# Commonwealth Parliamentary Inquiry into Homelessness

## About Bolton Clarke Homeless Persons Program

Established in 1978, Bolton Clarke (formerly RDNS) Homeless Persons Program (HPP) is a rights and equity-based model of health care, which is underpinned by the belief that people who experience homelessness have the right to holistic health care that is accessible and relevant; of a high standard; equivalent to that received by the general community; and self-determined. The program works from the premise that the care is driven by the client's need, not what the program is able to deliver. The program utilises Primary Health Care strategies to address the many social, cultural, environmental, biological and economic determinants of health.

HPP community health nurses assertively outreach to people on the streets, in parks, at food programs, boarding houses or other sites such as caravan parks. Mobile outreach can provide a highly flexible response, with the scope to seek out vulnerable individuals with complex needs who are not connected with services. An HPP nurse is often a first point of contact for clients and the client then directs the care they receive.

The HPP model of practice successfully engages homeless people in actively participating in their healthcare. HPP nurses deliver successful interventions by building ongoing collaborative relationships with clients as individuals, with their identified community supports and within the broader service network. By facilitating both service delivery and developing the clients personal coping skills and resources, the nurses can maximise the client's potential for health recovery.

Over the last few years, HPP has grown and expanded into the outer metropolitan areas of Melbourne, the Mornington Peninsula and Geelong as the issue of homelessness and rough sleeping has become common place across these regions. Many staff also work in and around inner metropolitan Melbourne and the CBD. HPP staff have undertaken visits to approximately 2,600 clients over the last 12 months. HPP has also expanded to incorporate Bolton Clarke's longstanding HIV Program. The integration the HIV Program with HPP recognises that people living with HIV and those at risk (Including young LGBTIQ people, people who use drugs and other marginalised groups) experience high rates of homelessness. The HPP practice framework enhances care for this group too.

This submission draws on our work.

# Response to the Terms of Reference

## 1. The incidence of homelessness in Australia

Whilst there are varying definitions of what constitutes homelessness, Bolton Clarke would like to draw attention to three groups we consider not well recognised or serviced.

**Overcrowding, particularly in caravan parks**

It is common for families, particularly in outer suburban Melbourne to end up in caravan parks as accommodation of last resort. It is not uncommon to have entire families and extended families living in very cramped conditions designed for the short-term use of individuals or couples. Many of these new caravan park residents have not previously experienced homelessness and are unaware of support services. Frequently it is intended to be short term, but due to the challenges of accessing private rental it becomes long term. Caravan park residents are particularly vulnerable to park closure, recently a local council run park closed suddenly due to Covid-19 leaving some residents with nowhere to go.

> ***Case study***
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> *Joyce is a 62-year-old woman evicted from her private rental when she was unable to continue working due to ill health and physical disability. She moved with her two adult children (one with a disability) and a teenage grandson into a small caravan with an annexe in an outer suburban caravan park. As a person with a disability, she required a walking frame and was unable to navigate the caravan stairs and walk the distance to the toilet block, requiring her to use a commode chair in the kitchen of the caravan. The other members of the household slept in temporary bedding in the annexe.*

**'Couch surfing' particularly among young people and Aboriginal and Torres Strait Islander people.**

Couch surfing is common amongst these groups. Frequently young people are not connected to the housing service system and come in contact with our nurses through their friends and word of mouth. Couch surfing is a common precursor to chronic homelessness [1].

**Residents of supported residential services in Victoria (SRS)**

Supported Residential Services (SRS) are privately operated accommodation services that operate in Victoria and are required to be registered and operate within the Victorian Supported Residential Services (private Proprietors) Act 2010. SRS provide a private or shared bedroom, a shared living environment, three daily meals and personal support.

Many residents are there as a result of deinstitutionalisation policies and a lack of other supported housing options. There is limited security of tenure, a lack of privacy and autonomy. Residents often have little or no social support network, little community participation and usually have few resources, resulting in few choices. Residents of SRS comprise one of the most underprivileged and vulnerable population groups within our community [2].

