T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Homelessness in Victoria

Melbourne—Tuesday, 23 June 2020

Hearing via videoconference

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Mr Lee Tarlamis

WITNESSES

Ms Mary-Anne Rushford, Manager, Homeless Persons Program,

Ms Julie Fry, Team Coordinator, and

Ms Karyn Gellie, Team Coordinator, Bolton Clarke.

The CHAIR: I now declare open the Standing Committee on Legal and Social Issues public hearing for the Inquiry into Homelessness in Victoria. We have just come back from a short break, so thank you, everyone, for your patience and thanks to everyone who is watching the broadcast live from wherever in the world you may be. Thank you for coming today. I have just got some information to provide to you before we get going. All evidence taken at this hearing is protected by parliamentary privilege, as provided by our *Constitution Act* and the standing orders of our Legislative Council. This means that any information you provide during this hearing is protected by law, but if you were to repeat those comments outside, they may not have the same protection. Any deliberately false evidence or misleading of the committee may be considered a contempt of the Parliament.

As you have obviously become aware, this is being broadcast. It is also being recorded, and we have Hansard taking an accurate transcript of this session. You will receive a copy of that, so I really encourage you to have a read of it and make sure that we have not misrepresented anything that you said. Ultimately, that transcript will form part of our report and will go up on our website. Again, Karyn, Julie and Mary-Anne from Bolton Clarke, thank you so much for making the time to meet with us, and thank you for your very detailed submission as well. All members have received a copy of that. If you would like to make some opening remarks, and if you can keep it to around 10 minutes, we can then open it up for the committee to ask some questions and have further discussion.

Ms RUSHFORD: Thank you, Fiona. We would like to start by thanking you for giving us the opportunity to provide evidence to this inquiry on behalf of Bolton Clarke. Bolton Clarke is one of Australia's largest not-for-profit providers of healthcare and aged-care services through home nursing, at-home support, retirement living and residential aged care and specialist services. It was formed when the Royal District Nursing Service, also known as RDNS, which has operated in Melbourne since 1885, merged with RSL Care in 2016.

Since it started more than 100 years ago the organisation has been supporting people living in insecure housing or on the streets. In 1978 we started our dedicated Homeless Persons Program or, as we will call it, HPP. HPP is based on a rights- and equity-based model of health care. So this means we believe that people who are homeless have a right to health care that is the same as anybody else in the general community. HPP works with people experiencing homelessness or at risk of homelessness. So we use quite a broad definition: people that are socially isolated, live in unstable or unsafe housing, have a low income and little prospect of self-support. We work with homeless people to identify their needs and meet them in partnership with other community organisations, health and housing services. HPP has a team of 50 community health nurses, two personal care attendants and an HIV team consisting of five nurses, and we have quite a large geographical spread.

We are mostly government funded. State funding is through PYP, the Program for Younger People, for clients aged under 65 or under 50 if Aboriginal; IHSHY, which stands for Innovative Health Services for Homeless Youth—we have two nurses that work specifically with youth aged from 12 to 25; and commonwealth funding is via CHSP, or the Commonwealth Home Support Programme, for those aged over 65. Melbourne's Street to Home is funded by the National Partnership Agreement on Homelessness.

HPP nurses assertively outreach to people, which means they go out to where homeless people live and gather: crisis accommodation; on the streets; in parks; at lunch programs; in low-cost hotels, boarding houses or other sites, such as caravan parks. Assertive outreach works because it helps us reach people who have complex health issues but who are not generally engaged with the general health services. Often an HPP nurse is the first point of contact for clients with the healthcare system. The care is client driven. By that we mean that the client directs the care that they receive. This could include a health assessment; health education; a clinical response, such as a wound dressing; or referral to another service, such as a GP. The relationship that the community

health nurse develops with clients is based on trust, which means the nurse can support clients to identify the issues they wish to address and assist them to engage with other services.

