cohealth
care for all

Submission to:

Inquiry into Homelessness in Australia

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Contents

About cohealth

cohealth is one of Victoria's largest community health services, operating across nine local government areas in Victoria. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities.

A primary health service, cohealth provides integrated medical, dental, allied health, mental health and community support services. 950 staff over 34 sites provide these services, work directly with communities to understand their needs and develop responses, and deliver programs promoting community health and wellbeing.

Our service delivery model prioritises people who experience social disadvantage and are consequently marginalised from mainstream health and other services – people who have multiple health conditions, have a disability or mental illness, experience homelessness and unstable housing, those engaged in the criminal justice system, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, people who use alcohol and other drugs and LGBTIQ communities.

cohealth has had lengthy experience providing a range of health and other supports to people experiencing homeless. From sites in central Melbourne and the suburbs of Footscray, Collingwood, and Werribee, and via outreach, services are provided in the cities of Yarra, Melbourne, Maribyrnong, Brimbank and Wyndham.

Nearly 9 per cent of cohealth clients identify as experiencing insecure housing, a rate well in excess of the Australian rate of homelessness of 50 out of every 10,000 people (or 0.5 per cent).[1]

Our homelessness services offer a range of free primary health services for people experiencing of homelessness and or at risk of homelessness. With a strong interdisciplinary focus, they provide integrated service delivery designed to meet the complex care and support needs of clients who may not be able to seek support from mainstream social and health services.

cohealth's Central City Community Health Service (CCCHS), located in Melbourne's CBD, provides a range of person-centred, assertive outreach, wrap around health services including general practice, mental health outreach, alcohol and drug counselling, physiotherapy (including a specialist women's physiotherapy service), exercise physiology, podiatry, dietetics, nursing outreach (Bolton Clarke's Homeless Persons Program), family violence counselling and case management and homelessness case management and support. At CCCHS people experiencing homelessness can access showers, facilities for washing clothes, meal programs and other practical support.

cohealth also provides a number of programs to respond to the social isolation, stigma and long-term health outcomes faced by many people experiencing homelessness. These include the cohealth Kangaroos football and cricket team, gym programs and a psycho-social support service that aims to improve people's social connectedness.

Issues relating to housing and homelessness also touch many of the other programs cohealth provides. Our doctors, nurses, oral health and allied health programs, along with a

[1] https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services

diverse range of social support services - family violence, drug and alcohol, mental health, Aboriginal and Torres Strait Islander health, refugee health, child and family services – and our community building and health promotion activities all work with people who experience homelessness, insecure or poor housing.

In an innovative response to the housing crisis cohealth has partnered with housing provider Unison to develop a proposal to build social housing and a new community health centre at our inner-city site at 365 Hoddle Street Collingwood, Victoria. This ground-breaking project will bring low-cost health services for vulnerable people and much-needed social housing together under one roof. This project will give people a safe permanent home located close to GPs, nurses, pharmacy, counsellors, mental health practitioners and chronic disease specialists. We are currently exploring opportunities with governments and other funders to realise our vision. cohealth would be happy to provide the Committee with more information about the proposal upon request.

cohealth recognises that health – including mental health - is affected by many factors including social inclusion and participation, safety, education, housing, employment, and access to fresh food, and we are committed to addressing these underlying causes of health inequality. To this end, we work directly with people and in the community to design our services, and deliver advocacy, health promotion and education activities to improve health and connectedness.

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Executive summary

cohealth welcomes the opportunity to provide a submission to the *Inquiry into Homelessness in Australia* by the House of Representatives Standing Committee on Social Policy and Legal Affairs.

cohealth has had lengthy experience providing services to people experiencing homelessness. We provide services specifically designed to meet the needs of people who are homeless, along with working to ensure all our generalist services prioritise, and are welcoming to, people who experience homelessness.

Homelessness in Australia is growing, with more than 116,000 Australians homeless on any given night.[2] This is number grew 30 per cent between 2006 and 2016.[3] Our flagship homeless service – Central City Community Health Service (described below) – reflects this increase, with a 15 per cent increase in client numbers and a 30 per cent increase in the number of client support hours provided in 2018/19 alone.

People who are homeless experience significantly poorer health than other Australians. Life on the streets, in squats, couch surfing with family and friends and in rooming houses is deeply damaging both to people's physical and mental health.

Without access to appropriate, safe and secure accommodation, people are exposed to extreme temperatures, violence, unhygienic living conditions, greater contact with communicable disease and have little control over their living quarters or who they share them with.

The current coronavirus crisis has acutely highlighted this vulnerability of people experiencing homelessness. Whether they are sleeping rough, living in overcrowded dwellings, squats, emergency accommodation, couch surfing or in other precarious housing, the challenges they face during this time are immense. Self-isolation, hand washing and sanitising are next to impossible in these circumstances. Already living with a range of health conditions means that the risk of becoming infected is greater, as is the poorer health outcomes if they do. The consequences for the health of individuals, communities and to public health, have reinforced the critical need to take bold steps to eliminate homelessness.

Perversely, despite their greater health burden, people experiencing homelessness are less likely to access primary healthcare due to a range of social, physical and logistical barriers.

Improving the lives and achieving better health for people experiencing homelessness requires a multi-facetted approach that responds not just to individual health factors but also to the social structures and the systemic policies and practices that are so influential on health and wellbeing.

Key amongst this must be urgently addressing the acute shortage of secure, affordable and appropriate accommodation. There is now less federal funding for new social and

[2] https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services
[3] https://www.abs.gov.au/ausstats/abs@.nsf/lookup/2049.0Media%20Release12016

affordable housing than at any time over the last decade.[4] Significantly increasing the amount of social housing, along with policies and programs to increases access to, and sustain, secure homes in private rental will ensure many more Australians have a home of their own, and take pressure off the housing and other social support systems, enabling them to provide more targeted and specialised support to those with more complex needs.

Compounding this is the short-term nature and poor quality of much of the accommodation available for people in housing crisis. Private rooming houses, motels and caravan parks provide no tenure, can be unsafe and consume a large proportion of an income support payment.

People who are chronically homeless need wrap-around support that addresses all their needs.[5] An increase in the supply of affordable housing and specialist housing models that link accommodation and support is critical to reducing homelessness.

Housing is a fundamental human right, and Australia is party to a number of international human rights treaties asserting this. The International Covenant on Economic, Social and Cultural Rights recognises all persons' right to appropriate and suitable health care, adequate food and housing. Australia is also a party to the UN Convention Relating to the Status of Refugees, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Elimination of Racial Discrimination and is bound by the human rights principles contained in these instruments. The provisions of each of these treaties contain housing as a right.[6] It is high time that our policies and systems met these obligations and ensured that everyone has a home.

As a provider of health and social support services to people who experience homelessness, this submission will first explore the incidence and the health impacts of homelessness in Australia. We then respond the Terms of Reference that relate to our areas of experience and expertise:

2. Factors affecting the incidence of homelessness, including housing-market factors;
4. Opportunities for early intervention and prevention of homelessness;
5. Services to support people who are homeless or at risk of homelessness, including housing assistance, social housing, and specialist homelessness services;
6. Support and services for people at particular risk of homelessness;
10. Governance and funding arrangements in relation to housing and homelessness.

[4] http://theconversation.com/the-new-national-housing-agreement-wont-achieve-its-goals-without-enough-funding-99936
[5] Department of Families, Housing, Community Services and Indigenous Affairs (2008) *The road home: a national approach to reducing homelessness* White Paper https://apo.org.au/node/2882
[6] Liddy, N., Sanders, S., and Coleman, C. (2010) Australia's Hidden Homeless: Community-based options for asylum homelessness, Hotham Mission Asylum Seeker Project, Melbourne.

Recommendations

Recommendation 1

Services should implement policies and procedures to address barriers to access to healthcare by people who experience homelessness, such as ensuring that people who are homeless receive prioritised access to care, including same day appointments.

Recommendation 2

Improve access to GPs and nurse practitioners to reduce the need for hospital attendance, particularly those practitioners who have expertise working with people experiencing homelessness. Increasing funding to the Street Doctor program would enable expanded operating hours and locations.

Recommendation 3

Increase funding, and the flexibility of funding, to respond to the health needs of people experiencing homelessness who also have mental health and/or alcohol and drug issues.

Recommendation 4

Provide funding to provide services to reach out to vulnerable groups to support them through the assessment processes and the transition to NDIS and MAC supports.

Recommendation 5

The Federal Government create a taskforce on health equity, housing and homelessness to develop a national policy response in collaboration with State Governments, Primary Healthcare Networks and the community sector.

Recommendation 6

Develop a funding model that better reflects the costs of providing consultations in outreach locations.

Recommendation 7

Develop a National Housing Strategy to meet Australia's shortfall of 500,000 social and affordable homes.

Recommendation 8

That the rate of Newstart/Jobseeker Allowance, and related payments, be immediately increased to a liveable income level, by an amount that is in line with recommendations from ACOSS (the Australian Council of Social Service).

Recommendation 9

Increase the maximum rate of Rent Assistance by 30%, to provide immediate relief to renters on low incomes, and index the payment to ensure it reflects movements in rents.

Recommendation 10

The experiences of people with lived experience of homelessness and precarious housing, must be the central focus of all systems, policies and programs designed to respond to homelessness.

Recommendation 11

Take action to reduce stigma and discrimination against people experiencing homelessness, across a broad range of sectors and in the community.

Recommendation 12

Increase flexible supported housing approaches to ensure that:

- **People are able to establish and retain their housing.**
- **The housing and support needs of most vulnerable and marginalised clients, including those with alcohol and other drug or mental health issues, are met eg through increased Housing First programs and increased Transitional Housing stock.**

Recommendation 13

Governments and relevant institutions such as hospitals, mental health facilities and prisons make a commitment that no-one is discharged into homelessness or costly, insecure, substandard housing (such as unregulated rooming houses).

Recommendation 14

Significantly increase investment in programs that integrate housing and mental health and alcohol and drug support.

Recommendation 15

Ensure that income support, health care and social support is available to all people seeking asylum and refugees, regardless of their visa category.

Recommendation 16

Provide specific services to support people of refugee backgrounds to find and secure ongoing housing and to support them over a sufficient period of time to ensure that housing can be successfully maintained. Providing supports in community language, and by peer or bi-cultural workers, is essential.

Recommendation 17

Increase collaboration between family violence and housing/homelessness sectors to ensure more support is provided to women and children of refugee background.

Recommendation 18

Ensure that the needs of Supported Residential Services (SRS) residents are considered in responding to homelessness.

Recommendation 19

Improve the governance, accreditation and regulation of SRS's so that there are mechanisms to address the health and wellbeing needs of residents.

Recommendation 20

Invest in programs that enhance social and community connection through meaningful activities as part of an integrated plan to prevent and respond to homelessness.

Recommendation 21

Develop the knowledge of the workforce including through increasing the peer workforce and enhancing the education and awareness of health care practitioners about homelessness, including the physical and mental health needs of people who experience homelessness.

Recommendation 22

Governance arrangements need to ensure that outcomes and continuity of care are central priorities. Investment in robust impact and outcome measurement and evaluation is required, as are funding periods that are of sufficient duration to enable cycles of program development, evaluation and improvement.

1. The incidence of homelessness in Australia (Terms of Reference 1)

Everyone needs a stable, secure home as the basis for a good life. Secure, adequate housing is fundamental to the wellbeing of individuals and families.[7]

Sadly, for too many people the Australian housing market does not make this possible.

