T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Homelessness in Victoria

Melbourne—Wednesday, 9 September 2020

(via videoconference)

MEMBERS

Ms Fiona Patten—Chair
Dr Tien Kieu—Deputy Chair
Ms Jane Garrett
Ms Wendy Lovell
Ms Tania Maxwell
Mr Craig Ondarchie
Ms Kaushaliya Vaghela

PARTICIPATING MEMBERS

Dr Matthew Bach
Ms Melina Bath
Mr Rodney Barton
Ms Georgie Crozier
Dr Catherine Cumming
Mr Enver Erdogan
Mr Stuart Grimley
Mr David Limbrick
Mr Edward O'Donohue
Mr Tim Quilty
Dr Samantha Ratnam
Ms Harriet Shing
Mr Lee Tarlamis

WITNESSES

Associate Professor Tony Walker, Chief Executive Officer, Ambulance Victoria; and

Assistant Commissioner Timothy Hansen, Service Delivery Transformation Command, Victoria Police.

The CHAIR: Welcome back, everyone, and thank you for joining us. I would like to declare open again the Standing Committee on Legal and Social Issues public hearing for the Inquiry into Homelessness in Victoria. This has been a really terrific day, so I hope those who have been able to watch online have got as much out of it as we have.

We are now very pleased to be able to welcome our witnesses: Associate Professor Tony Walker, the CEO of Ambulance Victoria; and Assistant Commissioner Timothy Hansen from the Service Delivery Transformation Command of Victoria Police.

With me today on the committee I have Tien Kieu, the Deputy Chair; Rod Barton; Wendy Lovell; Lee Tarlamis; Kaushaliya Vaghela; and I am Fiona Patten.

To our witnesses: just to let you know that all the evidence taken at this hearing is protected by law, and that is under our *Constitution Act* but also the standing orders of our Legislative Council. This means that any information you provide to us today is protected by law. However, any comment repeated outside this hearing may not have the same protection, and any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

As you are probably aware, we have a team of people recording this and transcribing it, and you will receive a transcript of today's proceedings. I would encourage you to have a look at it and make sure that we have not made any misrepresentations, because ultimately it will form an important part of our report and it will go onto the committee's website.

We would be very grateful if you would like to open up with some comments, and then we can open it up to a broader committee discussion. Thank you.

Assoc. Prof. WALKER: Wonderful, Ms Patten. Shall I go first?

The CHAIR: Yes. Thanks, Tony.

Assoc. Prof. WALKER: Wonderful. Thank you, and good afternoon. I would like to start off today by thanking the committee for the invitation to participate at today's hearings, alongside my colleague from other emergency services and frontline agencies. On behalf of Ambulance Victoria, we appreciate the opportunity to contribute further to your Inquiry into Homelessness in Victoria. As highlighted in our submission, we have made a number of recommendations for our organisation to implement so we can gain a greater insight into patients requiring our services who have no permanent residence. I will go through these recommendations shortly, but we would like to provide the committee with some context to our role, particularly for those who are experiencing homelessness.

Each year we respond to more than 600 000 calls for assistance from members of the public. We are committed to providing the best care to Victorians, which drives us to continually explore how we can provide even better care for every person every time. Serving the community can take many forms, which in a modern ambulance service does not necessarily mean the lights-and-sirens response the public most strongly associate with Ambulance Victoria. We have spent considerable energy and time over the past few years trying to understand the emergency health needs of Victorians, and as a result we developed a service model underpinned by the philosophies of an ambulance service for the whole community and connecting every person with the right care at the right time at the right place. This includes connecting patients with other healthcare services and partners through our expanding secondary triage service or our specially trained clinicians, paramedics and nurses who undertake further assessment of patients.

Looking at our data, less than 1 per cent of the calls we receive are from or for patients with no fixed address. Little data is kept on a person's living conditions, as we rely on the information gathered by the Emergency Services Telecommunications Authority at the time of call to 000 on the medical status and location of a patient

for timely treatment and response. We believe we have treated approximately 8000 patients who have been identified as homeless in the past two years. This number may have been higher had the resident's place of residence been asked for at the time of call. Almost half of these 8000 patients were seeking mental health assistance, which is double the rate of the Victorian population. Given mental health issues can be a catalyst for homelessness, this figure should not be surprising but is often not fully stated or explored. Our data also shows that less than a quarter of those patients are transported to hospital. Rather, these call-outs are for on-scene assistance and other medical care. This low transfer rate may reflect a patient's resistance to entering the hospital system or may indicate that the emergency care and transport to hospital may not have been the best pathway of care for these patients, just as it is not for around 20 per cent of callers to 000.

