Inquiry into Homelessness in Victoria

Ms Anne-Maree Kaser

Organisation Name: Windana Drug and Alcohol Recovery Ltd
Your position or role: CEO

SURVEY QUESTIONS

Drag the statements below to reorder them. In order of priority, please rank the themes you believe are most important for this inquiry into homelessness to consider::
Rough sleeping,Services,Public housing,Indigenous people,Family violence,Housing affordability,Mental health,Employment

What best describes your interest in our Inquiry? (select all that apply) :
Working in the alcohol or other drug services sector

Are there any additional themes we should consider?

YOUR SUBMISSION

Submission:

Do you have any additional comments or suggestions?:

FILE ATTACHMENTS

File1: 5e3385212a602-2020 01 31 SUB_homelessness inquiry.docx
File2:
File3:

Signature:
Anne-Maree Kaser

WINDANA
Life. Changing.

31 January 2020

Legal and Social Affairs Committee
Victorian Parliamentary Inquiry into Homelessness

ABOUT WINDANA

Windana Drug and Alcohol Recovery (Windana) is a leading Victorian based alcohol and other drug (AOD) treatment service specialising in holistic, client-focused recovery programs. Clients choose from residential and a range of supportive community-based, harm reduction, recovery and rehabilitation programs. We help people rebuild their lives in a safe, caring environment and support our clients wherever they are in the recovery process.
Windana assists close to 2,000 people across Victoria per annum by providing AOD treatment services including residential withdrawal services, residential rehabilitation and a suite of non-residential services.

RECOMMENDATIONS

Recommendation 1: Prioritise a housing first model post discharge from institutional settings for those experiencing AOD dependency.

Recommendation 2: Subsidise the dispensing fee for Opioid Replacement Therapy.

Recommendation 3: Government prioritise additional support for enhanced coordination of care to improve referral pathways and support at risk cohorts to navigate the broader community service systems.

Recommendation 4: Individuals presenting to support services with a range of co-occurring morbidities can engage in a step up / step down model of care.

This submission will respond to the three Terms of Reference from the perspective of a leading Victorian alcohol and other drug treatment provider.

1. PROVIDE AN INDEPENDENT ANALYSIS OF THE CHANGING SCALE AND NATURE OF HOMELESSNESS ACROSS VICTORIA

Homelessness in Victoria is an enduring and expanding issue which often accompanies various aspects of disadvantage.

Windana acknowledges the breadth and depth of evidence provided to this Inquiry to date and will not seek to replicate this, but rather reflect on elements which intersect and are relevant to alcohol and other drug (AOD) dependency.

The Australian Institute of Health and Welfare (2020) notes the following as it applies to the intersection between AOD and homelessness across the nation.

- In 2018/19, 10 percent of those presenting to homelessness services reported AOD issues.
- This cohort has, for the four years leading to 2018/19, utilised greater support from homelessness services than other service users.
- Three in four service users from this cohort had previously engaged with homelessness services.
- Service users engaging the homelessness sector with AOD issues were less likely to be provided with accommodation; the absence of secure housing impairs recovery from AOD issues.
- The Illicit Drug Report System (IDRS, Stafford & Breen 2017) which surveys people who inject drugs, reports that 80 percent of those surveyed had a history of homelessness; and
- Service users engaging both AOD and homelessness services are three times more likely to be seeking treatment for multiple substances compared to those engaging the AOD sector and had fewer positive outcomes when compared to those who needed to engage either AOD or homelessness services.

This data aligns with observations of service users engaging with Windana who have a history of homelessness with the addition of an increased likelihood of further morbidities such as mental health concerns, chronic illness or presentation as a forensic service user. 11.8 percent of service users engaging Windana's treatment services between July 2018 and January 2020 presented while homeless. If accounting for prison, rooming house and other institutional settings, this increases to 19 percent – just under one in five service users. More than one in five service users (22.5 percent) present with a mental health issue. This data does not account for a prior history of homelessness. It is likely that these additional morbidities, coupled with AOD dependency, erect barriers to sustainable housing.

2. INVESTIGATE THE MANY SOCIAL, ECONOMIC AND POLICY FACTORS THAT IMPACT ON HOMELESSNESS

Willoughby et al (2019) cite a two to five-fold increase in mortality among homeless people when compared to the general population; mortality is often related to potentially preventable causes such as suicide and at-risk substance use and likely exacerbated by poor general health.