Over 116,000 Australians are homeless on any given night.[8] They include families with children, young people, older people, single adults, people with disabilities, people in regional and rural areas and people in urban neighbourhoods.[9] The number of people experiencing homelessness has risen dramatically in recent years, with a 30 per cent increase between 2006 and 2016.[10] Family violence is the single biggest driver of homelessness in Australia.[11] In Victoria 45 per cent of clients seeking help from Specialist Homelessness Services in 2018-19 had experienced domestic and family violence, up from 36 per cent in 2013-14.[12]

While the most visible form of homelessness is sleeping rough[13], the commonly accepted definition of homelessness extends to those who experience other forms of insecure, unsafe or inappropriate housing. Homelessness is about not having a home, and the sense of security, stability, privacy, safety, and the ability to control living space that comes from having a home. As such, homelessness not only includes sleeping rough (or in structures such as tents or cars) and emergency accommodation provided by homelessness services, but also staying temporarily with others but without tenure rights (eg couch surfing), in short-term housing arrangements without legal tenancy, in accommodation that lacks private facilities (eg many boarding or rooming houses and caravan parks) and in severely crowded dwellings.

This 'hidden homelessness' makes up the vast majority of homelessness, while people sleeping rough making up around 7 per cent of homelessness nationally.[14]

Over the five years to 2016-17 there was a 72 per cent increase in the number of clients sleeping rough when first seeking support from specialist homelessness services.[15] It is also widely understood that 'the longer people remain homeless, the more complex their social, emotional and health needs are likely to become'.[16]

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[7] Indeed, housing is considered a fundamental human right, with the Universal Declaration of Human Rights stating that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.'
[8] https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services
[9] https://chp.org.au/homelessness/homelessness-in-victoria/
[10] https://www.abs.gov.au/ausstats/abs@.nsf/lookup/2049.0Media%20Release12016
[11] Department of Families, Housing, Community Services and Indigenous Affairs (2008) *The road home: a national approach to reducing homelessness* White Paper https://apo.org.au/node/2882
[12] https://www.aihw.gov.au/reports/homelessness-services/shs-annual-report-18-19/data
[13] That is, the ABS homelessness category 'persons living in improvised dwellings, tents or sleeping out'.
[14] http://chp.org.au/homelessness/
[15] Victoria's Homelessness and Rough Sleeping Action Plan (2018) https://www.dhhs.vic.gov.au/sites/default/files/documents/201802/Rough%20Sleeping%20Action%20Plan_20180207.pdf
[16] City of Melbourne Street Count 2014 in Stevens, K (2018) Evaluation of the cohealth family violence casework/counselling service at central city

The Australian Homelessness Monitor 2018 ('the Monitor')[17] provides a thorough overview of the worsening state of homelessness in Australia. It finds that:

- Nationally, rough sleeping grew by 20 per cent in the five years to 2016. This was especially true in Melbourne where the 2016 City of Melbourne StreetCount showed numbers up by more than 200 per cent over this period.
- Homelessness service user data suggest that recent increases in overall homelessness have been substantially driven by rising numbers of (primarily) women in need of accommodation or other help due to domestic violence, the 'housing crisis' or 'housing affordability stress'.
- Older people in the 55-74 bracket were the fastest growing age cohort within the overall homeless population.
- The rate of Indigenous homelessness remained 10 times that of the non-Indigenous population, despite a fall in Indigenous homelessness of 9 per cent in the five years to 2016.
- The biggest increase in homelessness over the past few years is attributed to the growing problem of severe overcrowding. That is, people crammed into dwellings with at least four bedrooms fewer than required. The number of people in this situation grew by 23 per cent in the five years to 2016.

The experience of homelessness is different for everyone, and this has an impact on the types and levels of support they need. For example, housing provider Unison recently reviewed six years of data from their Initial Assessment and Planning (IAP) [18] service and found that there are four distinct patterns in the way households use IAP services.[19]

For some people, homelessness is an isolated event – it happens once and for a short time. 79 per cent of households accessing IAP presented once in a 12-month period. A significant majority of households who accessed IAP – 67 per cent - were in this category, had a single support period in a single year and did not return. A further 12 per cent of all households had multiple support periods but in one year only. This group would benefit from funding and programs aimed at sustaining tenancies.

A smaller number of households returned over a longer period. 11 per cent of households had single support periods in multiple years. 10 per cent of households returned in multiple years and had multiple support periods in those years. While these two groups accounted for 21 per cent of service users, they consumed nearly half of all the support periods (41 per cent) and support days (43 per cent).'[20]

For this minority, homelessness is part of a chaotic and uncertain life of poverty and disadvantage. These people tend to cycle in and out of homelessness and when they do

[17] Australian Homelessness Monitor 2018 https://www.launchhousing.org.au/site/wp-content/uploads/2018/05/LaunchHousing_AHM2018_Report.pdf
[18] IAPs are the 'front door' to the homelessness service system in Victoria, through which access to specialist support services occurs. Unison's IAP service is the front door for households seeking support in Melbourne's west, including parts of the CBD.
[19] Taylor, S. and Johnson, G. (2019) Service use patterns at a high-volume homelessness service: A longitudinal analysis of six years of administrative data. Unison Housing, Melbourne. https://unison.org.au/about-us/publications
[20] Taylor, S. and Johnson, G. (2019) Service use patterns at a high-volume homelessness service: A longitudinal analysis of six years of administrative data. Unison Housing, Melbourne. https://unison.org.au/about-us/publications

find housing, it tends to be short term, unsafe and costly. This group is highly vulnerable to chronic homelessness, stigma and poorer health outcomes.

2 Homelessness and health

2.1 Impact of homelessness on physical and mental health

'All basic needs are very difficult to sort out when you are sleeping rough'

Survey Respondent, Surviving the Streets Survey[21]

Secure, adequate housing is fundamental to the wellbeing of individuals and families.

Responses to homelessness most often, and understandably, focus on the pressing need to find accommodation and other basic necessities. However, homelessness also has profound impacts on physical and mental health.

We now also know how important safe and stable housing is for children's development and wellbeing. There is substantial and growing evidence of the impact of homelessness on children. The instability and chaotic nature of homelessness can have profound effects on a child's physical health, psychological development and academic achievement. A critical impact on children is disrupted schooling, which in turn can increase the risk of homelessness in adulthood.[22]

According to recent studies, homeless people experience significantly higher rates of death, disability and chronic illness than the general population, including:

- Reduced life expectancy. Research has found that homeless people and other socially excluded population groups living in high income countries had mortality rates around ten times that of the general population.[23]
- Poor dental health
- Eye problems
- Podiatry issues
- Infectious diseases
- Sexually transmitted diseases such as tuberculosis, hepatitis C and HIV infection
- Pneumonia
- Lack of preventive and routine health care
- Inappropriate use of medication
- Higher rates of mental illness[24]
- Substance use
- Chronic disease
- Musculoskeletal disorders

[21] Surviving the Streets Survey – Rough Sleeping Co-Design Project
[22] Department of Families, Housing, Community Services and Indigenous Affairs (2008) *The road home: a national approach to reducing homelessness* White Paper https://apo.org.au/node/2882
[23] Davies, A & Wood, Lisa (2018) Homeless health care: meeting the challenges of providing primary care, MJA (209) 5 3 September 2018 https://www.mja.com.au/journal/2018/209/5/homeless-health-care-meeting-challenges-providing-primary-care
[24] Department of Families, Housing, Community Services and Indigenous Affairs (2008) *The road home: a national approach to reducing homelessness* White Paper https://apo.org.au/node/2882

In a survey cohealth conducted with people with present or past experience of sleeping rough[25], respondents identified some specific impacts of homelessness on their health and wellbeing:

- Getting enough sleep, particularly quality sleep, was a significant issue for many. This has flow on effects on mood, physical and mental health, judgement and decision-making ability and ability to get along with people.
- Fatigue
- Anxiety
- Being 'run down'
- Exacerbation of physical and mental health conditions
- More vulnerable to colds and viruses, which are harder to recover from without proper sleep and safety

Experiencing homelessness both causes illness and exacerbates pre-existing health issues:

- Some health conditions can cause a person to become homeless. For example, poor physical or mental health can reduce a person's ability to find or maintain employment or earn an adequate income.
- Some health conditions are the consequence of homelessness, including depression, poor nutrition, poor dental health, substance abuse, mental health and other chronic diseases.
- Homelessness complicates the treatment of many health conditions. People experiencing homelessness have significantly less access to health services than the broader population. Reasons for this may include financial hardship, lack of transportation to medical facilities, lack of identification or Medicare Card, and difficulty maintaining appointments or treatment regimes.
- Ongoing uncertainty and stress about ability to meet the costs of housing (rent or mortgage) has a significant impact on mental health. [26]

In a 2011 study, researchers identified that a person's precarious housing also has a significant impact on their physical and mental health.[27] Precarious housing is that which is:

- unaffordable - high housing costs relative to income; and/or
- unsuitable - overcrowded and/or poor dwelling condition and/or unsafe and/or poorly located; and/or
- insecure - insecure tenure type and subject to forced moves.

The researchers found that:

- People in precarious housing had, on average, worse health than people who were not precariously housed. This relationship existed regardless of income, employment, education, occupation and other demographic factors.

[25] Surviving the Streets Survey – Rough Sleeping Co-Design Project
[26] Mallett, S, Bentley, R, Baker, E, Mason, K, Keys, D, Kolar, V & Krnjacki, L (2011). *Precarious housing and health inequalities: what are the links? Summary report*. Hanover Welfare Services, University of Melbourne, University of Adelaide, Melbourne City Mission, Australia. https://www.vichealth.vic.gov.au/media-and-resources/publications/precarious-housing-and-health-inequalities
[27] Mallett, S, et al 2011 *Precarious housing and health inequalities: what are the links? Summary report.* https://www.vichealth.vic.gov.au/~/media/resourcecentre/publicationsandresources/health%20inequalities/precarious%20housing/precarious%20housing_summary%20report_web.pdf?la=en

- The poorer people's housing, the poorer their mental health.
- The relationship between health and precarious housing is graded. As health mental or physical worsened, the likelihood of living in precarious housing increased.
- Poor health can lead to precarious housing. People with the worst mental or physical health were the most likely to be in precarious housing.

2.2 Barriers to accessing health care

'There is a lot of illness and health problems on the street - liver, brain etc illnesses but many people cannot get to a clinic on their own often due to trauma and they may have lost trust with medical workers due to experience in hospitals and with medical staff. Also being so exhausted and mental illness can prevent people from attending appointments with GPs. People often have low self-esteem after being on the streets and they have lost the knowledge of how to access medical care so just put up with the pain - even if cancer etc - they just accept that they will die as they don't think anyone would help them because they are homeless or they don't think they are able to go on the healing journey so there's no point to get an appointment. Keeping appointments is really hard for those on the streets. A GP bus would be great and would help people to get better and get back to a normal life.'

Survey Respondent, Surviving the Streets Survey[28]

Despite the poorer health experienced by people who are homeless, they face a range of barriers to accessing appropriate care when it is needed.

1. Meeting day-to-day needs takes precedence

'Visiting a GP is not a priority for people when we are sleeping rough as we are too busy managing safety, food and sleep - we are too exhausted and don't have enough [phone] credit to make appointments'

Survey Respondent, Surviving the Streets Survey[29]

Meeting the basic day-to-day needs such as finding a place to sleep, food to eat and safety are the main priorities for people who are homeless. Not knowing where you'll be sleeping week to week makes it difficult to plan ahead or prioritise anything other than where you'll sleep for the night or get your next meal.