That is why we believe research is key to understanding what the homeless community want and need from frontline organisations, such as Ambulance Victoria, so we can use this information to provide appropriate support they can trust and it does not add additional stress. Trust, along with access to the right care, is a key issue here because placing someone with a mental health condition into the back of an ambulance and taking them to an emergency department can exacerbate distress. Where possible, treatment on scene and referral to primary health care such as GPs and mental health services is better both for the patient and for the broader healthcare system. Although work has been largely centred on emergency care management, what we have learned is that we also have a role in emergency prevention through collaboration and partnerships with other agencies and alternative healthcare referrals and through research.

Helping paramedics to provide better medical care by understanding the homeless community is a crucial part of this equation. This means our paramedics can bring empathy, compassion, situational awareness and communication to their work with every patient, including the homeless community. As part of our ongoing professional development program, we help paramedics develop additional skills to deal with this vulnerable group and their complex healthcare needs. This program actively focuses on helping paramedics overcome biases that may negatively impact their decisions in treating marginalised groups. We have continued to provide this training during the pandemic under the pilot program being delivered to our paramedics using online platforms.

I have touched on the importance of partnerships, and I am pleased with our investment in this area, working side by side with other frontline agencies. Through the current police and ambulance triage team, or PATT program, we help vulnerable community members outside conventional pathways. Ambulance Victoria and Victoria Police have worked on PATT since 2016 in Melbourne's CBD, linking people to relevant services away from the traditional assessment routes of police stations or hospitals. Importantly, while PATT does not focus on people who are homeless, its location within the CBD means this mobile triage service frequently interacts with and assists those who are homeless. PATT's work reduces both hospital transport and police custody rates, which reduces load for both services and also potentially impacts on reducing occupational violence. The program has strengthened direct links with community services for the homeless, thus directing this group to the right care.

Alongside Victoria Police we are also working closely with the Salvation Army and St Vincent's Hospital. In 2018 together we supported the Community Hub at the Salvation Army's Bourke Street location. The hub provides rough sleepers with health care. It is currently being expanded as an access point for other services, including free health assessments for referrals, addressing health literacy queries or accessing family violence support or other social services. Anecdotally my staff would tell me that when the hub operates we have fewer emergency calls in the CBD, which our data shows is where we typically receive the most call-outs for assistance from homeless Victorians. This suggests not only is the hub a useful health service for Melbourne's homeless community, it is a form of crisis prevention that in our mind actually works.

As part of our ongoing work and the inquiry into homelessness, we have considered how best to involve our services to address the health needs of homeless Victorians. We believe research-backed evidence treatments we know will work is the way forward. We need to know what is proven to help so we can deliver the right care every time. At Ambulance Victoria we will continue to focus on working collaboratively with stakeholders to actively listen to their concerns, needs and ideas to provide sensitive and relevant services. Part of our focus will be looking at how Ambulance Victoria performs using data to determine viable issues in the future.

One option for research expansion is our secondary triage service. This has helped us build a strong network of external healthcare providers who help us transition patients to the most appropriate and timely care in real

time. Our existing patient management plans, also known as care plans, which provide streamlined and coordinated care for high-frequency ambulance users, can also include people who are homeless. We are currently researching how to incorporate more people from the homeless community who do not have a physical address through the use of a secondary identifier, which could be used to help understand their history and that sent to appropriate services.

So once again I thank you for the opportunity to contribute further today, and I obviously welcome questions at the appropriate time. Thank you.

The CHAIR: Thank you very much, Tony. Assistant Commissioner?

Asst Comm. HANSEN: Thank you. I would like to likewise thank the committee for the opportunity to present today and the invitation to speak. Before going any further I would also like to acknowledge the traditional owners of the land on which we meet and pay our respects to elders past, present and emerging.

My name is Tim Hansen, and I am an assistant commissioner with Victoria Police in the Service Delivery Transformation Command, but maybe to give some context I can just give a brief overview of my most recent experience. Up until last week I was the Commander for the north-west metro region, which incorporates the CBD and Melbourne's western suburbs. Prior to that I have predominantly serviced or my policing career has focused on the inner city environments of Melbourne's CBD. This has given me a great insight into the operations of the inner-city boarding houses and guesthouses that operate and house many people experiencing crisis, many people released from prison or incarceration, and many people escaping the scourge of family violence. Also as an extra activity I was involved in St Kilda Youth Service, on their board for approximately five years servicing the role of secretariat general board member. Again, through that program and through that organisation I helped deliver a lot of innovative programs addressed towards the issues of youth engagement but also homelessness, which is obviously related to that as well.

