt enough (Resident 8).

As demonstrated in the following fieldnotes, while many residents valued their time at the Park, either briefly or for a longer period, being housed was the important foundation for their self-care, self-worth, health and connection:

[Resident] was there helping [COF] by sweeping up. [COF] said, "[Resident] tell Rose your news". [Resident], very excitedly, told me he got a place in [suburb]. A small housing unit in a complex of 8. He said it was mostly older people. He was "happy to put my roots down so…" and he indicated with his arms that his branches could then grow. He said he was sad about leaving the Park Hotel – it's been 10 months – but he is also very ready to have his own place. They were organising his furniture tomorrow. [Resident] said he

thinks [COF] is going to do outreach with him for 6 months (Fieldnotes 12 Oct 2022).

6. Discussion and recommendations

Throughout this paper, we have drawn on interviews and observations with residents, service practitioners, and hospitality staff at the Park, as well as robust administrative data sources. In doing so, we have developed a picture of the Park model, illustrated how the model is delivered in practice, and examined how entries, stays, and exits are experienced by residents. To conclude, we highlight key recommendations for the consideration of the Society, the Queensland Government, and other organisations and jurisdictions seeking to implement similar models.

The service delivery model

Our findings regarding the Park service delivery model highlight that the experimental model is a key and significant strength of the Park. Indeed, the provision of single rooms is key to the model's innovative potential, in turn, creating the conditions for innovative approaches to practice. What is novel about the Park is viewing people who are experiencing homelessness as having the capacity to make decisions to pursue their desired life outcomes. This understanding of people is inseparable from the role of both the place and practice at the Park. It is the coming together of these three elements – People, Place, and Practice – that constitutes the critical ingredients of the Park's theory of change.

However, with experimental approaches come divergent views on practice, capabilities, actions, and opportunities. These divergent views can be harnessed as a strength and means to foster the Society's continuous improvement agenda. To facilitate this, we recommend:

1. The Society continues to create the conditions for engagement with divergent views by embedding a community of practice environment for service practitioners to think, reflect and debate.
2. The Society continues to support residents in ways that respect their dignity and autonomy to make decisions about their own lives.
3. The Society establishes training frameworks and practice guidelines that are consistent with the development of a trauma-informed and strengths-based approach to case management at the Park.

Working with residents

Our findings foreground residents' highly complex experiences of homelessness. These experiences must be understood within the broader context of overlapping systemic failures,

most notably lack of adequate, affordable, and safe housing options. Indeed, the lack of affordable housing stock was the most prominent issue reported by people presenting to the Park. This has important implications for the Society. First, it means that the Park Hotel model offers a temporary relief from a long-term crisis. As such, residents that enter the Park cannot be expected to exit successfully within a relatively short timeframe. Imposing limits on the length of stay risks moving people into other forms of homelessness. Second, the complex experiences that lead people to the Park are highly intimate and often traumatic. These are experiences that residents should not reasonably be expected to share in their entirety in an intake interview. Ongoing engagement after the intake interview could provide opportunities for service practitioners to learn more about the residents. Information that residents are willing to disclose should be uploaded into SHIP and added to demographic datasets as well as kept in case notes.

Moving forward, we recommend:

1. The Queensland Government increases funding for and construction of social housing, and the Society continues to advocate for this.
2. The Society uses intake interviews as an opportunity to open conversations that are enveloped in empathic engagement and awareness of the contextual factors that underpin residents' experiences of homelessness, and ongoing efforts are made to continue to engage with residents' experiences throughout their stay.

Living at and leaving the Park

The findings regarding living at and leaving the Park have several key implications. First, they reinforce that residents entering the Park constitute a diverse group with various backgrounds and challenges. For some of these residents, having a safe place to stay even for just a few nights may be the only type of support they seek. For others, a case management approach with regular check-ins may be more appropriate. Given that residents' experiences and needs are highly versatile, a one-size-fits-all approach to service delivery is unlikely to be effective. The resident-led and individual-based approach adopted at the Park represents positive progress in homelessness service delivery, and is a solid foundation to build upon.

Second, the findings foreground the importance of developing practices that support and facilitate residents' sense of autonomy and volition. Residents spoke most positively about the Park when they felt they were being heard and respected, and when they felt supported to address their self-identified needs. This highlights the importance of adopting practices that enable service practitioners to walk alongside people who are living in poverty and who are living with the consequences and trauma of societal, familial, and structural failures.

Third, in conducting our analyses of the administrative data, we identified opportunities to improve the measurement and collection of existing data on resident outcomes. For example, there is currently no single definition of what constitutes a 'successful' resident outcome, and measures such as 'duration of need' and 'reasons for exit' do not adequately capture the realities faced by residents once they exit the Park. In addition, greater clarity on the reasons for resident exit is needed. In particular, the distinction between some of the exit categories such as 'resident no longer requested assistance' and 'resident's immediate needs met' remains unclear and increases the chances of reporting errors. Data reporting on the Park's practices and outcomes is stipulated through its Specialist Homelessness Services funding agreement. There are many opportunities for the data that is required to be collected to be improved so that it is more effectively able to measure if intended outcomes are achieved.

To address these issues, we recommend:

1. The Society recognises differences in residents' circumstances and ensures that staff have the resources and skills to provide flexible support to meet people's individual needs and circumstances.
2. The Society draws upon existing best-practice evidence to continue its development of reflective and resident-led practice.
3. The Society advocates for the national data to better identify outcomes, reasons for exit and housing/homelessness trajectories post exit. The latter will involve the Queensland Government making available administrative data sources that capture people's housing journeys, including journeys into social housing.

7. References

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