Keeping appointments with Centrelink and housing services take precedence over the medical appointments. Without a home it is also hard to store and keep track of personal health information including immunisation records, Medicare and Health Care cards, hard copy referrals and other documents required for many health appointments.

[28] Surviving the Streets Survey – Rough Sleeping Co-Design Project
[29] Surviving the Streets Survey – Rough Sleeping Co-Design Project

2. Cost

Finding a GP who bulk bills can be difficult, particularly one who is welcoming and able to respond to the unique health problems of people experiencing homelessness.

Many GP clinics run on thin operating margins so don't bulk-bill, even for people with healthcare cards. Practices that do bulk bill low-income earners have to juggle financial viability, so rely on high patient volume and short consultation times. The complex health needs of people who are homeless can take longer than the base consultation time of seven minutes in the standard model of a bulk billing clinic.

Other costs that can be prohibitive for people experiencing homelessness include:

- Cost of transport to get to appointments
- Cost of prescribed and/or over the counter medications and other treatment requirements (such as dressings, bandages)
- Appointment based medical care. Medical clinics don't always bulk bill, and specialist care has out of pocket costs that are prohibitive for people who are homeless.

3. Practical barriers
    - Ability to be contacted for appointment reminders and follow up care is a barrier for people without an address, or who may lose or have their mobile phones stolen or have variable phone credit.
    - Loss of medication, identification, Medicare and Health Care Card when possessions are stolen or removed by authorities.
    - Inability to pay for out-of-pocket expenses due to the combination of low Centrelink payments (particularly Newstart – now Jobseeker - Allowance) and the high cost of temporary accommodation (which can be up to 85 per cent of Centrelink payments[30]).
    - Busy clinics and waiting areas are not welcoming. Often bulk billing medical clinics or hospitals are crowded, wait times are long and late attendance or poor past attendance often mean greater wait times. Environmental barriers such as sensory stimulation and long waits are real barriers for people experiencing homelessness.

4. Travelling to health, housing, Centrelink and material aid appointments is difficult when you're homeless

Travelling to multiple appointments across town via public transport is time consuming and costly. The transient nature of people who are experiencing homelessness often means that many of their services are spread across multiple localities. It requires planning and navigation, sometimes without a phone to let people know you're running late.

[30] Davies, A & Wood, L (2018) Homeless health care: meeting the challenges of providing primary care, MJA (209) 5 3 September 2018 https://www.mja.com.au/journal/2018/209/5/homeless-health-care-meeting-challenges-providing-primary-care

Sometimes people might have a phone, but no internet connection, mobile phone data or battery charge to enable them to access services and online travel guides such as public transport apps or Google maps.

Without secure accommodation people are also faced with the challenge of what to do with their belongings while are attending medical and other appointments.

5. Treatment plans often rely on a patient having safe accommodation

Many health conditions suffered by people experiencing homelessness are a direct result of their lack of housing, such as pneumonia during the winter months, arthritic joints, musculoskeletal problems from carrying their belongings around, gait and foot problems from prolonged walking, infected wounds from poor hygiene related to lack of showering facilities and clean clothing, diabetes exacerbated by poor diet and food insecurity, or a combination of these.

Clinicians can prescribe medication, provide dressings and outline regimes for the patient to undertake, but following through on those plans is hard if you don't have a private, clean, safe place to live, shower, store your belongings and wash your clothes and adequate facilities to prepare regular, healthy meals.

6. Experiences of stigma and judgement

People who experience homelessness may not feel welcomed or comfortable in generalist services. Previous experiences of being judged, or of stigma, contribute to people feeling reluctant to put themselves in a position where this may happen again. As a result, seeking medical care may be delayed.

Because of these systemic and logistical barriers to healthcare, many people who are homeless delay seeking medical help. As a result, there is excessive use of emergency departments for medical conditions that would be better managed in primary care, and chronic diseases are seen at an advanced stage when they require more extensive and expensive treatment.

The additional burden of work and costs on emergency departments and the acute care health services is substantial. Across Australia, people who are homeless are among the most frequent presenters to emergency departments. Their rate of unplanned hospital admissions is high, and their average stay is also longer.[31]

At the same time, when a person experiencing homelessness presents at a hospital service they can encounter further barriers. In emergency departments they may need to wait for many hours, unless they are in crisis, and may leave before receiving treatment. Similarly, referral to an outpatient clinic can involve lengthy waiting times – to receive an appointment, to see a doctor on the day, and for any surgery or procedures. These wait times themselves can be barriers, and people who are homeless may not receive letters or text message communication about appointment dates, and so miss them.

[31] Lisa Wood, Associate Professor, School of Population and Global Health, University of Western Australia http://theconversation.com/hospital-discharges-to-no-fixed-address-heres-a-much-better-way-106602

As a result, hospitals report to us that people experiencing homelessness have high fail-to-attend rates for post discharge outpatient appointments. Follow up care is therefore compromised, and their next presentation may be in a crisis when treatment has failed and/or their health has deteriorated. Discharge could be better supported, and health outcomes improved, if linked to the wrap-around support of a community health program that can provide intensive support to optimise the opportunity to enact treatment plans and stabilise health following a hospital presentation or admission. This may include, for example, facilitating assistance with medication management, attendance at GP or outpatient appointments, and housing support. The cohealth HOMHS program, described later in this submission, is an example of this approach.

These barriers also impact on the ability of people experiencing homelessness to access personal supports they may be eligible for – and need - through the National Disability Insurance Scheme (NDIS) or My Aged Care (MAC). Developing the trust with a service and/or worker that can assist people experiencing homelessness to link with the NDIS or MAC can take time, but this is not sufficiently resourced in these consumer-directed care funding arrangements. While cohealth fully supports the principles of consumer choice and control, the current model assumes a level of individual agency - language and other literacy skills, ability to navigate complex systems, understanding of available options, and capacity to self-advocate - that is often compromised within cohealth's consumer base. Greater funding is required to provide services to reach out to vulnerable groups to support them through the assessment processes, the transition to NDIS and MAC supports and to enable their community and economic participation and independent living.

Despite the poorer health of people who experience homelessness, the barriers they face accessing healthcare and the shared Federal and State responsibility for both housing and health there is no nationally consistent and coordinated response. As recommended by the Australian Alliance to End Homelessness the Federal Government should create a taskforce on health equity, housing and homelessness to develop a national policy response in collaboration with State Governments, Primary Healthcare Networks, the community sector[32] and people with lived experience of homelessness.

2.3 Improving health care access for people experiencing homelessness

'Just because you're homeless doesn't mean that you should feel like you can't walk into a mainstream service'

cohealth worker

Preventing illness and ill health by providing care earlier is key to improving health and relieving the pressure on hospital emergency departments. As described above, people experiencing homelessness may need longer consultation times, but the standard Medicare funding model does not provide the financial incentive for longer consultations and additional requirements of street outreach, such as setting up a mobile clinic. Developing a funding model to enable these longer consultations in outreach locations is critical to improving care. Options could include creating a specific Medicare item number for outreach care; or incorporating a component of block funding, in addition to Medicare

[32] https://aaeh.org.au/assets/docs/20200120-POLICY-PROPOSAL_Leaving-no-one-Behind.pdf

scheduled fees, to provide the foundation to more effectively treat people experiencing homelessness.

Hospital emergency and outpatient departments could help reduce these barriers, and address their poorer health, by prioritising access and coordinating the care of people experiencing homelessness.

Whatever the health care setting, professional development and training for health care professionals and customer service staff on working with people experiencing homelessness is critical to ensure that the complex physical and mental health conditions and the social circumstances of people experiencing homelessness are understood and to ensure services are welcoming for people experiencing homelessness and able to respond effectively to complex presentations.

Services which can provide prioritised access that is non-judgemental and person centred will more easily develop trust and this can reduce barriers for people experiencing homelessness. The prioritisation and care coordination of clients with complex needs, including mental health and/or alcohol and other drug issues would help meet the needs of this group. However, programs are constrained by insufficient and inflexible funding.

cohealth's Street Doctor program, providing assertive outreach to key locations across Melbourne's CBD and in the cities of Hobsons Bay and Yarra, and described later in this submission, demonstrates the positive health outcomes that accrue from providing a service tailored to the specific needs of people experiencing homelessness. Increasing funding to the Street Doctor program, currently operating two days per week in the CBD, to enable full time and after-hours operation, and expansion to other areas of Victoria where there are populations of people experiencing homelessness, would be a sound step towards improving health outcomes for this particularly disadvantaged group.

However, what will improve the health and well-being of homeless people the most is providing secure, affordable housing, and reducing poverty. The causes of homelessness are myriad, but the crux is a lack of affordable private housing and a critical shortage of social housing. While the benefits of the Street Doctor program, and other programs that address the barriers to healthcare faced by people experiencing homelessness, are clear – improving the health of homeless people, reducing the burden on hospital emergency departments and providing avenues for homeless people to access other services - the real benefits for homeless people will come with providing safe and secure housing and an adequate minimum basic income.

Recommendation 1

Services should implement policies and procedures to address barriers to access to healthcare by people who experience homelessness, such as ensuring that people who are homeless receive prioritised access to care, including same day appointments.

Recommendation 2

Improve access to GPs and nurse practitioners to reduce the need for hospital attendance, particularly those practitioners who have expertise working with people experiencing homelessness. Increasing funding to the Street Doctor program would enable expanded operating hours and locations.

Recommendation 3

Increase funding, and the flexibility of funding, to respond to the health needs of people experiencing homelessness who also have mental health and/or alcohol and drug issues.

Recommendation 4

Provide funding to provide services to reach out to vulnerable groups to support them through the assessment processes and the transition to NDIS and MAC supports.

Recommendation 5

The Federal Government create a taskforce on health equity, housing and homelessness to develop a national policy response in collaboration with State Governments, Primary Healthcare Networks and the community sector.

Recommendation 6

Develop a funding model that better reflects the costs of providing consultations in outreach locations.

3 Factors affecting the incidence of homelessness and housing overcrowding (Terms of Reference 2 and 3)

Boston Health Care for the Homeless Program 'street doctor' Dr Jim O'Connell describes homelessness as a prism that reveals the shortcomings in society.[33]

> 'Refracted in vivid colors are the weaknesses in each sector, especially housing, education, welfare, labor, health, and justice. Homelessness will never truly be abolished until our society addresses persistent poverty as the most powerful social determinant of health.'[34]

Similarly, in 2008 *The road home: a national approach to reducing homelessness* White Paper noted:

> 'Homelessness can be prevented by tackling the structural drivers of homelessness such as entrenched disadvantage, unemployment and the shortage of affordable housing; and targeting groups who are at risk of homelessness such as older people in housing stress, women and children leaving violence, Indigenous Australians and people leaving state care.'[35]

This combination of factors remains as relevant today as it was in 2008. However, in the intervening period rental properties have become significantly more expensive, and the gap between social housing demand and supply has widened even more.

3.1 Increasing affordable housing

'Just build more affordable housing'

Survey Respondent, Surviving the Streets Survey [36]

The single most effective solution to homelessness is an immediate and substantial increase in social and public housing. The lack of affordable housing, coupled with low incomes, is the key contributor to the dramatic increases in homelessness.