Our model is to co-locate with other organisations who also work with homeless people but their core business is not necessarily health care—for example, Launch Housing and the Salvation Army. This creates networks and builds relationships that lead to better outcomes for our clients. It also increases knowledge amongst non-health workers and develops strong partnerships.

In this financial year HPP have supported just over 2400 clients, with 49 400 visits. Sixty-six per cent of our clients identify as male and 34 per cent female, 7 per cent identify as Aboriginal, 33 per cent of our clients are aged 40 years or younger, 28 per cent are between 40 and 49 years and 39 per cent are aged over 50. A recent snapshot of our rough sleepers showed that 43 per cent had attended A and E or hospital three times in the previous year, with 84 per cent reporting substance issues, 61 per cent a mental illness and 70 per cent reported a serious medical condition. Whilst we have had a presence in St Kilda, Springvale and Dandenong for over 20 years, since 2013 we have expanded our services in the south to Frankston, Rosebud and Cheltenham and have increased our nursing positions in Dandenong. HPP have nurses placed with Neami and Launch Housing in the south in their rough sleeper teams as a result of *Victoria's Homelessness and Rough Sleeping Action Plan.* We support the multidisciplinary and systems approach in achieving successful client outcomes. I will now hand you over to my colleague Julie, who will speak to our Frankston evaluation project.

Ms FRY: I am going to talk about the expansions to the south of our program that commenced in 2013. It started originally in 2008 when HPP became aware that Frankston had the highest proportion of people experiencing primary homelessness in the Southern Region. We subsequently undertook a needs analysis, which identified that a high level of unmet health needs existed amongst that population. We then sought funding from a variety of agencies, but we were fortunate enough to get funding from Gandel Philanthropy for three years for a community health nurse to implement the HPP model of care in Frankston. So by the time that all happened and got established it was 2013 when we started.

HPP also committed to the funder to undertake an evaluation of this initiative so that we could show if we had made a difference in the local community about what we were rolling out. The model that we used was the one that we used with HPP across a lot of our outreach positions, which included in this case a regular drop-in clinic for the nurse who was co-located with CityLife, which was a Christian-based organisation that had a meals program, and also included assertive outreach to other meals programs and welfare services across the Frankston local government area and included going out with the local ranger even to rough sleepers on the foreshore of Frankston, where a lot of them would gather.

One of the things that we did was we formed a local advisory group and steering committee because we wanted to implement it in a way that the local community had a say in what we were doing so it was not just us, 'Here's our model. Take it'. We met with them and talked to them about what would work within their area, and it included key stakeholders such as the local council, Medicare Local, Centrelink, community health service and welfare organisations. We tailored the response that we were giving to the local need.

The development of this collegiate and collaborative work was also very important to us being able to make a difference within the local community as we were working with other service providers in the area. So between 2013 and 2015, 39 clients were admitted to the HPP service in Frankston, and all those 39 clients received assistance from the community health nurse.

The evaluation of the program that we did do with our dedicated institute that we have within our organisation of research showed that there was an improvement in the health and wellbeing of the clients, and there were improvements in the local homelessness-specific services as well. Cathy, our nurse, was able to roll out a number of primary health and health promotion programs that really started to do this cross-linking between a lot of organisations, so there was a Pets in the Park, the Mental Health Legal Centre started running a clinic for the legal issues of our clients group. She started a community garden within the local Rotary so that her clients could come and participate in that. There was really an upticking in the way that our clients saw themselves being able to contribute as well.

These initiatives were embraced by the clients and other services, as they did fill in gaps within the local service delivery and then they enhanced the social connectedness of the clients. I think the value of a community health

nurse from HPP, not just to Frankston but across most of our positions as well, is because we are able to prioritise and focus on the primary healthcare needs while working with other agencies. Then they can focus on other areas of the client's need but we can just have the health lens, which I think really supports our clients in trying to get their health needs sorted out.