I would just like to take the opportunity to highlight that Victoria Police is one of the few organisations across the state that operates 24 hours a day, seven days a week at a statewide level. We are obviously charged with the responsibility of keeping the community safe. We do not have the luxury of considering one community over another. This is a responsibility that we discharge equitably and fairly across all the different cohorts that make up our great Victorian community, and we take that responsibility very seriously.

We provide a visible policing presence not only in the Melbourne CBD but across the suburbs and rural and regional Victoria. Due to the nature of our work, our members are most likely to be exposed to homelessness in the form where people are sleeping rough. The contribution of homelessness to Victoria Police crime data or to our police interactions is not fully known, because we do not collate that data in any meaningful fashion. Whilst the most obvious crime category where homelessness would be a significant causal factor would be the summary offence charge of begging alms, they are also representative in other crime categories and service delivery demands, we know, anecdotally, such as family violence, mental health crisis response and drug and alcohol abuse. Whilst policing operates at the pointy end of the crisis response, we do retain a holistic prevention approach to the issue of homelessness, and certainly Mr Walker outlined some of the key joint activities that we do not only with Ambulance Victoria, our emergency services partner, but also with organisations such as the Salvation Army, St Vincent's Hospital, the City of Melbourne and the department of human services.

If I could just focus on the Melbourne CBD initially and then reflect out more broadly across the state, certainly across the Melbourne CBD we see the issue of sleeping rough being a huge contributor to our demand response. I have seen data going back to 2016 to 2019, where approximately 200 to 300 persons per night had been recorded to be sleeping rough across the CBD. Some of the key—and I have highlighted our preventative and our whole-of-government approach to this issue—agencies and bodies that we work with I have cited, but the governance that sits across the issues of assisting those that are experiencing homelessness is quite significant.

So we have the Homelessness Advisory Committee, we have the executive partnership group, which includes the City of Melbourne, includes Victoria Police and then includes important health stakeholders. From this, through the COVID pandemic, a program has been established by the Department of Health and Human Services known as the hotels task force. The goal of this operation, if you like, is to accommodate persons

experiencing homelessness in hotels, both across the CBD and the state. This is, from our perspective, a great initiative and returning great dividends in protecting some of those more vulnerable people that do sleep rough across the CBD. It does create challenges for police and there is no doubt about that, but we are working with our partners to work through those challenges, and maybe we might get an opportunity during the course of this afternoon to highlight some of those challenges.

I would also just like to flag the great concept, which again, Mr Walker spoke about, which is the Community Hub that operates across Melbourne CBD. This for me—and I have been hands-on down at the program, done a walk through the hub, talked repeatedly with our partners in the Salvation Army and St Vincent's Hospital—is close to world's best practice. This is the agencies and the services coming together.

From a policing perspective, we go down there proactively and discuss management plans for the warrants that might be outstanding for some of those that are experiencing homelessness. We work with Salvation Army to identify social support and other health needs as well, and obviously Ambulance Victoria provide a significant level of assistance down there, not only to the physical health but the mental health of attendees. So successful is this program, I am advised by my managers, that Victoria Police members off duty volunteer their time down at the hub and also get involved in associated programs, such as soup kitchens and the like, that are coordinated through the hub. I think that in and of itself provides a great level of evidence about how the members on the ground feel towards that.

I would like just to outline quickly, if I may, Operation Protocol, which is effectively our number one, I am going to call it, enforcement approach across the CBD. Obviously when it comes to issues of public safety a regulatory or enforcement element needs to be present from a policing perspective, and whilst it is not our number one focus—as I said, our focus in respect of persons experiencing homelessness is to work with services and to make sure people are connected and their vulnerability is reduced—we do have another element of that, which is the enforcement element as well, because we do see a connection to crime and we need to prevent that crime. Operation Protocol has provided us a really strong balance around referring people into drug and alcohol counselling and getting them crisis support for mental health and other health concerns. We operate joint outreach teams with both the Salvation Army and City of Melbourne staff and ourselves where we go out on active patrols and we take a joint enforcement but services-connected approach as well.