Willoughby et al (2019) further cite an increased likelihood of people without stable accommodation engaging with emergency services. Nambiar et al (2018) and Lubman et al (2017) note a higher prevalence of emergency department engagement among those experiencing AOD dependency. The corollary of both sets of data is a higher frequency of emergency department engagement among those experiencing homelessness and AOD dependency.

The average cost of a non-admitted emergency department attendance is $533 increasing to $969 if admitted (Independent Hospital Pricing Authority n.d). These costs are exorbitant and wasteful, especially if they can be prevented through an earlier intervention by timely access to the necessary supports. The likely harms accompanying an emergency department visit are also likely to be significant, enduring yet in many cases preventable.

Timely access to support services, such as AOD treatment, can be measured through systemic integrity and adequate capacity with a high frequency of emergency department visits a likely symptom of limitations in these areas. A core factor to the success of a course of AOD treatment is the presence of suitable and stable arrangements following discharge. The likelihood of relapse is greatly increased in cases where associated morbidities are not addressed and if barriers remain across various environmental and social factors, such as stable accommodation. Willoughby et al (2019) reflect on a 'housing first' model, whereby the procurement of suitable accommodation is prioritised for those experiencing AOD dependency, which is often a barrier to suitable accommodation. In Finland, the Housing First model has been operating for over a decade and during that time Finland has been the only European country to experience a reduction in homelessness[1]. The Finnish model provides for caseworkers to assist in coordinating support services as well as financial planning (Glösel 2019).

Recommendation 1: Prioritise a housing first model post discharge from institutional settings for those experiencing AOD dependency.

Specific barriers to AOD treatment, beyond system capacity, include the financial impost to engage in opioid replacement therapy (ORT). Apart from those who have been released in prison over the past month, people experiencing opioid dependency (such as heroin dependence) are required to pay a dispensing fee of at least $5 per day to be on the program. ORT is a lifesaving, evidence informed program which is impaired by the financial burden of the dispensing fee. Windana maintains the view that the dispensing fee should be subsidised by government for all ORT participants, including those experiencing homelessness. This cohort is likely to also experience financial duress and poverty; they may find the daily dispensing fee a barrier to access.

Recommendation 2: Subsidise the dispensing fee for Opioid Replacement Therapy.

[1] In the 30 years up to 2017, Finland has experienced a reduction in families experiencing homelessness from 1,370 to 214 as well as single people experiencing homelessness, which has decreased from 17,110 to 6,615; 5,528 of the 6,615 reside temporarily with friends or relatives (Kaakinen 2019).

3. IDENTIFY POLICIES AND PRACTICES FROM ALL LEVELS OF GOVERNMENT THAT HAVE A BEARING ON DELIVERING SERVICES TO THE HOMELESS.

While not for profit community service sectors generally provide evidence informed support, issues remain on service access, supporting a process of 'continuum of care' and cross sector capacity and coordination.

As noted above, limitations in access can be the result of systemic issues, such as referral pathways, intake and assessment processes, an overly complex system or an uninformed client base. Limitations in access may also be the result of a lack of capacity to meet demand. A combination of multiple factors often limits service access.

Prioritising a 'continuum of care' aligns practice with the notion that episodic approaches to support have limitations due to the durability of various complexities. With regard to AOD treatment, the funding structures are episodic with relapse being fairly common. AOD dependency, like many health issues, often reoccur. Despite this, the outcomes overall are highly effective with a return on investment of up to $7 for each dollar spent (Coyne et al 2015). Ongoing support post the conclusion of a treatment episode further improves the treatment outcome. Ongoing support can be achieved through the implementation of a multidisciplinary model of care that provides for a step up / step down approach to support. This enables the level of support required to be titrated based on severity of need and not on the duration of a funded episode of care, ensuring the right level of support is available when it is needed.

Both the Royal Commission into Family Violence and Royal Commission into Mental Health have referred to silos within various service systems and subsequent adverse implications on outcomes. Funding and governance structures can impede cross sector collaboration and capacity building as these elements remain difficult to measure and can be viewed as external to the key aims of funded service provision. A funding model which accounts for a narrowly focussed outcome limits collaboration, blocks cross sector pathways and perpetuates siloes. A greater emphasis on coordination of care with funding streams to support this type of work should be prioritised.

Recommendation 3: Government prioritise additional support for enhanced coordination of care to improve referral pathways and support at risk cohorts to navigate the broader community service systems.

Recommendation 4: Individuals presenting to support services with a range of co-occurring morbidities can engage in a step up / step down model of care.

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