Some residents of SRS are in a cycle of eviction, crisis housing responses and movement between different SRS, rooming houses and periods of sleeping rough. They can be evicted from SRS due to

behaviour, substance use or leave due to wanting more autonomy around their life choices and finances.

**New Zealand Citizens**

HPP sees many New Zealand citizens in Australia on Special Category Visas who have become homeless due to unemployment and sometimes family violence. They are not eligible for permanent visas due to income requirements and they have no safety net. As a result, they are unable to pay rent, purchase food or medicines. They are ineligible for many charitable services as they do not have a Centrelink card. They are reliant on volunteers to provide food and sometimes temporary housing as they are ineligible for social housing.

## 2. Factors affecting the incidence of homelessness

**Health and homelessness**

Homelessness and health are intertwined, poor health is recognised as both a pathway to homelessness and impact of homelessness [3,4]. Pathways to homelessness vary but are largely a result of social and economically derived factors including the social gradient which impacts on vulnerable populations through-out their life course [5].

People experiencing homelessness have significantly poorer health than the general public. Chronic health conditions, early mortality, poor mental health and increased substance use are highly common [6,7,8,9]. Chronic health issues can result in homelessness, due to issues such as a loss of employment, inability to afford housing and the impact of poor mental health.

A key social determinant of health is access to housing and the quality of housing [10]. The impact of the social gradient along with other social determinants such as unemployment, exposure to violence, social exclusion, lack of income, lack of transport, food insecurity, poor access to health care, addiction, poor early childhood experiences and lack of education opportunities [11] impact on people experiencing homelessness disproportionately. The combination of social inequalities leaves homeless people distrustful, under resourced and less likely to ask for assistance. Social injustice has a disempowering effect [12].

Many people experiencing homelessness have experienced childhood or adolescence trauma [13]. Homelessness also increases the risk of experiencing a traumatic event [13]. Trauma impacts on an individual's ability to engage and maintain relationships and results in further social exclusion [13]. This results in poor health [6,14].

**A lack of affordable housing, safe and suitable housing**

There is a lack of access to affordable housing. Waiting lists for social housing are long. In the outer suburbs there are few one-bedroom properties, limiting access for single people or couples. Privately operated rooming houses are often a last resort, the cost of rent can be exorbitant and there is often a lack of privacy and safety. For single people on the Jobseeker payment or with complex and multiple disabilities private rental is rarely a viable and sustainable option.

**Income**

The Jobseeker payment rate is too low to enable people meet their basic needs. People are forced to make unsustainable choices such as between paying rent, having food security and purchasing

medication. Due to the complex nature of homelessness, many people are unable to meet the requirements of Centrelink and have their payments stopped, further increasing their vulnerability. In addition, Centrelink processes have become increasingly difficult to navigate for those with low literacy, a lack of computer and internet access.

Due to the complexities, extreme marginalisation and multiple disabilities, it has become increasingly difficult to meet the criteria for acceptance on to the Disability Support Pension (DSP). Low levels of literacy, cognitive impairment, lack of insight, transience, lack of continuity of medical care and difficulty attending appointments are all barriers to completing the process of applying for a DSP.

**Acquired Brain Injury and Traumatic Brain Injury**

Under identified and poorly understood, acquired brain injury (ABI) has been a neglected area of strategy and support for people experiencing homelessness. A recent meta-analysis and systematic review of Traumatic Brain Injury (TBI) in homeless and marginally housed individuals found a 53.4% lifetime prevalence of TBI [15].

Some people experiencing homelessness also acquire a brain injury through alcohol and other substance use, this occurs over time and the risks are exacerbated by alcohol and other drug (AOD) models of care which are short term and do not respond to the needs of people experiencing homelessness. HPP has also seen an increasing number of women with TBI as a result of family violence.

Brain Injuries are consistently associated with poorer self-reported physical and mental health, higher suicidality, memory concerns, increased health service use and criminal justice system involvement [15]. Brain injury results in challenges to executive function such as; impulsivity, memory difficulties, insight, judgment, ability to plan and organise. In practice this can translate to difficulty maintaining housing and relationships, difficulty managing money, organising for needs to be met, planning for the future and navigating systems.