The other issue related to, can I say, Operation Protocol is our observations around professional begging. This really does cloud the discussions that might be had at a point in time about the decriminalisation of elements of the *Summary Offences Act*. This is of significant concern for police. It requires significant hours and resources to investigate, and it does have a negative impact on the amenity of the CBD area and absolutely has our attention.

If I could just talk about regional Victoria, in winding up, whilst the optics and the visuality of persons experiencing homelessness plays out across the CBD, we are obviously aware that there are also other forms of homelessness that play out in metropolitan and rural Victoria. Some of these are a result of drug and alcohol abuse, family violence or even emergencies and disaster relief. So we work extensively with local agents and committees to address these issues, such as the risk assessment management panels, the emergency management planning committees in local councils and drug and alcohol services across rural and regional Victoria.

In concluding I would like to highlight the work of our Victoria Police e-Referral program. This is our single point of entry into government services. It is an electronic referral program and up until July 2020 made 737 referrals specifically for the issue of homelessness. In March 2019 we expanded our referral processes for homelessness with a six-month pilot commencing in both the Hume and Moreland LGAs. The success of that program, can I say, where we were making 15 to 30 referrals per month, has seen it expand to include both the Brimbank and Melton LGAs, Geelong and Surf Coast LGAs and the Ballarat LGA. On the basis of the results of the data we are seeing through this trial, homelessness would quite quickly become a top-five referral for Victoria Police if we were to roll this out statewide. Again, thank you for the opportunity to appear before the committee, and we are happy to take some questions.

The CHAIR: Thank you to you both. That was a great snapshot. It is really great to see that what we traditionally see as policing and ambulance work is almost the tip of the iceberg of the actual work that your agencies conduct out there, so I very much appreciate that. We have got some brief time for discussion. I do not

have the exact timing but probably about half an hour. I would be interested in exploring what happens to people when they are released from hospital or maybe released from remand or released from police stations or released from prison. We have certainly heard that that cohort of people is a significant range of people, and it seems almost inhumane that someone would be admitted into hospital and then just released out onto the street, and certainly the same with prison or remand—that someone would be in custody and then actually released straight into homelessness. I am wondering if either of you have any thoughts or comments on that or can tell me about some of the actions that are being taken out there.

Asst Comm. HANSEN: I might kick off first of all. I can certainly talk about persons when they are released from custody. One of the key things we talk to our frontline practitioners about is their use of our Victoria Police e-Referral program. That is about trying to make sure that people are connected to services. One of the challenges with that, although it is an electronic referral process, is it may take the system a week or two to catch up with an individual, and if an individual is of no fixed place of abode or itinerant in their movements, it takes even longer obviously. So one of the things we really struggle with, if I can make this observation, is the issue of information sharing across government. As I have said, we are one of probably three agencies—Salvation Army, AV and ourselves are probably the three agencies—that operate 24 hours a day, seven days a week. We really suffer and find it really difficult to connect into services at 2.00 am on a Wednesday morning. It does not matter if I am in the CBD of Melbourne or rural Victoria.

When we reach out to DHHS or other funded agencies and look for that information sharing, which would give us hopefully an overview of someone's case management arrangements, who are contacts for after-hours case workers, parole officers, even a higher-level view of treatment plans, which may give you an opportunity to consider both a person's safety and health and connectivity to services—an overview of that—we really struggle. In fact when we overtly—and we have recently gone back into DHHS—seek that information, we are refused it. We get that, we understand why, but it is an absolute challenge in that real-time aspect of our work.

The CHAIR: Tony, before you comment, could I just ask Tim a quick question. We have heard from the City of Melbourne and I think the Salvation Army that there is a by-name list, and I think that particularly applies to rough sleepers. Are you part of that by-name list? Do you have access to that?

Asst Comm. HANSEN: No, we do not.

The CHAIR: Okay.

Asst Comm. HANSEN: In the COVID context in relation to public housing, where there was quarantine in place, we did get it—there was a state-of-emergency provision, but in a normal world we do not have access to that detail, and so we have concerns. Some of the concerns we have raised with DHHS around accessing that for us is there are legal and lawful requirements—say, for example, registered sex offenders. In the hotel aspect of the COVID world there were large numbers of people cohabiting, and we had no vision around who there was a registered sex offender, or whatever.

The CHAIR: Yes. Okay, thank you. That is really important. Yes, Tony.