Australia has a huge shortfall of affordable housing, with a shortage of over 500,000 rental dwellings that are affordable and available to the lowest-income households.[37] In Victoria alone there are 82,000 people on the waiting list for public and community housing.[38] A lack of investment in social housing over many years has resulted in increasing unmet demand. Investment in social housing for people on the lowest incomes has shrunk from 5.6 per cent to 4.7 per cent of all housing over the past decade and a half.[39] There is now less federal funding for new social and affordable housing than at any time over the last

[33] https://harvardmagazine.com/2016/01/street-doctor
[34] *Dr Jim O'Connell Stories from the Shadows: Reflections of a Street Doctor*
[35] Department of Families, Housing, Community Services and Indigenous Affairs (2008) *The road home: a national approach to reducing homelessness* White Paper https://apo.org.au/node/2882
[36] Surviving the Streets Survey – Rough Sleeping Co-Design Project
[37] https://www.acoss.org.au/policy-priorities-for-the-next-govt-housing-homelessness/
[38] VCOSS A State of Wellbeing: 2020 Victorian Budget Submission http://www.vcoss.org.au/wellbeing2020/
[39] https://www.acoss.org.au/policy-priorities-for-the-next-govt-housing-homelessness/

decade.[40] Coupled with rapidly rising private rents in much of the country we have a situation where affordable, secure housing is out of reach for many individuals and families on low incomes.

The Australian Homelessness Monitor provides a thorough analysis of the many policies that have impacted on homelessness, including:

- Significant underinvestment in social and affordable housing over many years
- Increasing rates of poverty, particularly among those dependent on income support payments
- Escalating property prices and private rents due to favourable tax treatment
- Unfavourable housing market conditions that keep people locked out of housing

Policy decisions represent choices made by governments and as such can be changed.

As Anglicare's Rental Affordability Snapshot states 'Governments in Australia used to strongly invest in social housing to meet need. It was valued as a public asset for reducing poverty and inequality. But in recent years governments have withdrawn from this responsibility. Social housing stock has simply not kept pace with the growth in population'.[41]

Other research has concluded that governments can improve the mental health of economically vulnerable populations through more supportive housing policies.[42]

Despite our knowledge of the importance of stable, affordable housing, the current housing market has many well documented shortcomings – increasing homelessness, 1 in 9 people are paying more for housing than they can afford and rental properties in many areas are scarce, costly and too often of poor quality.[43] The stresses associated with the lack of housing and precarious housing are a significant contributor to mental ill health. Urgent action to increase crisis, social and affordable housing would go a long way to improving mental health across the community in general.

500,000 new social and affordable homes are needed to meet the current shortfall in these homes.[44] cohealth supports the call by the Everybody's Home campaign, backed by a wide range of civil society members, for the development of a National Housing Strategy to meet this need.[45]

At the same time that social housing stocks have been stagnating, private rents have been rising rapidly. To a significant extent this is due the favourable tax treatment provided to housing investment, which drives up the price of housing for everyone. Resetting housing

[40] http://theconversation.com/the-new-national-housing-agreement-wont-achieve-its-goals-without-enough-funding-99936
[41] Anglicare Australia Rental Affordability Snapshot 2019 https://www.anglicare.asn.au/research-advocacy/the-rental-affordability-snapshot/docs/default-source/default-document-library/final---rental-affordability-snapshot9d02da309d6962baacc1ff0000899bca
[42] Bentley, R et al 2016 'Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis' Housing Studies, Vol 31:2 pp 208-222 https://doi.org/10.1080/02673037.2015.1070796
[43] https://everybodyshome.com.au/our-campaign/more-social-and-affordable-homes/
[44] https://everybodyshome.com.au/our-campaign/more-social-and-affordable-homes/
[45] https://everybodyshome.com.au/our-campaign/more-social-and-affordable-homes/

taxation, by reducing negative gearing and capital gains tax exemptions, will deliver fairer housing outcomes and reduce private rents. The billions of dollars saved could be redirected to investment in social and affordable housing.

A lack of appropriate housing options can lead to acute hospital services being faced with a difficult choice when discharging patients – do they discharge someone into homelessness or inappropriate housing, or keep an acute bed occupied by someone when it may not be clinically required. For example, the number of Victorians who have exited mental health facilities into homelessness has grown by 65 per cent over the past five years.[46] At the same time, there are increasing accounts of people with complex needs staying in acute settings for lengthy periods of time due to the lack of appropriate supported housing.[47]

Similarly, a significant proportion of people leaving prison expect to be homeless on release. Research conducted by the Australian institute of Health and Wellbeing found that in 2018 54 per cent of people leaving prison expected to be homeless – staying in short term or crisis accommodation, sleeping rough or not knowing where they'd stay.[48] This is a significant increase from the 43 per cent who expected to be homeless on release from prison in 2012.

The best way to stop homelessness is to prevent people becoming homeless in the first place.

As Victoria's Homelessness and Rough Sleeping Action Plan[49] observes:

> 'To reduce the incidence and impacts of rough sleeping in Victoria, we must stop the flow of people into homelessness. This requires prevention across the Victorian community aimed at the causes of homelessness and rough sleeping – such as housing stress and family violence – as well as early intervention with those who are recently homeless and sleeping rough or who are at risk.'

While the Australian Homelessness Monitor observes that the causes of homelessness are complex 'and results from a variety of factors including structural, systemic and individual causes. For an individual, loss of suitable accommodation may result from the coincidence of several problematic life events although it may be triggered by a single catastrophic event'[50], the lack of affordable and secure housing lies at the heart of homelessness.

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[46] CHP 2018 *Victorian Homelessness Election Platform* https://chp.org.au/wp-content/uploads/2018/09/Victorian-Homelessness-Election-Platform-2018.pdf
[47] Perkins, M 2019 '"We are drowning": Sam doesn't have a mental illness, yet he's living in a psych ward' The Age https://www.theage.com.au/national/victoria/we-are-drowning-sam-doesn-t-have-mental-illness-yet-he-s-living-in-a-psych-ward-20190306-p5128a.html
[48] AIHW (2019) The health of Australia's prisoners 2018 https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents
[49] Victoria's Homelessness and Rough Sleeping Action Plan (2018) https://www.dhhs.vic.gov.au/sites/default/files/documents/201802/Rough%20Sleeping%20Action%20Plan_20180207.pdf
[50] Australian Homelessness Monitor 2018 https://www.launchhousing.org.au/site/wp-content/uploads/2018/05/LaunchHousing_AHM2018_Report.pdf

'[there needs to be] Less criticism of people sleeping rough - people need to know that people don't choose this situation and there are real reasons why people are sleeping rough. Sometimes people have gone through grief, lost their kids, feel suicidal.'

Survey Respondent, Surviving the Streets Survey [51]

3.2 Rent Assistance

In the meantime, an immediate 30% increase in Rent Assistance, in line with ACOSS recommendations, will provide some relief to people in private rental. Rent Assistance provides important assistance to low income residents of private rental housing but has failed to keep pace with steep increases in rents. Data also show that Rent Assistance payments do not come close to achieving affordable rents for many households with 42 per cent of households still in rental stress after receiving Rent Assistance.[52]

3.3 Income

'You don't live a life on the street, I don't smoke and I eat what I can afford. Money or being good with your money does not create a pathway out of homelessness. It is useless!!! No one can manage on Newstart it's such a small amount.'

'That's why we are homeless. Because you lose your job and are on Centrelink and then can't afford rent and other basic things'

Survey Respondents, Surviving the Streets Survey [53]

Low income is the other side of this equation. People reliant on income support payments face serious challenges in the private rental market. Indeed, when Anglicare Australia surveyed over 69,000 properties in April 2019 they found that Australia-wide there were just two properties that would be affordable for a single person without children on Newstart (and receiving Rent Assistance).[54] The appallingly low rate of Newstart Allowance (now renamed Jobseeker Allowance) exacerbates this problem. This payment is now so far below all poverty benchmarks that it works against the ability of people to seek work and contributes to homelessness, social isolation and marginalisation. Prior to the recent introduction of the Coronavirus Supplement the payment had not been increased for 26 years, despite significant increases in the cost of living – particularly housing – during this time.

In the *Surviving the Streets* survey cohealth conducted with people with present or past experience of sleeping rough[55], a common theme in responses was that the low rate of

[51] Surviving the Streets Survey – Rough Sleeping Co-Design Project
[52] ACOSS, Budget Priorities Statement: Federal Budget 2018-19 https://www.acoss.org.au/wp-content/uploads/2018/02/ACOSS-Budget-Priorities-Statement-2018-19_FINAL.pdf
[53] Surviving the Streets Survey – Rough Sleeping Co-Design Project
[54] Anglicare Australia (2019) 'Rental Affordability Snapshot 2019' https://www.anglicare.asn.au/research-advocacy/the-rental-affordability-snapshot/docs/default-source/default-document-library/final---rental-affordability-snapshot9d02da309d6962baacc1ff0000899bca
[55] Surviving the Streets Survey – Rough Sleeping Co-Design Project

Newstart was not enough for people to meet the costs of living, particularly the cost of rent. As one participant stated 'Newstart money is not enough to survive and pay rent.'[56]

It is now imperative that the rate of Newstart/Jobseeker Allowance is immediately increased on a permanent and ongoing basis.

The regular single rate of Jobseeker/Newstart is $278 per week – less than $40 per day. This is more than $100 per week below the poverty line, and less than 40 per cent of the minimum wage. Youth Allowance is even less.[57] Despite government claims that Newstart recipients receive other payments, the reality is that the only payment that all receive is the Energy Supplement, of $4.40 per week. Other payments, such as rent assistance and family payments are designed to meet additional expenses, such as the cost of raising children.[58]

People who are locked out of paid work find that the rate of Newstart Allowance is too low for them to afford essentials such as a roof over their head and food on the table. They must make difficult choices between eating a meal, paying a bill or maintaining their health. The many impacts of the low rate of Newstart Allowance have been thoroughly documented over many years by wide range of organisations and individuals, including by ACOSS, The Salvation Army, St Vincent de Paul Society and Anglicare, to name just a few. Common experiences include struggling to meet costs of housing, utilities, food and job search, going without meals, and children unable to participate in school and community life. It has also been recognised that the rate of Newstart is now so low that it hampers people's ability to seek employment.

This low rate of income support is a key driver of homelessness.

There is now broad support – from business and industry groups, community sector, unions and civil society - for the urgent increase in Newstart/Jobseeker payment. cohealth strongly supports these calls, recognising the benefits to the physical and mental wellbeing of individuals and families that will flow from such an overdue measure.

Recommendation 7

Develop a National Housing Strategy to meet Australia's shortfall of 500,000 social and affordable homes.

Recommendation 8

That the rate of Newstart/Jobseeker Allowance, and related payments, be immediately increased to a liveable income level, by an amount that is in line with recommendations from ACOSS (the Australian Council of Social Service).

[56] Surviving the Streets Survey – Rough Sleeping Co-Design Project
[57] ACOSS 2019, Survey of People on Newstart and Youth Allowance https://www.acoss.org.au/media-releases/?media_release=more-food-for-my-kids-replace-worn-through-clothing-keep-a-car-running-to-get-to-a-job-acoss-survey-shows-what-a-newstart-increase-wou
[58] https://raisetherate.org.au/wp-content/uploads/2019/05/What-payments-do-people-on-Newstart-get.pdf

Recommendation 9

Increase the maximum rate of Rent Assistance by 30%, to provide immediate relief to renters on low incomes, and index the payment to ensure it reflects movements in rents.