The establishment of the HPP community health nurse in Frankston improved the ability of people experiencing homelessness to access services, address their health needs, engage in social activities and increase the client's self-determination and personal sense of empowerment. And importantly for us I think the evaluation that we did do enabled us to articulate the practice framework and the model that we use and to formally document the success of the program in delivering health care and better health outcomes for people experiencing homelessness. Now I am going to hand over to my colleague Karyn.

Ms GELLIE: Thank you. Just to sum up our presentation, health and homelessness are intertwined. Poor health is both a pathway to homelessness and an impact of homelessness. The health inequalities of people experiencing homelessness are well established in both morbidity and mortality. The underlying causes of the health inequality are social inequality and a lack of access to society's resources: for example, housing—it is very difficult to improve health without adequate housing—food security, income and others. People experiencing homelessness are impacted on by multiple social determinants of health, and this results in extreme exclusion. The impact of the social gradient is evident in people experiencing homelessness, with one researcher from the UK describing the slope of the gradient as a cliff when it comes to rough sleepers in terms of their health outcomes. A lack of access to health care exacerbates health inequality, but it is not the underlying cause. Social and health inequality results in individuals being under-resourced, distrustful and disempowered.

To improve the overall outcomes for people with homelessness, we believe that we need earlier intervention. We need to address the underlying social determinants of health with collaborative approaches, including access to housing and, in particular for our client group who often have significant disabilities, supported housing access. We need to use evidence-based approaches that are empowering, including Housing First approaches, building engagement and trust, doing assertive outreach, and flexible and low-barrier access to services. We need to better understand of the impact of acquired brain injury as a pathway to homelessness and as a complexity in resolving homelessness. We need improvements in hospital systems and collaborations between services to ensure people are not discharged into homelessness. We need a greater geographical reach of assertive outreach programs to cover Victoria. There are lots of gaps in the system. That concludes our address, and we would welcome any questions.

The CHAIR: Thank you, all. And thank you for the amazing work that you have managed to continue for the centuries that it has been running for—that is great. I wanted to, in my short time of asking questions, ask you about that exit from hospital. I think it would disturb everyone in the community to realise that people with ABIs or with significant health issues are actually being discharged into homelessness. You touch on in your submission medical respite units, and I am wondering if one of you could expand on that and what we can do to just make it impossible for someone to be discharged into homelessness from a hospital in Victoria.

Ms GELLIE: Thanks for the question. Yes, I think it is quite shocking to many people to know that people are discharged into homelessness, and I say that understanding that the system is complex and it is very difficult for hospitals to be able to provide an appropriate discharge place for people. It comes down to a lack of crisis accommodation and a lack of other suitable housing options. Often people are discharged into supportive residential services, and this can be problematic as well, although it can be a good option for some people. I do not know if I have all the answers to how to resolve this issue, but I think with most things to do with complex homeless issues it comes down to collaborating with services—collaboration with housing services—and coming up with new models that may address this issue. I do not know exactly what some of those look like, but I think that we do need to put more priority on developing those models.

In terms of the medical respite—I think medical respite is maybe not the best term; I think it is one that has been used a lot overseas, and that is what some of the research is around—we certainly already have a small respite-type service based at St Vincent's Hospital called The Cottage, which has been there for a long time and has provided wonderful support to many people experiencing homelessness.

Currently there is a project to look at expanding that, which St Vincent's already talked about in one of the other hearings as well. I think that is probably all I can comment on.

The CHAIR: Great, thank you. I think certainly The Cottage program is interesting, and we will continue to explore how we can get that happening in the south and in more regions outside the CBD.

Dr KIEU: Thank you for the submission and the very good work that you have been doing. This is a big problem. I just have two questions. One is that in the south-east in particular there are a lot of people from multicultural ethnic backgrounds and also there are a large number of either refugees or asylum seekers who are not entitled or have not been able to receive services otherwise. So what then is the need for those cohorts and, secondly, have you any experience in dealing with them and helping them? That is my first question. The second is that homelessness is a very big issue, and we recognise it has been helped by various levels of government. For example, the state government has put $1 billion into the Victorian Social Housing Growth Fund and $180 million and more for redevelopment. But it is complicated because, as you mentioned, this is connected to health, either physical or mental health. So from your point of view, would operations based on case management be a preferable method rather than an output where the people come in and out and without being followed up on and being helped in the longer term?