Assoc. Prof. WALKER: From our perspective we do not really get much of a sense of it. We will respond obviously to the emergency that occurs and they will be taken to an emergency department. It is often once we arrive at the emergency department that we will get a sense of some of their history. So our current systems do not allow us to tap into someone's medical history more broadly at the point of call or when they are being assessed. Now, we are working towards that at the moment. One of our pieces of work is on how we can actually connect in and get access to medical records so that our crews can, in real time, actually be making an assessment of their sort of broader history and what their needs would be. Right now it is very much the experience of the individual when we are called, and they are making an assessment of what their particular needs are, and in the majority of cases where it is unclear, it is to an emergency department, which is not ideally the best place for them at that time but it is probably the only pathway for us.

The CHAIR: So you do not see them as they are leaving the hospital, obviously? You are dropping them off, but as they are released they—

Assoc. Prof. WALKER: That is correct, although my crews will tell me there are times when we will get called and we will be taking them back in. They may have been there earlier that day. So again, their underlying

issue is still there; the emergency department probably was not the right place, but they have got nowhere else to go.

The CHAIR: Thank you. Tien.

Dr KIEU: Thank you. Thank you both for presenting here today. I am a bit concerned. This theme appears again and again, about data collection, availability and reliability so that various agencies across the board can work together and identify the problem and at the higher level we can have a better understanding of the problem and hence policy formation. I understand the problem of privacy of course but, for example, in terms of emergency when an ambulance arrives to a person who is very distressed or in a very difficult situation, their personal medical history is something that would help the person rather than something that would impinge on the privacy of the person. So that is something we have heard, and we are a little bit concerned about that—at least I am. I have a question: both of you, Tony and Tim, have mentioned the preventive measures, so can you go into detail a little bit? From the context of your work and your agency, what could you do and what would you like to see done more?

Asst Comm. HANSEN: Well, I think I have given an overview of our approach to joined-up services. We see intervention and the connection of services, which I think goes to your point around information sharing as well, as a critical factor in our ability to provide a tailored response to people who are in crisis—so a whole-of-government approach that is led by principles of information sharing but also of services connection. The issue of data collection is a vexed one from a policing perspective—can I just highlight that? When we start collecting data, we need to be mindful not only of a person's human rights but also that we do not face allegations that we are profiling specific groups, cohorts or for that matter communities. So collecting data is important to us because it forms the evidence and the intelligence for us then to task resources into hotspot places. But we also need to be mindful when it comes to individual characteristics and descriptors that we do not fall into a world where we are inadvertently or otherwise profiling specific groups. That is one of the challenges for us.

Look, I think prevention is absolutely critical. I now sit over a command which is about service delivery transformation. One of the big focuses for this organisation moving forward is: how do we keep delivering tailored, specific responses to issues of harm? And so therefore the lesser crimes or the lesser incidents of harms, how do we minimise our commitment to resources there? Therefore, how do we effectively prevent the need for police to be involved in the first place? So absolutely you can look at the homelessness issue just through the lens of housing stock—cheap, affordable housing, public housing. But from our perspective—and this is what our e-referral process is based upon and our community and our partnership approaches all are based on—you need to address the symptoms not the causes. You need to think about an individual's safety, their mental and physical health and their connection to community, and when you take care of those issues from our perspective in totality, issues of persons experiencing homelessness start to take care of themselves. Hence my view that we need a holistic and well-coordinated, centrally coordinated, capability across government.

The CHAIR: Tony, did you want to comment on that?

Assoc. Prof. WALKER: Yes, thank you. I think from our perspective we are the safety net, in some ways, of urgent care, so we will be called because someone has a particular health crisis. In many cases with the homeless that is not an emergency, but we are the service that they call by themselves or by somebody around them. I think a lot of the work is about: how do you avoid, for example, the uncontrolled blood pressure issues, wounds that are not being properly cared for? How do you ensure that access to good primary health that is sensitive to their needs is there? I must admit I am not across it in detail, but I have been impressed by some of the stuff I have heard about Cohealth and taking GPs directly out to the homeless in the community. The work we have been doing in the health hub, obviously, is a space where people who are homeless can come and seek that primary care, because untreated primary care issues will by their nature become emergencies over time. Or alternatively in the absence of it they will then seek help in an emergency department or somewhere else for their primary care—which again is not an ideal location but is maybe the only thing available to them.

I think we would say that focusing energy on accessible primary care that is sensitive to the needs of the homeless—as well as, as Tim said, the importance around housing and all those core things that address wellness—is a significant benefit of investment. Otherwise we will continue and obviously we will always

continue to provide that safety net, but it is not necessarily the best care for them at that time from our perspective.