4 Opportunities for early intervention and prevention of homelessness (Terms of Reference 4)

Delivering services to people experiencing homelessness requires responses across the spectrum from preventing homelessness from occurring, intervening early to reduce the impact of homelessness and providing services that respond to the breadth of needs. At the same time, the systemic factors that contribute to homelessness and housing insecurity need much greater attention in order to prevent the circumstances and conditions that lead to homelessness.

Responses must be re-oriented to focus on preventing homelessness, rather than waiting until there is a crisis. Until there is an increase in secure and affordable housing we will continue to have the situation where there are no long-term housing options for people should they encounter housing problems. This also creates bottlenecks in the system where people are unable to access emergency accommodation when its needed, or they cycle between precarious housing and emergency accommodation.

All responses to homelessness should be underpinned by a common set of guiding principles.

First and foremost, the experiences of people with present or past experience of homelessness and precarious housing must be the central focus of all systems, policies and programs designed to reduce homelessness and provide supports and services. Program and service design should be co-designed with consumers to ensure they provide the most appropriate and effective responses.

Other essential principles that should underpin all homelessness responses include:

- Human rights – from safe and available housing, to having individual views and choices respected, to being treated with dignity and respect.
- Cultural safety and appropriateness - cultural safety can be defined as 'an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need.'[59]
- Trauma informed – evidence indicates that trauma can be both a cause of homelessness and result from the experience of homelessness. The majority of people using cohealth homeless services report a history of trauma from early childhood including neglect, physical and sexual abuse and limited education. Family violence is a common experience for women, and both men and women experience violence when sleeping rough, or in boarding houses, crisis accommodation and other precarious housing. Other clients have been involved with the criminal justice system. Acknowledging the relationship with past events and trauma is critical in responding effectively to homelessness.
- Recovery based
- Person centred

[59] Williams, R 'Cultural Safety – What does it mean for our work practice?' https://www.researchgate.net/publication/12967462_Cultural_safety_-_What_does_it_mean_for_our_work_practice

- Holistic approach with wrap around support - where a person's housing situation is considered as part of the whole person, including physical and mental health, family commitments, social connections, participation in work, study and volunteering.

Recommendation 10

The experiences of people with lived experience of homelessness and precarious housing, must be the central focus of all systems, policies and programs designed to respond to homelessness.

4.1 Key approaches to prevention and intervention

1. Significant increases in social and public housing to provide homes that are affordable and secure.

   The single most effective response is to urgently increase the amount of affordable and secure housing in Australia.

   500,000 new social and affordable homes are needed to meet the current shortfall in these homes.[60]

2. Support to assist people to retain rental tenancies, across the public, community and private rental sectors. A change in circumstances, such as illness, loss of job, or relationship breakdown can lead to difficulties paying rent or mortgage and precipitate a housing crisis. Programs providing assistance at these times to help people maintain their housing and their connection with community will have significant cost savings for individuals, family and government.

   Support can include assistance with rent arrears, legal advice, assistance with negotiating with landlords or short-term case management, and ensure that setbacks don't become crises. Currently there are programs that provide these supports (in Victoria these include Tenancy Plus and the Private Rental Assistance Program[61]), however they are under resourced and often unable to provide the assistance needed to prevent a housing crisis or singles and families becoming homeless. This under-resourcing has implications for services such as cohealth which are not housing specialists but nonetheless need to respond to requests for support and advocate for clients, reducing our capacity to meet other needs.

   Many people will require only a small amount of assistance to ensure they retain their home, leading to significant benefits to them, and cost savings to the government.[62] Increased access to these support services will prevent homelessness and deliver significant benefits to the community.

[60] https://everybodyshome.com.au/our-campaign/more-social-and-affordable-homes/
[61] CHP 2018 *Victorian Homelessness Election Platform* https://chp.org.au/wp-content/uploads/2018/09/Victorian-Homelessness-Election-Platform-2018.pdf
[62] Launch Housing (2019) Housing is good for mental health care Appendix 8 https://www.launchhousing.org.au/housing-is-good-mental-healthcare/

VCOSS, the Victorian Council of Social Services, described this well in their 2019 Victorian pre-budget submission.[63] While referring to actions the Victorian government should take, the principles also apply nationally.

> 'Victoria can better prevent people becoming homeless by funding more homelessness prevention services and improving the alignment and integration of the existing services.
>
> A better service system could assess a person's needs, and combine legal assistance, financial counselling and emergency financial relief, flexible funding packages, negotiation with landlords and real estate agents to save tenancies, and links to other social supports, regardless of whether they were in public, community or private housing.
>
> As things stand, there is a hodgepodge of under-funded, narrow and disconnected homelessness prevention programs. The help people get depends strongly on where they turn. For instance, Tenancy Plus helps save public and social housing tenants from eviction, whereas the Tenant Assistance and Advocacy Program helps in the private sector. Other services respond where they can: community legal centres may fight evictions, financial counsellors or emergency relief services might deal with rent arrears, or people might access Private Rental Assistance.
>
> Flexible support means combining legal, social and financial responses, wherever people live. The Victorian Government can fight homelessness with a clear, integrated, multi-disciplinary and properly funded homelessness prevention program.'

4.2 Addressing stigma and discrimination

'It can be very difficult to go to things as I feel like people will judge me or do something to me. I feel shame about being homeless and going to the places I would like to go to.'

Survey Respondent, Surviving the Streets Survey[64]

Despite the multitude of challenges faced by people experiencing homelessness, and the complex, trauma related contributors to homelessness, cohealth has observed that the people using our homeless services have real strengths and resilience. As a cohealth worker observed:

> 'People who experience homelessness have a diversity of past experiences including complex trauma with a range of ways this impacts on their lives. Despite this many have the courage to survive and move forward by engaging with services to work for something better. It is an honour to share with an individual their story, which always highlights their resilience and strength. This is particularly evident when the systems are

[63] VCOSS 2019 *Delivering Fairness: 2019 VCOSS Budget Submission* https://vcoss.org.au/delivering-fairness/a-safe-place-to-call-home/
[64] Surviving the Streets Survey – Rough Sleeper Project

> so complex and they're surviving in an environment where the political and social structures have caused and are keeping them in homelessness.'

However, people experiencing homelessness face persistent stigma and discrimination in a range of contexts.[65] This can occur in access to health care, as discussed earlier, and in the attitudes of members of public and service providers. As the Australian Human Rights Commission notes, discrimination against homeless people can also occur where certain laws operate in a manner that disadvantages them, compared to other members of the community, such as laws that criminalise certain activities in public places.[66]

At the same time some groups in the community experience stigma and discrimination on the basis of other characteristics, which can contribute to increasing their risk of homelessness. For example, in the private rental market single parents, people of refugee backgrounds, people with disabilities and Aboriginal and Torres Strait Islander people all report that they believe their lack of success securing tenancies is due to their personal characteristic, not whether they can pay the rent or care for the property. [67]

Emerging evidence indicates that stigma and discrimination are fundamental causes of health inequalities.[68] Stigma directly influences the physical and mental health outcomes of people with specific characteristics (eg their race, sexuality or gender identity, or particular illness). Stigma and discrimination also limits or disrupts access to the structural, interpersonal and psychological resources that could otherwise be used by individuals or communities to improve health. People experiencing stigma may not seek care if they perceive providers to be unwelcoming or unsafe. Health systems may not provide the same level of care to particular groups due to inappropriate assumptions made about their health and behaviour.

Actions to reduce stigma and discrimination need to be part of responses to homelessness and will contribute to improving the physical and mental health of people experiencing homelessness.

Recommendation 11

Take action to reduce stigma and discrimination against people experiencing homelessness, across a broad range of sectors and in the community.

[65] HR&EOC 2008 Homelessness is a Human Rights Issue https://www.humanrights.gov.au/our-work/homelessness-human-rights-issue-2008#6_7
[66] HR&EOC 2008 Homelessness is a Human Rights Issue https://www.humanrights.gov.au/our-work/homelessness-human-rights-issue-2008#6_7
[67] Choice, National Shelter & NATO, 2017 *Unsettled: Life in Australia's private rental market* *http://tutas.org.au/wp-content/uploads/2017/02/The-Australian-Rental-Market-Report-2017.pdf*
[68] Hatzenbuehler, M, Phelan, J & Link, B 2013 'Stigma as a fundamental cause of population health inequalities' American Journal of Public Health Vol 103 (5) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682466/

5 Services to support people who are homeless or at risk of homelessness (Terms of Reference 5)

5.1 A range of housing and support options are needed

A variety of different housing options are required to respond to the differing circumstances of those who are experiencing or at risk of homelessness. Many people will need little or no assistance accessing housing – if the stock of affordable housing increases – while at the other end of the spectrum people with complex psychosocial support needs may need intensive, ongoing support. Contributions to this inquiry from other organisations will provide more detail about the various housing options required to address homelessness and respond to the varying support needs of different groups experiencing homelessness. In summary, these approaches include:

1. Flexible supported housing for people with more complex personal, health or housing circumstances, that is proportionate to their needs.

    a. Some people need more intensive support, and for a longer period of time, due the complexity of their circumstances. Specialist housing models that link accommodation and case management or goal-directed support in relation to mental health, family violence, disability and alcohol and drugs, for example, should all be mindful of the housing circumstances of individuals and families and be able to provide support to maintain housing.

    In Victoria Transitional Housing (THM) is a valuable part of the housing system for people who are more vulnerable or have complex needs. Transitional Housing properties are those people can stay in while they are waiting for a safe, secure long-term housing option in social housing or private rental. Support services, such as cohealth, work in partnership with housing providers to achieve successful tenancy outcomes for clients by working with them to establish the tenancy, work on daily living skills, community participation and prepare them for permanent tenancies.

    b. Permanent supportive housing, also known as Housing First approaches, ensures the provision of ongoing, long-term housing coupled with supportive services for individuals and families experiencing chronic homelessness.

    Australian and international evidence strongly supports the Housing First approach as the most effective way to achieve housing stability and improved wellbeing for people with histories of chronic homelessness.[69] Housing First approaches quickly move people with complex needs experiencing chronic homelessness into permanent housing with flexible and individual support for as long as needed. Assertive outreach, intensive case management and multidisciplinary supports assist individuals to establish and maintain their homes for the long term.

[69] CHP 2018 *Housing First: Permanent Supportive Housing* https://chp.org.au/policy/policy-updates/

Once permanent housing is secured, individuals can more easily build support and health services around them. Ideally these supports should share goals in ensuring stable tenancies and be flexible to individual needs as circumstances change over time.

Access to housing and resourcing for integrated, long term support is required for these approaches to be successful.

2. Tailored options to respond to the specific needs of particular groups in the community, including:
    - Aboriginal and Torres Straight Islanders
    - Young people
    - Women and children escaping family violence
    - People who are refugees or seeking asylum
    - People leaving prison
    - Young people leaving out-of-home care
    - People with mental illness and/or who use alcohol and other drugs

3. Information about rights and responsibilities. The *Surviving the Streets* project conducted with people with present or past experience of sleeping rough identified the lack of clear, accurate and consistent information on rights and responsibilities as a key issue. Participants identified that without accurate, clear and consistent information it is impossible to make good decisions about their life and how to conduct themselves. An outcome of this project has been a small series of tailored information resources. Information about rights and responsibilities, in addition to services and supports, needs to be available in a variety of formats to meet the different needs of various groups.