The relationship between homelessness and brain injuries may be bidirectional, homelessness increases the risk of a TBI and having a TBI may increase the risk of homelessness [15]. Six studies from the systematic review found in between 51% and 92% of participants, homelessness was experienced after their first TBI [15].

***Case study***

*Paul is a man in his forties, living in an outer suburban caravan park. The Community Health Nurse observed him walking around with no shoes when assertively outreaching to the park. Initially he was suspicious of services but engaged when the nurse offered to contact his financial administrator and arrange a pair of new shoes. Paul sustained a Traumatic Brain Injury following a car accident when he was a teenager. He had previous periods of rough sleeping and had lived in unstable accommodation such as rooming houses and caravan parks all his adult life. He used alcohol heavily and other drugs regularly and experienced depression. As engagement increased the nurse, was able to support Paul to address some long-standing health issues. Due to the length of time since his brain injury diagnosis, the nurse undertook a significant amount of advocacy and commenced establishing his disability diagnosis which involved a referral for an updated neuro-psychological assessment in order to access appropriate support services. Unfortunately, Paul was seriously assaulted at the caravan park and hospitalised. HPP was able to advocate and work with the hospital social worker to move Paul into safer accommodation in*

*another caravan park. With a flexible, assertive, long term approach HPP was able to continue working with Paul, including referring and advocating for long term, affordable supported housing and other support services. He remains on the waiting list but without ongoing engagement would easily fall through the gaps.*

## 3.The causes of, and contributing factors to, housing overcrowding

Bolton Clarke HPP observes a lack of affordable private rental, a lack of social housing and low Jobseeker payments as being major contributors to overcrowding. Young people experiencing family breakdown and violence often results in 'couch surfing'.

Women and children experiencing homelessness and often escaping family violence are at times inappropriately accommodated due to a lack of housing. In an outer suburb of Melbourne, women and children presenting at the housing access point in crisis are frequently accommodated for many months if not longer in a motel style accommodation due to a lack of other options. There is one room with a double bed, a small kitchenette and no safe outside play space.

## 4. Opportunities for early intervention and prevention of homelessness

In order to address the extreme exclusion of homelessness, broad 'upstream' action is required across all levels of government, across government departments and partnerships with non-government organisations. Action is required to reduce inequity and the impact of the social gradient, a slope which becomes a 'cliff' when it comes to people experiencing homelessness [8]. All policy needs to be viewed with an equity lens to ensure they do not inadvertently increase inequity to those most vulnerable and leave marginalised members of the community behind [5]. To reduce this inequity, alongside population-based interventions, there needs to be targeted intervention for those at the bottom of the health and social gradient.

Prevention of homelessness for individuals begins in early childhood and needs to address the extreme social exclusion that results in homelessness. Risk factors such as substance use, low income, a lack of suitable housing and poor health overlap in socially excluded populations. Addressing the multiple and complex needs of socially excluded population is needed rather than focusing on single risk factors[16].

Other events and signs of distress along the lifespan offer opportunity for early intervention such as responses to school difficulties, contact with the justice system, leaving out of home care and problematic substance use. Early intervention with mental health issues and responses to traumatic experiences are opportunities to prevent homelessness.

Another timepoint for earlier intervention to prevent reoccurring homelessness is the first point of contact with the housing 'system'. At this time a holistic assessment completed by workers with the skills to identify 'hidden' disability and vulnerabilities such as ABI and undiagnosed mental health issues which may be barriers to sustaining housing should be conducted. This will enhance the capacity to intervene early and develop an appropriate, individualised plan and supported referral which results in sustainable outcomes.

Engaging individuals with primary health care and addressing chronic health conditions is required to reduce the high rates of mortality and morbidity in people experiencing homelessness [9]. Aldridge

and colleagues found that a third of deaths that occurred in UK hospitals among people experiencing homelessness were 'amenable' to timely healthcare [9].