Ms RUSHFORD: Thank you for your questions. Asylum seekers and refugees are a problem amongst the homeless population, and it is complicated by the fact that they often have no income, so that makes options for housing extremely difficult. I guess we have a very successful partnership with the Mental Health Legal Centre, so we would rely on their assistance. While asylum seekers may not be their specialist area, they are certainly usually able to refer us to another legal service that can look into those issues for our clients. Does anybody else want to add anything?

Ms FRY: I think that we have been able to do some good work with refugees and asylum seekers. Around Dandenong in particular we have a nurse who works pretty closely with that community with Wayss, the housing service. They will often come in there looking for housing, so we will often try and pick up and follow up with the health issues. But I do acknowledge that it is a big problem in terms of how we help these people, because we cannot get them housed because they are not eligible. They are often in cramped situations. They are often in overcrowded housing or rough sleeping in warehouses. We have come across them in lots of different areas. So I do acknowledge that that has been a huge problem, and we are conscious of it. We would love to have the opportunity to be able to do more, but it is around funding and where we can take them to and how we can help them. So that is sort of like another part of what we do as well.

Dr KIEU: And any comment on the model of case management versus in and out of the door for immediate needs?

Ms GELLIE: I think that case management-type approaches certainly can improve outcomes for people. It is based on that trusting relationship and that engagement and the ongoing relationships, because obviously a lot of the issues that people are experiencing are complex and any short-term actions are usually just bandaiding the situation. So it is those longer term relationships, not necessarily with one person but with a service, and again collaborative relationships that can address the complexities. Whether it is alcohol, drug issues or mental health, they will certainly get better outcomes in the long term.

Ms RUSHFORD: And also I just wanted to add that many services have restrictions around how long staff can work with clients, but we do not have any such restriction. Many homeless people are quite transient, so one of the benefits of working with HPP is—

As I mentioned, we have a team of 50 nurses working across a large geographical area of Melbourne. All of our client notes and client records are electronic, so it makes it very easy for our nurses to see that one of their colleagues has been working with somebody, they can very quickly see the work that has already been done, so they are not doubling up on that care, and they can even usually ring that nurse and have a conversation about the client. So it does lead to better outcomes for our clients, having that continuous care.

Ms LOVELL: The district nursing service used to run a very successful outreach nursing program in Fitzroy—Brunswick Street. Is this the same program now? Has it just become HPP?

Ms RUSHFORD: Yes, it probably is, I would imagine. We have been in St Kilda for probably since the 1970s.

Ms LOVELL: So obviously it is an established, proven service. If you were the minister, what would be your answer to your problems?

Ms GELLIE: That is the million-dollar question, isn't it? I think, as you said, it is an evaluated and trialled model and we do believe that providing comprehensive primary health care in people's local area, adapted to local needs, in collaborative approaches that address the social determinants and the underlying health as well as providing that assertive outreach where we provide a service at the point of contact, really does get health outcomes for people, and that is what we believe is best practice.

Ms LOVELL: So is the solution just more funding or are there other ways that the government can help you with the red tape or regulatory things that need to be reduced so that it allows you to do your work better or more easily?

Ms GELLIE: I think more funding is always welcome. As I said in the initial introduction, there are geographical areas that are not covered by outreach or other assertive outreach and certainly not by outreach health services. I think there is certainly additional funding. One of the things that we do impress is that without that stable housing it is very difficult for anyone to address their health needs. They are under-resourced. We do believe in extending Housing First programs, where the person is getting that stable housing but also getting that comprehensive wraparound support that comes from multi-disciplinary teams so that we can really start to address some of the issues that were causing their homelessness in the first place.