The CHAIR: Thank you. Rod?

Mr BARTON: Thank you, Chair. In your submission you say that just under 1 per cent of your call-outs are to homeless people. There is obviously a cost to doing that. Can you put a dollar figure on that? Would you know that?

Assoc. Prof. WALKER: I could. I would probably have to come back to you with what it is, but in essence every case that we respond to would be charged around $1200. That is the normal cost, picked up usually by either a healthcare card or by the membership scheme, so it is a sort of an indicative figure. But we can certainly calculate that and come back on what the overall cost would be.

The majority of the homeless are covered through a healthcare card, although in many cases we are writing off any bills associated with the homeless because we just do not have any addresses. Even if they are covered by a healthcare card, we just do not have that information, so those, by their nature, are written off.

Mr BARTON: And just roughly—I cannot remember what you said just previously—it was about 20 per cent of those do not need to go to hospital, but the challenge for you is that you do not know until you get there, do you?

Assoc. Prof. WALKER: That is correct. Our secondary triage area is a really good system that actually has nurses and paramedics who can do a detailed assessment over the phone and sometimes therefore work out a different pathway for them. But often when they are calling via 000 we do not have that information, and we treat it as an emergency on the basis of what we have.

So you are correct: it is only when we get there that we realise that actually they do not need us. They may need some care, or they may need some referral elsewhere. So it is difficult to determine, and we take a risk-based approach to when that call comes in, obviously. If we do not have a lot of information, we will obviously respond.

Mr TARLAMIS: Thank you, Tim and Tony. Are there any specific programs or training that police officers or paramedics undertake to give them an understanding about the complex needs or issues that homeless people may be facing to better help them deal with the situations they find themselves in when they are coming into contact with them?

Assoc. Prof. WALKER: I am happy to kick off if you like. Not specifically for us at Ambulance. The introduction of the hub in the city has been a very useful place for us to actually get greater exposure. That has been a useful tool in some ways, for us to have a lot of our paramedics who work in the CBD actually get exposure in a non-emergent situation with the homeless and develop communication skills.

Monash University did an interesting piece of work with paramedic students where they actually exposed them to spending time with the homeless. That was shown to increase their empathy for the homeless in the community. That exposure many people do not have when they have come from backgrounds where they have had no experience with the homeless, so this gave them a rich opportunity to learn more about that.

We are obviously doing a lot of work in ensuring we are being sensitive to particular needs of individuals, but it does not address the homeless in a specific sense.

Asst Comm. HANSEN: First of all, in their initial 20-week training, so whilst going to the academy, they participate in what we call the Victoria Police Community Encounters program. That provides our police recruits an opportunity to engage with a diverse group of volunteers, some of which are obviously connected to homelessness agencies. Also, at several points through that training they go into a dedicated training workplace program, where they go out into the field, and all recruits pass through the CBD, where they are exposed to the Community Hub in the CBD and the thinking that sits behind that.

The other couple of issues that I will just add to that—all members undergo extensive training in dealing with people experiencing mental health. That has been a big focus of the organisation in recent years. And then from a program perspective, we have the embedded youth outreach program operating across Melbourne's inner

western suburbs, which we run jointly with YSAS. Again, that has a strong focus on issues of homelessness. That has a YSAS worker working with a VicPol member, and those two employees drive around together and trade capabilities, effectively. We really do see some value in our police members being exposed to what I am going to call the softer skills of youth engagement and other alternative options apart from enforcement in which they can get better outcomes for a youth who might be in crisis.

And finally, we have a 'walk in their shoes' program run by the Melbourne East police station. That is designed to provide police with knowledge about people experiencing homelessness in Melbourne's CBD. That is a collaborative program that is undertaken in conjunction with Justice Connect and the Council to Homeless Persons.

Mr TARLAMIS: Thanks. Just by way of follow-up, you have both spoken about the hub model and how successful it is. Is there a model like that that operates in other areas outside of the CBD? And if not, do you think that that is something that could be rolled out to other areas and would be effective?

Assoc. Prof. WALKER: I am not aware of it operating elsewhere. I think there is also a critical mass around it, so I think obviously the Salvation Army services have been built around the fact there is a critical mass of homelessness within the broader CBD. Tim may be aware of it, but no, I am not aware of it operating elsewhere. If we look at our data, and we obviously do not have full data on the homeless issue in the community, certainly it is around the CBD where the volume for us exists. I am not sure how significant it would be in the locations to have that critical mass to build a similar service, but again Tim may have some more info on that.