Recommendation 12

Increase flexible supported housing approaches to ensure that:

- **People are able to establish and retain their housing.**
- **The housing and support needs of most vulnerable and marginalised clients, including those with alcohol and other drug or mental health issues, are met eg through increased Housing First programs and increased Transitional Housing stock.**

5.2 Improving access to health services

'We need more GPs with a real heart that will work with homeless people and will be accepting of the things that homeless people cannot meet. They should also have a social worker on the bus that could talk to people accessing the GP - they could assist with housing right there and then on the street in the bus while person accessing GP - this would be better than suggesting to homeless people to go to housing services themselves.'

Survey Respondent, Surviving the Streets Survey[70]

As described earlier, the health needs of people experiencing homelessness are significant. To respond to the needs of people experiencing homelessness, including those who experience mental illness and/or use alcohol or other drugs, cohealth has developed a range of responses. Key to responding effectively is basing responses on the guiding principles outlined above – including using a person centred, trauma informed, recovery-oriented approach – in which integrated responses are provided by a range of services.

Our experience indicates other features of services that are essential to ensure they meet the needs of all those who need them, and, particularly, are accessible to those with the most complex needs.

These features include:

- Assertive outreach. Taking services, information and support to where people are, rather than expecting them to attend centre-based services
- Flexibility to respond to individual circumstances, needs and preferences
- Integration with other services – one stop shop
- Goal directed. Listening to the changes individuals want to make in their lives, giving them choice and ensuing they are the leaders in their care
- Recognising the importance of being able to meet immediate needs, while providing or linking in with longer term support and assistance
- Responding to the cost barriers facing people experiencing homelessness

5.2.a Central City Community Health Service

Central City Community Health Centre (CCCHS) has been providing centrally located community health services to people who are homeless or at risk of becoming homeless since 2012. A partnership between the City of Melbourne and cohealth, CCCHS aims to alleviate homelessness, address the health needs and improve the quality of life of people who are homeless or at risk of becoming homeless.

This is achieved through providing a primary health care response via assertive outreach activities and flexible centre-based services. CCCHS seeks to be welcoming and responsive to the needs of people who are homeless or at risk of becoming homeless. The CCCHS service is underpinned by a social model of health, co-ordination of health, welfare and housing services and sector advocacy.

Effectively meeting the needs of people with complex health and social support needs requires services to work in close partnership with others, developing innovative

[70] Surviving the Streets Survey – Rough Sleeper Project

approaches to engage and work with individuals, families and communities. Service integration and coordination is well recognised, and a government policy aim, to meet these needs, and a fundamental philosophy of community health services.

One of the key principles of CCCHS is the importance of partnerships and co-located service delivery. A wide variety of integrated services are provided by the suite of agencies working at CCCHS to respond to the physical and mental health needs of people experiencing homelessness, and to address the social isolation and exclusion they experience. Agencies that operated from CCCHS during 2017/2018 included cohealth, Bolton Clarke (previously Royal District Nursing Service) Homeless Persons Program, Justice Connect, Inner West Mental Health Services, McAuley Women's Service, Launch Housing, Council to Homeless Persons and the Royal College of Optometry. These integrated, wrap around services respond to the complex health and social support needs of people experiencing homelessness.

People are welcome to drop in, use the facilities and find out about a range of specialist clinics on offer from cohealth and other health and support services provided in this non-judgmental setting.

Outreach services provide services where people are living, including parks, bridges, streets, car parks, squats, rooming houses, at places where people spend time, such as breakfast programs and recreation centres and at other services that clients may be accessing. These include allied health - physiotherapy, exercise physiology, dietetics, occupational therapy, podiatry and social work - along with GP and nursing.

Onsite services include GP, nursing and allied health along with mental health, alcohol and drug counselling, family violence counsellor/case worker, legal service, homelessness and community support worker, victims of crime program. Sport programs promote community inclusion. Clients can also access tea and coffee, storage, laundry and shower facilities on site.

People with lived experience are employed in positions that support all aspects of service delivery. This is achieved by employing people who have first-hand experience of homelessness into positions that support their involvement in team meetings, client allocation, on assertive outreach activities and supporting the implementation of individual client-centred goal-directed care plans.

5.2.b Street Doctor

The cohealth Street Doctor uses a mobile clinic bus to provide an assertive outreach medical clinic to respond to the complex health needs of people experiencing homelessness across Inner and Western Melbourne. The Street Doctor team of a GP, nurse and social worker provide medical and social services to address many of the barriers to healthcare experienced by people who are homeless and make healthcare much more accessible for homeless clients who often have complex health needs.

Street Doctor regularly visits sites where people experiencing homelessness meet, and other services are provided. Sites visited include St. Marks Community Centre (Fitzroy),

Hamodava Café (Project 614 in the CBD), Open Door, Flagstaff (North Melbourne), the over 55s McIntyre Drive – Unison Housing Development (Altona), the Paisley Park Housing Estate (Altona North) and Honey Hush Caravan Park (Laverton).

The Street Doctor service offers clinical assessment, blood tests, immunisations and wound care, and includes writing scripts, providing radiology referrals and preparing mental health care plans. In general, outreach health services to people experiencing homelessness are provided by nurses. GP involvement ensures that many additional services can be provided at the time the patient presents, to ensure their immediate needs can be met in a timely way.

In the first instance the goal of the program is to address the client's immediate health concerns, self-identified through completion of a brief form and/or assessment by health professional.

Underlying chronic and other health issues are identified and addressed where possible. This includes supporting access to standard screening for cancer, sexual health and other health issues providing access to key treatments such as for Hepatitis C and relevant vaccinations (including Hepatitis B) and providing linkages to key supports and services.

Once the client's initial health care needs have been addressed, where the client is engaged and willing, goal directed care planning is used to support the client to identify and develop strategies to improve their quality life including linking to services that can help them access housing.

The flexible, non-judgmental and person centred approach of the service model helps overcome the health care barriers, including stigma, faced by people experiencing homelessness and enables them to develop trust with the health providers. The Street Doctor also aims to improve health literacy and actively works to engage people so they feel more comfortable and confident accessing on site health services at cohealth and elsewhere.

The key outcomes of the Street Doctor project are that people experiencing homelessness receive necessary intervention to improve their health, are better able to manage their chronic and complex health issues, are better linked into key health and welfare services, have increased health literacy and live healthier, longer lives. The project also aims to increase the capacity of the local service sector to meet the needs of people experiencing homelessness.

5.2.c Homeless Outreach Mental Health Service

cohealth is a key partner in the Homeless Outreach Mental Health Service (HOMHS), which responds to clients with intersecting homelessness and mental illness needs. HOMHS demonstrates the importance of multi-disciplinary teams working in partnership to provide integrated supports to consumers.

The service is located at CCCHS and offers intensive clinical and community mental health care and case management to people with severe and enduring mental illness and a history of chronic homelessness. cohealth, as the lead agency, established the program in partnership with three agencies: Inner West Area Mental Health Service who

provide clinical mental health services; Launch Housing who provide links to stable and affordable housing; and McAuley Community Services for Women which provided specialist skills in engaging the growing number of women experiencing homelessness and embedded this capacity with the program delivery. The HOMHS interagency multidisciplinary team offers assessment, integrated clinical treatment, recovery support, housing support and care coordination, scaled in intensity to meet each client's needs, values and goals.

Through this interdisciplinary and multi-agency approach, HOMHS improves access for clients to mental health services, housing support – including stabilising housing - physical health care, and practical assistance. Examples of positive outcomes from the program include: 86 per cent of clients who were placed in stable housing have maintained it long term; 46 per cent were linked to a GP where they previously weren't; and there was a 42 per cent reduction in emergency department admissions.[71] The program's success in improving health and wellbeing lies in the intensive support provided to clients, combined with the joint clinical and community mental health supports and other support structures, including housing services.

[71] Liptrot, G, Pruden, D, Pollins A, Parkin, L & Alexander, D (2018) *Working together: Homeless Outreach Mental Health and Housing Service (HOMHS,)* Parity, Council to Homeless Persons Dec 2018

6 Support and Services for people at particular risk of homelessness (Terms of Reference 6)

6.1 Women experiencing family violence

The cohealth Homelessness Family Violence (HVF) service fills a gap in the homelessness and family violence service systems by locating a specialist family violence service within CCCHS.

The HFV service offers access to a new model of trauma-informed therapeutic casework embedded within a homelessness service to women experiencing issues of family violence and homelessness. It aims to address the client's immediate needs and intertwines casework with brief opportunistic counselling, risk assessment and risk planning to improve their safety. Key principles of the program are providing easy access to the HFV for women and being flexible and responsive. Providing drop-in capacity, flexible service delivery and avoiding waiting lists are all key features of the model. As such, the program is more responsive to women experiencing both homelessness and family violence than most homelessness or specialist family violence services.

CCCHS have observed that family violence and homelessness services are not well integrated despite the client's experiences of homelessness and family violence being intricately intertwined - family violence leading to homelessness and homelessness leading to family violence. One worker reflected that 'traditional family violence services don't know what to do with homeless clients.' Staff value having someone who understands the complexity of homelessness and women sleeping rough as well as having family violence expertise.

> *'It's really helpful to have someone who is focusing on this particular cohort because the reality for these women, particularly if rough sleeping, is that it's hard enough for women in stable though unsafe situations to access family violence services but the women that we see absolutely fall through the cracks of most services because they are harder to reach.'* CCCHS worker[72]

Offering the HFV service within a primary health and homelessness service with a multidisciplinary team approach, streamlined access to the Homelessness Family Violence Casework/Counsellor (HFVCC), the capacity to provide a flexible and responsive service and the model of trauma informed therapeutic casework that attends to both practical needs as well as physical and emotional health issues has made a difference for clients.

cohealth staff at CCCHS and staff from external agencies have identified a range of benefits flowing from co-locating the HFV service at the site:

- Increased confidence raising family violence issues with clients
- Provision of secondary consultation to assist in safety planning and risk assessment
- Support navigating the FV and housing service systems
- Clients get a clearer picture of the options available to them
- Direct access to the HFV casework/counsellor enables a collaborative and holistic response to clients with complex needs

[72] Stevens, K (2018) *Evaluation of the cohealth family violence casework/counselling service at city central*

- Increased knowledge of client's rights
- Capacity to make a warm referral to a known person with the confidence they will respond quickly and appropriately
- Reassurance that all is being done to improve safety
- The completion and implementation of joint client centred goal directed care plans
- Provision of up to date information about changes in the specialist family violence system

In an evaluation of the HFV service staff observed that having the HFVCC work collaboratively as part of a team was a safer and more responsive way to holistically understand and respond to clients with complex needs. While workers in the Homelessness Community Support Team were experienced in assessing risks and safety planning with clients, they reported that they saved time and that clients had faster outcomes as a consequence of working collaboratively with the HFVCC. The HFVCC's specialised and up to date knowledge of family violence services meant that less time was needed to navigate referral pathways and advocate for clients with other specialised family violence services.