Another crucial time point is when individuals are exiting institutions including mental health, hospitals and prisons. It is still common practice for people experiencing homelessness to be discharged from mental health facilities, public hospitals and the justice system into homelessness. There is a lack of suitable housing options, waitlists for crisis accommodation and complexity of issues such as substance use. There are limited options for respite or 'step down' facilities to facilitate full recovery and pressure on acute hospital beds. Step down units, sometimes known as 'medical respite' are an evidence-based strategy for better outcomes for people experiencing homelessness and reducing readmission to acute hospital beds [17,18]. Supported Residential Services (SRS) and other services are sometimes utilised, but issues can arise if they do not have suitably matched skills to address the complexities of health and social issues. Unlike Aged Care facilities, there is no legislation enforcing skill levels.

## 5. Services to support people who are homeless or at risk of homelessness, including housing assistance, social housing, and specialist homelessness services

Paradoxically, despite being some of the most vulnerable in our community, being homeless actually decreases the likelihood of accessing appropriate care due to complex need, exclusion from services based on program criteria or inflexible methods of service delivery[18].

Fragmentation of the 'system', the 'silos' between housing, mental health, alcohol and other drug services, disability, aged care, health and justice systems continues to be a major factor in poor outcomes for people experiencing homelessness. Navigating these systems requires an ability to self-advocate or have someone to do this on behalf of the person.

Assessment that occurs when trying to access services is often not holistic and can be based on what a service can provide not necessarily what the person needs. A holistic approach is required by skilled workers to identify and prioritise needs, including providing cultural safety and trauma informed care. There needs to be increased engagement, assertive outreach approaches and flexible models of care that can address these complexities and that are linked to appropriate housing options [18].

Assertive outreach is an evidence-based strategy[18]. It should be extended to those experiencing homelessness and at risk of homelessness to maximise opportunities to engage and ultimately prevent homelessness and initiate contact with the acute health services such as ambulance and emergency departments. Given the high rates of morbidity and mortality, assertive health responses are required [7,9].

Assertive outreach programs need timely access to mental health expertise and recognition that although some people are not in a crisis, they are not making a 'choice' about homelessness but are in fact disengaged, functionally impacted and experiencing psychological distress as a result of undiagnosed mental health issues and trauma. Without appropriate, assertive mental health care they are unable to shift from entrenched homelessness. People experiencing homelessness are less likely to engage with statutory mental health services[18]. Assertive outreach services with prompt or embedded access to clinical mental health expertise is required.

The 'Housing first' model with rapid access to long term housing and multidisciplinary support is an evidence-based strategy [4,19]. However, availability of timely and suitable housing is essential to engage, many people may choose rough sleeping when offered sub-standard forms of housing such as private rooming houses due to affordability, safety, lack of privacy and other factors.

Alcohol and other drug programs are often not appropriate for the complexities of people experiencing homelessness. They are usually too short term, have an extreme shortage of long-term rehabilitation programs and are reluctant to take people experiencing homelessness if they do not have accommodation pre-arranged for when they exit the program. The limited availability of women only detoxification and rehabilitation options are a barrier to some women who have experienced past trauma and violence.

## 6. Support and services for people at particular risk of homelessness

**People exiting institutions and other care arrangement**

Young people exiting out of home care are at elevated risk of homelessness [6]. Whilst some strategies have been introduced in Victoria, it is crucial that young people in out of home care have the correct supports including addressing trauma.

Early identification of people experiencing homelessness presenting at hospitals is necessary to develop a discharge plan including access to housing. Discharge planning needs to consist of a handover to community supports rather than a discharge report that becomes useless if the person is not connected with services.

Exiting prison into homelessness has poor outcomes. There is a high prevalence of incarcerated individuals with ABI [20] and other disabilities. Without appropriate exit arrangements many individuals lack the cognitive capacity to problem solve and plan independently.

**People aged 55 or older**

The homeless population is aging and prematurely aged [6]. Mainstream services do not always understand the issues faced by people experiencing homelessness. Strict eligibility requirements can cause challenges in accessing appropriate services for those under 65 years old and prematurely aged.

The shift to a consumer directed model for aged care has created many challenges for people experiencing homelessness. Whilst the consumer directed approach increases autonomy for many in the community, for some people experiencing homelessness the approach has resulted in increased difficulty in accessing and maintaining services. This in turn increases vulnerability and potentially places those in housing to be at increased risk of homelessness.