Asst Comm. HANSEN: No, I am not aware of it operating outside of the CBD. We would be supportive of an exploration of that, noting that it does take a significant commitment from local councils and agencies that needs to be considered, coordinated and resourced as well. But we would be supportive of exploring an expansion of that program.

Mr TARLAMIS: Thank you.

The CHAIR: Thank you. We will go to Wendy, then Kaushaliya.

Ms LOVELL: Thanks for your presentation. Tony, I was just wondering: I know there are a number of public housing estates where the ambulance will not go without police escorts; do you have the same problem in the inner city with the homeless? Are there areas that you cannot go to unless you have got police escorts with you, or are you quite comfortable with the homeless community?

Assoc. Prof. WALKER: I am not aware of any. I am not saying it does not happen, but I am not aware of any being brought to my attention. I think, generally speaking, our experience with the majority of the homeless that we address and interact with is a good relationship—

Ms LOVELL: That is good.

Assoc. Prof. WALKER: There are mental health or other issues. We are well trained to be able to deal with those. But no, I am not aware of any specific locations that we would have identified to have police assistance to respond to in the broader homeless community.

Ms LOVELL: Yes, okay. And just for Tim, the homeless community is inflated by a lot of people who tend to gravitate to them. They are not necessarily homeless, but they feel comfortable amongst that community. Is that a problem in itself? I mean, we saw that problem a couple of years ago when they tried to move them on from Flinders Street station during the tennis at that time. Is it the genuine homeless people that you tend to have a problem with, or is it the people who infiltrate their groups?

Asst Comm. HANSEN: I think it is a combination of both. I spoke about the emergence in recent years of what I am going to call 'professional beggars'. Certainly there is no doubt that people were masquerading across Melbourne's CBD, and I think it was about July 2019 where seven people actually were flown in from overseas to execute this function. And that is something that we see happen from time to time: the professional nature of begging. Not from time to time, to be honest with you—it happens quite regularly. So I think there is some cross-pollination or some infiltration there, if you like. There are certainly those that, if I could use the

term, hang out in the CBD with the homeless. There is certainly an element of that that have a place to go back to. Their housing may not necessarily be secure, but they certainly have a house to go back to.

I also just want to make note of the issue that, you know, I am fed back anecdotally quite regularly by frontline police that sometimes—well, many times—they go to the extra effort in trying to secure crisis accommodation for people. They source that accommodation, and they get the person experiencing homelessness into crisis accommodation or into public housing even on some occasions where they are fortunate enough. There is a cohort out there that within a couple of days or a week they are back out on the streets again. So this goes to my point: if we do not look at the whole [inaudible] or if we do not address the underpinning issues, then the housing stock in and of itself is not going to solve this problem for us.

Ms LOVELL: Yes. I totally agree with you. Homelessness is a far more complex issue than just housing. If you do not address those underlying issues, you are not going to maintain a tenancy anyway.

The professional begging—have you got any recommendations as to how that can be stopped? That not only makes the appearance of the numbers of homeless inflated, but it also gives the genuine homeless a very bad name because a lot of those professional beggars become very aggressive with people as well.

Asst Comm. HANSEN: Look, I will not take a position where I make a recommendation. But what I would say would be some of our challenges around professional begging. There has certainly been a paper that has previously been shared with us about the decriminalisation of begging or decriminalising passive begging. To prove the charges of professional begging and the elements of coordination and organisation is very, very resource intensive for us. So for us to try and differentiate between that would become really, really difficult, and I think you would end up with an unintended consequence, where we would probably be unable to enforce either element of that, to be 100 per cent honest, because of the nature of the resources that would be required.

The other problem with that approach too, from our perspective, would be you run the risk of—well, it is not a risk. Obviously there is an opportunity for people to become financially sustainable, which is a great outcome. But again, if we are not addressing the underpinning causes of their homelessness in the first place, they start to move away from the services that are there to wrap around them when they are homeless. I am not saying that is a great outcome, but again, I just flag that as potentially being an unintended consequence of that approach.

Ms LOVELL: Yes. So you would prefer it to be left there—begging is illegal—and with an easier way for you to police it?