6.2 Aboriginal and Torres Strait Islanders

Historically Aboriginal and Torres Strait Islander people have experienced much higher rates of homelessness than non-indigenous Australians. While the rate of homelessness amongst Aboriginal and Torres Strait Islanders has seen a welcome decline in recent years – from 571 per 10,000 population in 2006 to 361 in 2016 – the rate of homelessness rate is still 10 times that of non-Indigenous Australians.[73] The ongoing impacts of colonisation, dispossession, the Stolen Generation and discrimination have all contributed to this higher rate of homelessness.

cohealth supports the principles of self-determination and central role that Aboriginal controlled organisations must have in leading activities to prevent and respond to homelessness among Aboriginal and Torres Strait Islander peoples. At the same time, all organisations working in the area of homelessness must be accessible to Aboriginal and Torres Strait Islander people. Organisations need to be culturally safe – 'an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need.'[74]

[73] https://www.aihw.gov.au/reports/housing-assistance/indigenous-people-focus-housing-homelessness/contents/summary
[74] Williams, R 'Cultural Safety – What does it mean for our work practice?' https://www.researchgate.net/publication/12967462_Cultural_safety_-_What_does_it_mean_for_our_work_practice

6.3 People leaving institutions

Too many people are leaving our institutions without housing having been secured – in effect being discharged from a physical or mental health facility, prison or youth justice facility into homelessness.

Disturbingly, the Council to Homeless Persons in Victoria report a 65 per cent increase over the past five years of Victorians being discharged from mental health facilities into homelessness.[75] In addition to the hardships inherent with homelessness, follow up care and ongoing treatment for mental ill health is significantly harder. People with complex needs, such as mental illness, substance use, disability and a history of trauma too often cycle between homelessness and tertiary services such as emergency departments, acute mental health care and justice systems. At times they may stay longer in hospital than clinically needed, rather than be discharged into homelessness. The Council to Homeless Persons identifies an effective model that addresses both housing and the support to gain and sustain that housing – the approach known as Housing First or permanent supported housing, described earlier.[76]

The Productivity Commission in its recent Draft Report on Mental Health has recognised this problem, and recommends that 'Each State and Territory Government, with support from the Australian Government, should commit to a nationally consistent formal policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and prisons.'[77] This principle should apply to all people, regardless of the type of institution they are leaving, and whether they have a mental illness or other attribute.

Recommendation 13

Governments and relevant institutions such as hospitals, mental health facilities and prisons make a commitment that no-one is discharged into homelessness or costly, insecure, substandard housing (such as unregulated rooming houses).

6.4 People over 55 years of age

Older Australians, particularly women, are increasingly at risk of homelessness. One in every seven people homeless at the last Census was over 55, and the proportion of homeless people aged 65 to 74 years old jumped almost 40 per cent in the five years to 2016.[78] This was the fastest growing age cohort within the overall homeless population.

Life shocks such health problems, relationship breakdowns, deaths in the family and rental evictions are among the key factors leaving lifelong renters and property owners homeless

[75] CHP 2018 *Victorian Homelessness Election Platform* https://chp.org.au/wp-content/uploads/2018/09/Victorian-Homelessness-Election-Platform-2018.pdf
[76] CHP *Ending chronic homelessness: A permanent supportive housing solution* http://chp.org.au/wp-content/uploads/2017/07/170707-permanent-supportive-housing-FINAL-1.pdf
[77] https://www.pc.gov.au/inquiries/current/mental-health/draft
[78] Thredgold, C., Beer, A., Zufferey, C., Peters, A. and Spinney, A. (2019) An effective homelessness services system for older Australians, AHURI Final Report 322, Australian Housing and Urban Research Institute Limited, Melbourne, http://www.ahuri.edu.au/research/final-reports/322 , doi: 10.18408/ahuri-3219301.

in later years. [79] Women who have spent a lifetime in low paid or unpaid caring roles and have few financial resources to draw on are highly vulnerable, particularly those who have experienced family violence.

Many people experiencing homelessness later in life have limited knowledge of welfare services and support systems. They may need particular assistance in navigating these systems. In addition to need to increase the supply and range of affordable housing options and address the low incomes of people reliant on income support, referred to earlier, solutions that cater for the particular needs of older people are also required. These include supports to enable people to age in place, supported accommodation models for older people with more complex needs and specific residential aged care facilities that can provide intensive supports to the formerly homeless.

6.5 People with mental illness and/or who use alcohol and other drugs

Contrary to common perceptions, mental illness or alcohol and other drug use are not the cause of homelessness for the vast majority of people experiencing homelessness. However, the experience of homelessness can contribute to people developing mental ill health and/or starting to use alcohol and other drugs. Research has also demonstrated that housing insecurity both causes and exacerbates mental ill health, with a Victorian study finding that just 15 per cent of people accessing specialist homelessness services had a mental illness prior to homelessness, while another 16 per cent developed mental ill health after their experience of homelessness commenced. [80] As a result, the rate of mental illness among people experiencing housing crisis is significantly higher than that of the general population, with one third of people presenting to Specialist Homelessness Services in 2017-18 having a current mental health issue, compared to 20 per cent in the general population.[81]

Similarly, research from homelessness services in Melbourne showed that 43 per cent of the homeless population reported that they had alcohol and other drug use problems. Of these, one-third reported that they had these problems prior to becoming homeless, with the remaining two-thirds reporting that they developed problems with alcohol and other drugs following homelessness. [82]

Even higher rates of homelessness are experienced by people who have both mental health and substance use conditions (often referred to as dual diagnosis).[83] The co-occurrence of these conditions can add complexity to engagement, assessment, treatment and recovery.

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[79] https://www.ahuri.edu.au/research/final-reports/322
[80] Council to Homeless Persons 2019 Submission to the Royal Commission into Mental Health https://chp.org.au/wp-content/uploads/2019/07/190628-FINAL-CHP-submission-to-the-Royal-Commission-into-Victorias-Mental-Health-System.pdf
[81] Australian Institute of Health and Welfare 2019. Mental health services in brief 2019. https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-in-brief-2019/related-material
[82] AIHW 2020 Alcohol, tobacco & other drugs in Australia https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/homeless-people
[83] https://adf.org.au/insights/what-is-dual-diagnosis/

As the joint submission by Mental Health Victoria and the Victorian Healthcare Association to the Royal Commission into Victoria's Mental Health System observes 'Victorians with mental illness commonly experience insecure accommodation, frequent moves, unsuitable housing and homelessness. Both private and public rental accommodation are incredibly difficult for people with mental illness to access because of cost, availability, discrimination and stigma.'

At the same time, not having a stable, secure home can reduce the effectiveness of treatment for mental illness or substance use. The challenges of meeting day to day needs takes precedence over health care; storing medications and documentation can be difficult; the numerous barriers to accessing care discussed earlier; and lack of connection with supports such as family and community all make following treatment plans more difficult for people who experience homelessness.

Responses to homelessness must address the complexity of needs of people with mental health and/or alcohol and drug use issues, and provide flexible housing solutions that are responsive to, and knowledgeable about, the needs of these groups. Integrated services provided by a skilled and trauma-informed workforce that have the flexibility to respond to individual needs will provide the best outcomes for consumers. A range of housing options are needed to respond to the different needs of consumers. 'Housing First' models, that provide long term, secure housing with integrated, ongoing support to address mental health and alcohol and drug issues have been shown to provide impressive outcomes for people with complex needs. Other people may only require short term support to maintain a tenancy during a period of crisis.

However, as described earlier, there is a significant shortfall in all housing options, and those with more complex needs are the ones most likely to miss out. Significant and specific investment is needed to meet the needs of these groups.

Recommendation 14

Significantly increase investment in programs that integrate housing and mental health and alcohol and drug support.

6.6 Refugees and asylum seekers

People coming to Australia as asylum seekers or refugees are particularly vulnerable to homelessness due to poverty and social isolation. While they bring with them strength and resilience, they face a number of challenges. Visa conditions may restrict the right to work, the right to social security, entitlement to Medicare, and entitlement to government assistance for education and training. As new arrivals, many refugees have little knowledge about and understanding of services available to them. New arrivals also face social isolation caused by fragmentation of family units, language barriers and lack of connections with the community and support networks. They may also have survived conflict and trauma, and be grieving the loss of family, community and country.[84]

[84] https://www.humanrights.gov.au/our-work/rights-and-freedoms/publications/homelessness-human-rights-issue

The cohealth Refugee Asylum Seeker Health Program (RASHP) supports the health and wellbeing of people of refugee and asylum seeker background with a particular focus on those accessing services in inner north west Melbourne. Delivered by a team of refugee health nurses, coordination support workers, counsellors, women's health nurses, physiotherapists and people working in community engagement including bi-cultural workers, the program focuses on health assessment and monitoring, care co-ordination, capacity building, advocacy, education and the provision of person-centred culturally responsive health services. Individual mental health is monitored from the initial contact of each client until the client is referred to other services inside or outside cohealth.

Over the past decade the RASHP team and cohealth doctors specialising in refugee health have observed a dramatic increase in the numbers of refugees and asylum seekers experiencing homelessness. These families and individuals are sleeping rough; living in severely overcrowded dwellings – which can put relationships with family and community under immense pressure; cycling through periods in emergency accommodation, often in unsafe and unsuitable settings, particularly for children and women who've experienced trauma and violence; and having to move frequently to keep a roof over their heads.

The health impacts are significant, affecting the physical and mental health of adults and children:

- Constant anxiety and uncertainty about housing impacts on mental health
- Unable to develop the important trusting relationships with health professionals due to moving around
- Disconnection from communities through having to find housing in outer areas, contributing to social isolation
- Majority of income being used to pay for housing, so unable to afford food, heating/cooling, medications or travel to healthcare appoints
- Low cost housing is too often of very poor quality, including without heating or insulation, damp, mouldy, poorly ventilated – leading to or exacerbating health conditions.

Children's social, language and emotional development is also likely to be affected by the housing instability, frequent moves and living in overcrowded circumstances.

As with other people experiencing homelessness, the daily stresses associated with homelessness or precarious housing mean that health issues cannot get the attention they require. Existing health conditions are exacerbated, and new conditions develop.

The acute shortage of affordable housing has been the key driver of precarious housing among this group. Escalating rents, combined with limited social and public housing, over the period have placed housing out of reach of many refugees and asylum seekers.

This echoes the experiences described by other health professionals: 'In the early 2000's I don't remember [housing] being an issue. In comparison to now and the cost of housing. Melbourne is incredibly expensive…rental is really expensive'.[85]

[85] Kanhutu, K. *Health and the housing interface; experience of precarious housing amongst refugees in Melbourne and the perceived health impacts of housing***.** Research paper (unpublished)

In such a tight housing market we are also hearing of increased discrimination against people of colour in the private rental market, particularly affecting those of refugee backgrounds.

At the same time, federal government policy changes have compounded the situation. Settlement support services are no longer able to provide the comprehensive support they did in the past. Where previously they could assist a new arrival to find housing and provide support as they settled into their new life and learn about local systems, this support is more limited and may no longer be available if problems arise. This is a particular loss for new arrivals as backgrounds of complex trauma and low literacy can make navigating the private rental market and housing system challenging. As a result, cohealth services funded to provide health care – GPs and RASHP – are spending increasing time responding to clients dealing with immediate housing stress or crisis (eg explaining the housing system, providing letters of support for housing). Despite the health needs of people of refugee backgrounds our health professionals are unable to focus on them given the pressing housing needs.