My Aged Care processes and long waiting lists are barriers to accessing support services, due to complexity in referring, understanding the process, a lack of understanding of homelessness and complex needs, premature aging and long wait lists for services. People living with homelessness are often distrustful of 'faceless' government services and paperwork. Most services are not able to provide assertive outreach or deliver services to environments where people are living such as rooming houses due to concerns about safety for workers.

Assessment services frequently have a poor understanding of the issues faced by people experiencing homelessness and are unable to understand the underlying issues and develop appropriate flexible and responsive care plans.

**People living with disability and mental illness**

Many people experiencing repeat homelessness are living with a disability, not uncommonly undiagnosed. The shift to consumer driven disability supports has been detrimental to the many people experiencing homelessness. NDIS processes are barriers to accessing support. To access the NDIS there is a need to establish the disability diagnosis. Many people experiencing homelessness do not have formal diagnosis of mental health, physical or cognitive disabilities. Providing the evidence can be difficult despite the person having obvious functional challenges. There can be long waiting lists for neuro-psychology assessments and difficulty accessing mental health services. The cost of private neuro-psychology assessment service is prohibitive and access to bulk billing psychiatry limited. Cognitive challenges may make it difficult to collect the 'evidence', such as getting to appointments and having insight into needs. Fragmentation of medical history , transience and unstable housing contribute to the difficulty.

To develop an appropriate support plan the person needs to have insight into their disability and needs. Many people experiencing homelessness are disenfranchised and focused on meeting their basic needs, they can have difficulty looking beyond this to form goals that would enable the development of an NDIS plan. Life is frequently unstable and at time chaotic for some homeless individuals, NDIS plans lack the flexibility to respond to needs. Some of the NDIS processes involved are of a poor standard and inappropriate, for example, phone assessment and self-managed plans for people with an inability to self-advocate and manage finances.

Due to the complexity for many people experiencing homelessness, there is usually a need for long term, assertive support to avoid falling through the gaps. Despite assertive outreach being an evidence- based strategy for providing support for people experiencing homelessness there is little active follow up in the NDIS system. There is mostly a casualised workforce with a low level of skill working with complex and vulnerable members of the community. There is little accountability for services provided. There is no capacity to respond to people who may be transient and there is poor access to appropriate supported housing

People living in SRS experience some unique difficulties with NDIS. There is frequently a conflict of interest of proprietors being both landlord and support provider. Financial management is often undertaken by the manager or proprietor at times without informed consent. Our nurses have identified cases of proprietors of SRS operating separate companies registered to provide NDIS services to residents of their SRS, reducing the client's autonomy and creating a conflict of interest.

People living with a disability, especially those with re-occurring homelessness require assertive responses, accurate assessment, qualified workers, appropriate supported housing and medium to long term if not lifelong support.

Many people experiencing homelessness have undiagnosed mental health conditions and 'fly under the radar'. It is extremely difficult to access mental health services unless the person is in an acute crisis and even then, due to concurrent substance use, often the person falls between the service gaps. Often a police response is recommended which can have a negative and traumatising effect. It usually takes repeated and assertive attempts to engage the person with mental health services.

Mental health programs that *assertively* outreach and recognise that although some people are not in a crisis, they are not making a 'choice' about homelessness but are in fact disengaged, functionally impacted and experiencing psychological distress as a result of undiagnosed mental health issues and trauma are required. Without appropriate, assertive mental health care individuals are often unable to shift from entrenched homelessness.

**LBGTIQ People**

Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) people experience unique vulnerabilities and complex pathways to homelessness. They are twice as likely as heterosexuals to experience homelessness [21]. They often experience homelessness at a younger age due to family rejection [21]. Crisis and short-term accommodation can be unsafe and traumatic. LGBTIQ people experiencing homelessness frequently experience discrimination, harassment, misgendering and violence when accessing services, shared accommodation and rooming houses [21]. As a result, they may be less likely to seek out a service leading to rough sleeping or other unsafe alternatives.

Appropriate policy and service responses include, all homeless services should be LGBTIQ inclusive including safe and appropriate housing options. Early intervention and recognition of the multiple vulnerabilities including impacts of childhood trauma and family violence as a risk factor for LGBTQI young people [21].