Ms VAGHELA: Thanks, Mary-Anne, Karyn and Julie, for your time and submission and the great work that you do. I have got a two-part question. The first one is: how are the reasons affecting the younger people different than the elderly people in times of homelessness or housing sector? And the other one, what I understood from the submission that I read and also from the recommendation in the submission, and I think Karyn touched base a little bit on that, the link between the social inequality and the ill health and homelessness. What I am understanding that is just the manifestation of other underlying issues, say, for example, social inequality. So what are the three things you would recommend that we address in terms of social inequality will help us in addressing the homelessness or housing issues?

Ms FRY: Well, I will respond to the first part of your question, which is about the problem of youth homelessness. I was a youth outreach homelessness nurse when I first started with HPP, quite a lot of years ago now, but I do not think it has really changed that much. Certainly from my experience in that work the main issues were around family breakdown and all of those sorts of things that have happened for millennia, but I think the other problem that I saw a lot of was people leaving care, so people who had been brought up through foster or departmental care under the DHHS, and that that was often the beginning of a homelessness cycle. I think that we really need to do more work at that end of the cycle around how do we get young people connected who have experienced homelessness, especially if it started in their childhood—I guess a lot of those community hubs that exist that have schooling and housing—and going on to work as the way to go. I think that needs to expanded because—I think that is one of the things—if you lose young people really early from education and feeling like part of the community, they get disconnected so easily. They do not have that place to go home to for a Sunday roast or to do their washing that supports young people as they do go and become older. I think that with that sort of thing really what they miss out on is that family and community. I think that is a real problem that we really do need to look at.

Ms GELLIE: I will just respond to the second part of the question. It is a really good question, and I think I will harp on again about housing being one of the most important social determinants of health that needs to be addressed. I think there are a couple that are sort of intertwined. I think exposure to violence is an issue, and that particularly relates to family violence. I know that you have heard at some of the other hearings about that from people with more expertise than I have. I think the other one is linked to several, and that is income. We put in a submission around Newstart, or now the JobSeeker, and even though that is a commonwealth issue it is linked to people's food security, their ability to pay for medication and other health issues like their ability to afford housing. It is also tied with the social gradient as well, where we have got people with lower levels of health at the lower end of the social income gradient related to social inclusion and related to income. What we need is to look at each government policy with an equity lens on that so as to make sure that decisions that are

being made are not causing negative outcomes for people at the bottom of that social gradient and that we are applying additional supports and services that will address that inequity. What I mean by that is programs like ours that are actually specialist services and that can address those gaps in service provision to people that are marginalised and excluded socially.

Mr BARTON: Thank you, ladies. Just going back to the Chair's question earlier about discharging the homeless, is there any data that you have that could give us an indication of how big a problem that is?

Ms RUSHFORD: I am not sure that we actually have any data, but we are office based in here and it is not uncommon to get a call from a junior social worker at a hospital wanting to discharge somebody. And when you actually tease it out, our first question would be, 'Which geographical area are they going into?', so that we could check whether we had a nurse working in that region. Often they will say, 'Oh, we're discharging them to Launch Housing', and we would say to them, 'But Launch Housing is just a contact place that you would go to to inquire about housing'. Launch Housing—and I know that you are speaking with them later today and that you have probably already spoken to them—have a lot of people that turn up actually still in their hospital pyjamas at the intake points. You know, people believe that they are discharging them to some sort of house.

It is a real lack of understanding within the sector about what actually is available. I think we have all experienced that in the office taking referrals from hospitals—there is just a lack of understanding I guess and not a lot of discharge planning or thought going into it. They will often be saying to us, 'Oh, but the doctor says they're ready to go, they can be discharged today'. I took a referral recently from a Melbourne Hospital actually, where they were saying, 'This person's ready to leave the hospital. What are you going to do about it?'. I had to sort of say, 'Well, I think actually the question is really: what are you going to do about it?', that they have that duty of care to try and find some accommodation.