The situation is even more dire for people seeking asylum. The federal Status Resolution Support Service provides support to people seeking asylum while their visa applications are being assessed. It can include access to torture and trauma services, subsidised medication, casework and income support of 89 per cent of the Newstart Allowance. However, the Federal Government has cut funding for SRSS and reduced eligibility, resulting in many asylum seekers being without income. Without income, asylum seekers are often unable to access more than a couple of nights emergency accommodation through housing providers. The Asylum Seeker Resource Centre describes the impact in *Cutting the Safety Net: the impact of Cuts to Status Resolution Support Services*:

'There has been an increased need for:

- Crisis accommodation with capacity to provide no more than a couple of days of emergency relief housing funded by the Housing Establishment Fund
- Support and access to food parcels for people issued with Notice-to-vacate, VCAT hearings and imminent homelessness
- Emergency food care packs and emergency pharmaceuticals to fill the gaps
- Sleeping bags for people sleeping rough'[86]

The RASHP team have also observed particular challenges for women escaping family violence. The lack of housing means that women and children may stay with an abusive partner. Insufficient supports in languages other than English and that are culturally appropriate make it harder to seek support and navigate the system.

As new arrivals in Victoria with backgrounds of trauma and upheaval there is no longer sufficient support to help people establish themselves. Learning about, and navigating, new systems, services and culture takes time, and services need to be available to respond if and when any problems arise. The support currently available tends to be short term and is no longer available at the times when it's needed.

As another health professional has observed:

[86] https://www.asrc.org.au/2019/04/23/srss-report-release/

> 'When I first started all the people who came under a humanitarian visa had a house. They had support services going into the house for a six-month period until they adjusted. They always had somebody that they could call when they got stuck. But by the end of the six months they were always going to school. They knew who their doctor was. They were settled with less challenges than they have now. Now we don't have houses.'[87]

Led by Dr Kudzai Kanhutu, cohealth and the Royal Melbourne Hospital Refugee Health Program have been undertaking research into the experience of precarious housing amongst refugees in Melbourne and the perceived health impacts of housing. A recording of a radio show describing the research, and the impacts of homelessness on people of refugee backgrounds is available at: Precarious Housing and Refugee Health.[88] We encourage the Committee to listen to this recording.

All people of refugee and asylum seeker backgrounds must be entitled to income support, with standard eligibility requirements, while they are looking for work or if they are unable to work. They should have access to flexible support services that respond to individual needs for long enough to assist them to navigate systems and establish themselves. No one should be left without a form of income to pay for their rent, for vital medications, and to feed themselves and their families. cohealth calls on the Government to ensure that Centrelink income support payments, health care through Medicare and social support is available to all people seeking asylum and refugees, regardless of their visa category.

Recommendation 15

Ensure that income support, health care and social support is available to all people seeking asylum and refugees, regardless of their visa category.

Recommendation 16

Provide specific services to support people of refugee backgrounds to find and secure ongoing housing and to support them over a sufficient period of time to ensure that housing can be successfully maintained. Providing supports in community language, and by peer or bi-cultural workers, is essential.

Recommendation 17

Increase collaboration between family violence and housing/homelessness sectors to ensure more support is provided to women and children of refugee background.

6.7 People living in Supported Residential Services

Supported Residential Services (SRS) are privately operated businesses that provide accommodation and support for Victorians who need help with daily living. Each SRS determines the services it offers and its fee structure. There are two broad categories of SRS

[87] Kanhutu, K. *Health and the housing interface; experience of precarious housing amongst refugees in Melbourne and the perceived health impacts of housing*. Research paper (unpublished)
[88] https://www.3cr.org.au/womenontheline/episode-201809240830/precarious-housing-and-refugee-health

in Victoria – the above-pension sector with a population of older, frail adults; and the pension-level sector with a population of adults with a disability (particularly psychiatric disability, intellectual disability and acquired brain injury), chronic health problems, problematic drug and alcohol use, and sometimes with a history of homelessness.[89]

Pension-level SRS residents are considered at risk of homelessness. A number of factors contribute to this risk:

- SRS residents are among the most vulnerable in the community, presenting with multiple complexities and disabilities, which can include limited decision-making capacity. They are socially isolated, with poor links to significant others and services, and often have limited understanding of their tenancy rights while in an SRS. As such, these residents are very vulnerable to homelessness.
- SRSs are privately owned and operated businesses, generally understaffed and at many times run like any other business. Some private SRS proprietors and staff may not have the knowledge and understanding required to support the complex needs of the residents. Residents' rights and choices can at times be disregarded. There have been instances where residents may be breached and evicted without following due process and without appropriate support to seek alternative accommodation.
- The SRS sector is poorly regulated in comparison, for example, to the residential aged care sector. Regulatory monitoring mechanisms, such as Department of Health and Human Services (Victoria) authorised officers, seem to be under resourced and stretched in their capacities to regularly monitor SRSs.

People living in SRSs experience high rates of psychosocial disability and complex needs and have poor physical and mental health. They experience little choice and control over their lives, evidenced by extremely low levels of service engagement and community participation and minimal levels of connection with family or friends.[90] Despite this, the specific needs of people living in these facilities are often overlooked.

Recommendation 18

Ensure that the needs of Supported Residential Services (SRS) residents are considered in responding to homelessness.

Recommendation 19

Improve the governance, accreditation and regulation of SRS's so that there are mechanisms to address the health and wellbeing needs of residents.

[89] Eastern Metropolitan Region SRS Referral Kit
http://communications.each.com.au/images/_service_files/EMR_SRS_Referral_Kit.pdf
[90] Dearn L 2017 'Choice and control in supported residential services: the experience of people with psychosocial disability during the NDIS', research proposal (unpublished), RMIT

6.8 People experiencing isolation

'You "feel" homeless - you can create a status for yourself, especially if you've been homeless for some time. You feel isolated from the rest of community. Even when people are nice to you, it seems like this is because you are homeless. There's a cold feeling that you get, everyone else feels cold and distant, as in other people around you - the rest of public. You internalise this - if you feel like you are inferior, like there is a status thing, you act in a different way, you keep your distance.

Survey Respondent, Surviving the Streets Survey[91]

There is growing understanding of the serious impact social isolation has on both physical and mental health. People who are socially isolated or lonely are at risk of premature mortality at rates comparable with other well-established risk factors, including lack of physical activity, obesity, substance abuse, poor mental health, injury and violence. The research literature also identifies relationships between loneliness and poor mental health, including depression, lower levels of self-worth, and subjective wellbeing.[92]

People who experience homelessness are particularly susceptible to social isolation and loneliness. While there has been little research on this subject, a recent study found that 'They experienced rejection from the non-homeless: the loss of critical network members, including rejection from family and a lack of companionship, and low quality and precarious relationships within the homeless community. Participant's accounts signal that the homeless will likely continue feeling isolated if mainstream attitudes towards homelessness remain stigmatising and discriminatory.'[93]

Providing programs that enhance social inclusion through providing meaningful activities that retain or develop community connections are as important to wellbeing as health services. cohealth programs that aim to reduce social isolation and loneliness and enhance community connections include:

- cohealth Kangaroos - providing access to team sports for people who find it difficult to access mainstream sports clubs. The team takes part in the Reclink[94] football and cricket competitions, providing those who participate an opportunity to take part in a structured sporting activity within a team environment.
- Billabong BBQ - a weekly BBQ for Aboriginal and Torres Strait Islander people to get together and connect with the mob. While sharing healthy food community members can connect with a range of community services in one place.
- Inner Melbourne Connections program – a psychosocial and health support program for people experiencing homeless and mental illness to link into health, disability and welfare services, improve social connections, access recreation, education, employment and housing programs and improve daily living skills.

[91] Surviving the Streets Survey – Rough Sleeper Project
[92] Relationships Australia 2018 *Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics Survey* https://www.relationships.org.au/what-we-do/research/is-australia-experiencing-an-epidemic-of-loneliness
[93] Bower, M, Conroy, E & Perz, J (2017) *Australian homeless persons' experiences of social connectedness, isolation and loneliness* Health and Social Care in the Community, Vol 26, Issue 2 March 2018 https://onlinelibrary.wiley.com/doi/pdf/10.1111/hsc.12505
[94] Reclink Australia provides sport and art programs to disadvantaged Australians to create socially inclusive, life-changing opportunities: https://reclink.org/

- A range of community development activities for young people, families and older people living in the inner north west of Melbourne.

Recommendation 20

Invest in programs that enhance social and community connection through meaningful activities as part of an integrated plan to prevent and respond to homelessness.

7 Governance and funding arrangements in relation to housing and homelessness (Terms of Reference 10)

Programs to prevent homelessness and to support those experiencing homelessness need to be adequately funded and supported for this work. Too often funding for programs supporting people experiencing homelessness have been short term, have restrictive eligibility criteria and do not supported integrated, collaborative work. Future funding and governance arrangements must ensure that the wellbeing of consumers is the central priority. While provision of housing and support is the responsibility of the states, national leadership is required to ensure a coordinated response to homelessness, backed by funding and addressing the many policy levers that lie within the Federal jurisdiction.

To this end cohealth recommends that:

- Consumer wellbeing must be at the foundation of funding and governance arrangements. Funding models should have inbuilt opportunities for people with lived experience to lead adaptation and innovation to ensure they are responsive to the changing needs of those who use the services.
- Funding periods be long enough to enable program development, comprehensive and ongoing evaluation, and to implement improvements. Adequate time is required to build workforce capacity, including skilled staff and peer workforce, and to build and mature the effective partnerships that produce strong outcomes. The Productivity Commission recommended seven-year contracts for family services to address these same issues[95] and contracts of a minimum of five years for psychosocial supports.[96] We suggest that similar timeframes be considered for the funding of homelessness services.
- Six-month notice must be given of funding renewals or any significant changes to best manage the workforce and ensure the continuity of care for consumers essential for the development of trusting relationships.
- Providing effective services needs a skilled workforce and integrated services. Funding needs to include adequate provision for professional development, supervision, support and debriefing, and to resource effective collaboration between services.
- Development of the peer workforce. Peer workers have been used for some time in the mental health sector. While cohealth has engaged a homeless peer workforce since 2009 it is generally at an earlier stage in the homelessness sector. Peer workers bring many attributes to the role, including engaging with consumers through their lived experience and understanding how systems and processes work (or don't work) in reality and enhancing accessibility of services.
- Partnership resourcing – the most successful responses are those where services work together for the best outcomes for consumers. Partnerships and collaboration need investments of time and resources to work effectively, however provision for these activities is often not included in funding agreements. People experiencing

[95] Productivity Commission 2017 Introducing competition and informed user choice into human services: Reforms to human services. Inquiry report. https://www.pc.gov.au/inquiries/completed/human-services/reforms/report
[96] Productivity Commission 2019, *Mental Health*, Draft Report, Canberra https://www.pc.gov.au/inquiries/current/mental-health/draft

homelessness often have fragmented care and outcomes can be improved by leveraging partnerships and working collaboratively to create more integrated responses.

- Investment in robust impact and outcome measurement and evaluation, and reduced reporting on inputs and outputs. In transition to this approach reporting and accountability requirements need to be streamlined. Currently different sources of funding all come with their own reporting requirements, despite sharing similarities. The resources required to complete multiple reports is significant and would be more effectively used providing services to consumers.
- With such limited housing stock measuring successful outcomes should not focus solely on providing permanent housing solutions, rather also include other indicators of success, such as improved engagement with health and other social supports.

Recommendation 21

Develop the knowledge of the workforce including through increasing the peer workforce and enhancing the education and awareness of health care practitioners about homelessness, including the physical and mental health needs of people who experience homelessness.

Recommendation 22

Governance arrangements need to ensure that outcomes and continuity of care are central priorities. Investment in robust impact and outcome measurement and evaluation is required, as are funding periods that are of sufficient duration to enable cycles of program development, evaluation and improvement.