***Case study***

*Angelo is a 25-year-old man living in a privately-owned rooming house in an outer suburb. The Community Health Nurse met Angelo whilst assertively outreaching to the rooming house in partnership with the Tenants Union Outreach Worker. He has a history of childhood trauma, substance use, a hearing impairment and mental health issues. He is vulnerable and often taken advantage of by other residents of the rooming house. He has been assaulted a number of times and had his room damaged and belongings stolen. The landlord is now requiring him to repay for the damage caused to his room and is refusing to repair the door until he pays, leaving him with no security. He is reluctant to go to the police, tenancy or legal services as he is concerned, he will lose his accommodation or face further assaults. He has few social connections. The housing service has been unable to provide any other housing options and he is unable to afford private rental on Newstart. He has difficulty affording food, is reliant on charitable food services and has lost weight. He sometime skips his mental health medication when he runs out of money to pay for scripts. His hearing aid has been lost and he is unable to afford to purchase a new one. The level of hearing disability he has does not fit the criteria for NDIS to obtain financial assistance for a new hearing aid. His mental health condition is not considered 'permanent', so he doesn't qualify for a Disability Support Pension or NDIS. He has participated in alcohol and drug rehabilitation programs in the past but finds his living circumstances increase his depression and he is constantly exposed to others using alcohol and drugs. His substance use, hearing impairment and mental health has impacted on his ability to work despite many attempts at employment. He feels powerless to change his circumstances and has become entrenched in homelessness.*

## 7. The suitability of mainstream services for people who are homeless or at risk of homelessness

People experiencing homelessness report experiences of being labelled, stigmatised and not being treated as individuals with unique needs when trying to access health and social care [22]. The perception of receiving substandard care is also common [22]. Education and policy development are needed in the public hospital and other sectors to increase understanding of homelessness and the social determinants of health to reduce stigma and discrimination and enable better identification of homelessness.

Many mainstream services lack an understanding of homelessness and do not recognise the notion of extreme exclusion as a form of homelessness. For example, the person may have an address, such as a rooming house but still be 'homeless'. Mainstream services may lack the capacity and skills to respond to the needs of people experiencing homelessness. They may impose punitive measures without understanding the underlying barriers and issues the person is experiencing. They may lay blame for 'lifestyle' factors without having an understanding of the social determinants of health [12].

Whilst tailored, assertive homeless specific services are best practice for engaging and co-ordinating support for people experiencing homelessness, there can be advantages to engaging with mainstream services in terms of quality of care [18]. HPP believes people experiencing homelessness have the right to access the same standards of care as the general population. Only accessing specific homeless services, particularly in health care can limit the outcomes and opportunities. However, frequently referrals made to other services do not result in an outcome, either because the person does not have the capacity to access the service independently, they are prioritising meeting basic needs, or they have had negative experiences accessing services in the past. A supported referral approach that forms a bridge and supports people experiencing homelessness to engage with a new service.

## 8. Examples of best-practice approaches in Australia and internationally for preventing and addressing homelessness

**Early intervention approaches**

Approaches that focus on specific issues or risk groups can overlook the impact of multiple pathways and issues faced by excluded populations. Opportunities for early invention can occur with partnerships that address exclusion in overlapping marginalised groups [7]. Social inclusion involves a whole of government approach to policy and equity-based funding models.

Support for families, prevention of family violence and intervention in early childhood, for example qualified mental health workers in school, contribute to preventing homelessness. Low threshold access to mental health and AOD programs enhance early intervention.

Enhancing programs such as private rental assistance schemes, early intervention assertive outreach services and programs to prevent eviction will prevent homelessness. A shift needs to occur from crisis responses to affordable, sustainable housing options.

**Addressing homelessness**

Assertive outreach approaches that engage with people experiencing homelessness in a variety of environments are essential. Assertive outreach is central to engaging those who do not request a service and who are not connected with the service system. Assertive outreach maximises opportunities to engage and address complex issues and avoid contact with the acute health services such as ambulance and emergency departments.