And as Karyn has mentioned, that is often really, really difficult—to find somewhere appropriate for a client to go, especially if they are still maybe unwell or have some other clinical needs. They might need daily dressings or they may need assistance with their medication or their diabetes, for example. It is not easy. Again, the place that we would think of is The Cottage attached to St Vincent's, which is probably a facility that our nurses use quite frequently because it can be used for people discharging. Mind you, they are not really keen on just taking people from other hospitals—that would be what we would call a 'failed discharge' where there has not really been any real discharge planning going into that discharge, but they will take clients exiting other hospitals who still have some health issues that need to be addressed.

Mr BARTON: That need to be dealt with. Yes, a recipe for disaster just putting them out into a homelessness situation again, just a disaster.

Ms RUSHFORD: Yes, definitely.

Mr BARTON: One other thing, just in terms of the mechanics of how your clients get to you, I am assuming they are referred by the other agencies.

Ms RUSHFORD: Sometimes, yes.

Mr BARTON: Can people come to you? How does that work?

Ms RUSHFORD: We have a variety of different models. We have nurses based at the big crisis accommodations—for example, Flagstaff and Ozanam House—and our nurses will run a clinic there on different days of the week. So the staff at the crisis accoms would know when our nurses were working and either refer them themselves or often the client would just come and see the nurse themselves.

We also co-locate with other organisations that also work with homeless people. For example, you might be in an outreach position but you would work alongside workers from the other organisations to outreach to a caravan park or a rooming house or a lunch program. We would say that we assertively outreach, which is a skill in itself. You need to be able to go up to people and say, 'Hello, my name is Mary-Anne. I'm a nurse. I'm wondering if there's anything I could help you with' and talk about the sorts of things that you could assist with. And often it might not necessarily be a health issue; it might be a legal issue that they are very concerned about. We can refer them straight into our health justice partnership model with the Mental Health Legal Centre. In a way that is an engagement process as well, because if you can try and help get some of those other

things sorted that are really of concern to the client and causing stress and anxiety, that is a really good way to build that relationship so that you have then got that opportunity to assist them with their health needs as well.

Mr TARLAMIS: Thank you for coming along and presenting us to today. I was just wondering, with the current pandemic have you noticed any new issues emerging or just the current issues being exacerbated given the circumstances?

Ms RUSHFORD: Well, we have noticed nurses have really stepped up in the last few months and worked in ways that we have not possibly worked before. Some examples I can give you: many of the lunch programs and soup vans needed to close for obvious reasons, so a lot of our clients were faced with food insecurity. We do raise funds for food vouchers so we made food vouchers more available to our team and often if the clients were older and were at risk of going out into the community, our nurses would perhaps even do some shopping for them and deliver that food and get that to them. Also, a lot of the medical and health appointments moved to telehealth and many of our clients do not have that sort of equipment to access those appointments so our nurses were assisting to do that. Especially in the south I am aware of our nurses going into many rooming houses and doing some health promotion with the residents living there, plus with the proprietors, downloading forms from the DHHS website and placing them around the rooming house just to give some clients some information about COVID-19 and precautions that they needed to take.

Also St Vincent's Health set up a mobile fever clinic which was a car—two cars, actually—out on the road. Initially they were saying that they would only be able to test people in the CBD, but one of our nurses out in Dandenong and one in Frankston advocated to this team and actually got them coming out to a couple of the rooming houses and some of the bigger accommodations to get our clients tested. Of course if they had any symptoms, they were being referred to a drive-through, which obviously was not going to be possible because they do not have cars, mostly. So we have done some really great work in this COVID-19 space.

The CHAIR: Thank you, Mary-Anne, Karyn and Julie. Thank you so much for making the time today. I think it was very interesting and again you showed us that there are some pathways to solutions and the importance of health and the connection to homelessness. You will receive a transcript of this in the next little while so please have a look at that. Thank you again. Certainly the evidence you have provided today and the substantial submission you provided to us will assist us in our deliberations and our future recommendations, so we appreciate it all.

Ms RUSHFORD: Thank you.

Witnesses withdrew.