Asst Comm. HANSEN: We see it as a tool in our kit belt. What we are pushing our members towards is greater uptake of diversionary and caution outcomes but associated with the criminal offence. That, if done well and if done with the support of legislation, starts to give us a real opportunity to divert people back into the health centre but with a carrot-and-stick approach. As I say, we are charged with community safety, so for us an element of regulation should always be present when we have those discussions.

The CHAIR: Thank you. Kaushaliya?

Ms VAGHELA: Thanks, Chair, and thanks, Mr Walker and Mr Hansen, for your submissions and your presentations today. My first question is to Mr Walker. In your submission it states that nearly half of the call-outs related to people experiencing homelessness involve a mental health condition. Is there a way, do you think, we could prevent these call-outs?

Assoc. Prof. WALKER: I am not sure we can prevent them, other than we could possibly better triage them at the point of call. We have mental health nurses working in our secondary triage area that are actually able to deal quite well: identify someone's mental health history and be able to identify the best pathway for them and often give advice to them over the phone. It is specialist. The challenge with the homeless is because we do not have an address that we can link them with, we will not refer them on easily to secondary triage. So the ability to get information about that individual would help us bypass the normal 000 process and actually put them into secondary triage where we could spend more time identifying a right pathway for them rather than sending an ambulance. I also think there is that broader piece around—and Tim mentioned this before—the wraparound services: ensuring we have got the right mental health services to support them as well in location to meet their particular needs, which will probably not be the traditional ones that people will often access in a traditional health service.

Ms VAGHELA: And my next question is to Mr Hansen: in your submission there is mention of a lot of family violence, which is a key cause of homelessness. Following the Royal Commission into Family Violence, we have seen renewed efforts and resources to deal with this issue, but do you think that the measures that have been taken so far, in terms of the family violence space, have been successful, and if not, what are the other things that the government can do to prevent victims and perpetrators of family violence becoming homeless?

Asst Comm. HANSEN: I am not 100 per cent sure whether that is in my remit to comment on. We have not addressed it both in the submission and I do not sit specifically over the family violence command, so I do not have a direct line of sight of where the recommendation is at, apart from the fact that I have been briefed we are acquitting them. So obviously I will make this observation: family violence remains a significant driver of our service delivery demand. The representation of those that are experiencing homelessness either as an outcome of family violence or as a contributor to it is significant. So from that context, if you think through our role of keeping the community safe, there is still a lot of work to be done.

Ms VAGHELA: Just a last one: Victoria Police have had an operating protocol in place with the City of Melbourne for rough sleepers since 2017, I understand. Do you think this has been successful in addressing public amenity and safety?

Asst Comm. HANSEN: Sorry, I do not know if you are breaking up at my end or your end.

The CHAIR: Kaushaliya, that was just actually a little bit hard to hear you just then.

Ms VAGHELA: Have I got time?

The CHAIR: Go ahead. We just had trouble hearing you.

Ms VAGHELA: Victoria Police have had an operating protocol in place with the City of Melbourne for rough sleepers since 2017, I understand. Do you think this has been successful in addressing our public amenity and safety?

Asst Comm. HANSEN: You were just breaking up again. I think that was in relation to Operation Protocol. Is that right?

Ms VAGHELA: Yes.

Asst Comm. HANSEN: We think it is really successful. Again I spoke before about this. I am going to call it the two-pronged attack. It does give us an ability to have the stick there, but the primary focus of us is the joint outreach teams. We go out with other agencies and we address the underpinning causes of people's homelessness, I guess. The other element of that is we take a place-based approach to Operation Protocol. So we do work with council then about going back into areas where—I am going to use the term—tent cities pop up, and they rehabilitate a precinct. I have some data here somewhere where I think it was 1.5 tonnes a week were taken out of some of the key hotspots in relation to rehabilitation of those areas. That, from an aesthetics and an amenity point of view, being the CBD in a state that supports 5 million people, is a critical outcome as well.

The CHAIR: Thank you. It sounds like there are some drums going somewhere. Thank you both. That was really informative, and I think certainly, as I said earlier, it has given us a much deeper understanding of the underlying work that both of your agencies are able to do and the services that you are able to provide to people experiencing homelessness. I agree with you: it seems like—and as the deputy said—research, research, and I think certainly some of the programs that you are both doing really do need some evaluation to see whether we can build them up or move them into other locations that might be necessary. Again, thank you so much.

You will receive a transcript from this, so please have a look at it. Again, we really appreciate the work that you have been doing out there in the field on behalf of all of us but also the work that you are doing in regard to this particular cohort of our citizens. Thanks, everyone.

Witnesses withdrew.