Accessible services, that offer flexibility, non-appointment based and have engagement strategies in place are best practice. This includes cultural safety and trauma informed approaches. Specific services, strategies or workers for certain groups may enhance engagement for example for LBGQI people, women and young people.

Increased access to affordable housing ends homelessness for many people. For rough sleepers a housing first approaches with multi-disciplinary teams and with immediate permanent housing attached are successful at ending homelessness. For those with a disability, unable to live independently, increased access to affordable and appropriately staffed supported housing is essential to preventing re-occurring homelessness.

Comprehensive primary health care built on a social model of health that addresses the underlying social determinants of health in collaboration with other services is able to improve the health of people experiencing homelessness. An assertive outreach component is essential. 'Respite' programs also support people experiencing homelessness to transition from hospital and health services into housing and to prevent reoccurring presentations at emergency departments. Access to General Practitioners willing to work with complex clients and who are flexible and non-judgmental are essential.

Co-ordination of support for those that need it is essential. Whilst some people experiencing homelessness may require only a short intervention, many people due to complex issues require medium to long term support. This needs to include supported referrals that assist with removing barriers to accessing services including providing transport, financial assistance and advocacy.

Collaborative relationships between services that address the structural issues, for example partnerships between hospitals, mental health services and housing services, health justice projects between health and legal services can make a difference. With these partnerships (with appropriate funding and housing attached) issues such as people being exited into homelessness from institutions can be better addressed.

## 9. The adequacy of the collection and publication of housing, homelessness, and housing affordability related data

Data on unmet needs can be limited by the assessment undertaken and category of data collected. If a holistic assessment is not undertaken by staff trained to recognise underlying disabilities and chronic health issues, then unmet needs are potentially not recognised. Acquired brain injury is not recognised in the Specialist Homeless Services data.

Many people experiencing homelessness live long term in marginalised housing such as rooming houses or sleep rough without any connection to services. They may only seek a service at a late stage, for example, once evicted or with a serious health issue. There is limited data available on

those particularly marginalised and vulnerable individuals who do not seek services and their unmet needs are not generally recorded or recognised.

## 10. Governance and funding arrangements in relation to housing and homelessness

Access to the housing service system and funding models are mostly geared to crisis responses. People often cycle in and out of the crisis system due to a lack of viable and sustainable options. This is often costly due to reliance on private short-term housing providers such as rooming house operators and hotels. It impacts on the health of people experiencing homelessness, increases social exclusion and increases the difficulty of connecting with services due to mobility.

# Recommendations

1. Address overall social inequality through a whole of government approach. Similar to the Health in All Policy concept, apply a 'vulnerable person' lens to each government policy to ensure it does not impact negatively. An equity approach is required to address the extreme social exclusion that results in homelessness.

2. Increase the shift from crisis housing responses to 'upstream interventions'. Increase affordable social housing indexed to income. Enhance assertive early intervention responses such a private rental support. Fund access to non-profit supported housing for those with a disability including women only options.

3. Enhance other assertive early intervention responses. Recognise time points where early or prompt intervention could occur, for example school, exiting institutions and first access at housing services.

4. Increase the use of housing first models with multidisciplinary teams including clinical mental health and suitable housing attached.

5. Increase Jobseeker payments and review access to Disability Support Payment. Recognise long term homelessness as a disability.

6. Recognise acquired brain injury and other undiagnosed disability as both a pathway to homelessness and a factor in reoccurring homelessness. Enhance early intervention, improve assessment processes and access to support services. Improve data collection.

7. Utilise evidence-based strategies in funding models and services such as assertive outreach, flexible approaches and assertive case co-ordination.

8. Improve funding models for AOD, mental health and those with a disability who need assertive responses and medium to long term support. . Mental health rehabilitation services should have better access for people experiencing homelessness and stronger connections with housing services.

9. Improve knowledge of the social determinants of health and identifying homelessness within the health sector. Develop early intervention and intersectoral responses that address complexity.

10. Increase access to 'step down' or medical respite services. Fund for suitably qualified staff that are able to respond to the complexities of needs 24/7

11. Provide increased assertive outreach to SRS residents to address complex needs and increase social inclusion.

12. Increase investment in workforce development to meet the need and complexity of people experiencing homelessness.

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