Inquiry into Homelessness in Victoria

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Organisation Name: Alcohol and Drug Foundation
Your position or role: Knowledge Manager - Advocacy

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::
Public housing,Rough sleeping,Services,Mental health,Family violence,Indigenous people,Employment,Housing affordability

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:
Please find attached the Alcohol and Drug Foundations full submission to the inquiry.

Do you have any additional comments or suggestions?:

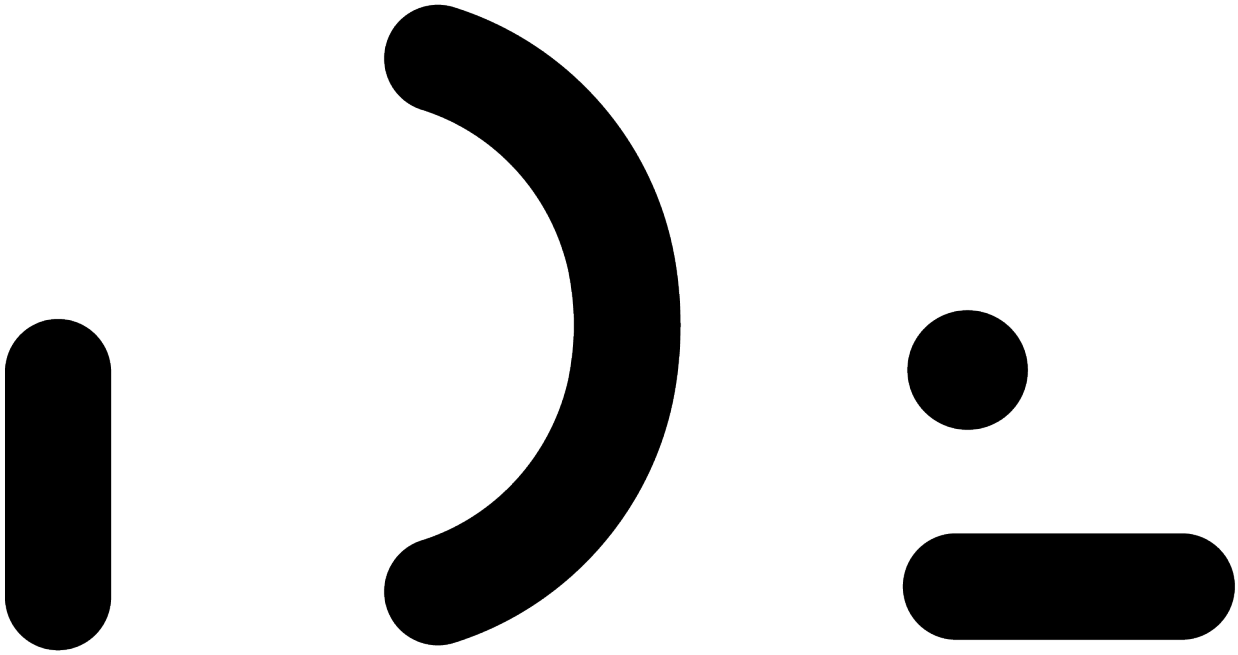
FILE ATTACHMENTS

File1: 5ec4a25b13026-Inquiry into homelessness in Vic. Alcohol and Drug Foundation. May2020.pdf
File2:
File3:

Signature:
Melinda Lucas

Alcohol and Drug Foundation

PREVENTING HARM IN AUSTRALIA



Inquiry into Homelessness in Victoria

Submission to Legal and Social Issues Committee
Legislative Council
Parliament of Victoria

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1 Contents

Inquiry into Homelessness in Victoria

2 Introduction - The Alcohol and Drug Foundation

The Alcohol and Drug Foundation (ADF) welcomes the opportunity to contribute to the Inquiry into Homelessness in Victoria.

Founded in 1959, the ADF has contributed 60 years of continuous service to communities across Australia. The ADF works in partnerships with communities to reduce the burden of disease caused by alcohol and other drug problems. We also provide information on alcohol and other drugs that reach all corners of Australia through our website, SMS and telephone services. Our focus is on prevention and early intervention and our strategies include community action, health promotion, education, information, policy, advocacy, and research.

3 Inquiry Terms of Reference:

That this House requires the Legal and Social Issues Committee to inquire into, consider and report, within 12 months, on the state of homelessness in Victoria, and the Committee should—

1. provide an independent analysis of the changing scale and nature of homelessness across Victoria;
2. investigate the many social, economic and policy factors that impact on homelessness; and
3. identify policies and practices from all levels of government that have a bearing on delivering services to the homeless.

4 Summary

There is not a single population of homeless people but subgroups of homeless people whose circumstances and needs differ. They are not necessarily always distinct groups as the populations can overlap. They include people whose homelessness is caused or compounded by dysfunctional use of alcohol and other drugs, and people whose homelessness is a consequence of family or intimate partner conflict and violence that is partly driven by excessive alcohol consumption.

A comprehensive response to homelessness will recognise the contribution of dysfunctional alcohol and other drug problems to homelessness and meet the immediate needs of people whose AOD use is a barrier to their enlisting support, by providing access to permanent longer term housing, by reducing toxic levels of alcohol consumption by those at risk of offending and by preventing recidivism among violent offenders.

The ADF submission provides evidence on how each of these issues can be addressed because policymakers can influence, if not determine, the rate of homelessness in a society. After the homeless rate rose by 169 per cent between 2010-2018 in the UK, the Minister for Housing stated the government needed to ask ‘hard questions’ about its polices, because “we have a duty to act and to do more” [1].

5 Relationship of Alcohol and other Drugs to Homelessness

While the Alcohol and Drug Foundation understands that many factors contribute to homelessness, (including unemployment, family conflict, lack of social housing), we think the symbiotic relationship between alcohol (and other drugs) and homelessness must be acknowledged or our responses to homelessness will lack grip. Dysfunctional use of alcohol and other psychoactive drugs (AOD) can propel people into homelessness and can prolong the experience of homelessness [2]. Conversely, people who are homeless are at risk of consuming toxic amounts of alcohol and other drugs as a consequence of coping with physical, emotional and mental stress. Problematic alcohol use in particular contributes to family violence which in turn drives many people, usually females, into seeking refuge outside the family home and can lead to homelessness.

Extensive research indicates alcohol and drug dependence is disproportionately high within homeless populations: a meta-analysis of psychiatric disorders among homeless people produced estimates of 38% for alcohol dependence, 24% for drug dependence as well as 12.7% for psychotic disorders and 11.4% for major depression [3]. Drug dependence compounds the marginalisation of homeless people because it results in less access to services and care as their continuing drug use is interpreted as an inability to benefit from help [4]. Housing services traditionally have demanded that drug dependent clients cease using substances before they are granted access to temporary and supported accommodation. That 'staircase' model of help has clients advancing to independent housing only after remaining compliant and abstinent during a period of supported accommodation; thus, clients who cannot achieve or sustain abstinence are locked out of help and remain homeless [4].

Note: The Housing First approach that has shown success in assisting homeless people with comorbid drug and/or mental health problems with maintain medium term accommodation is outlined below.

5.1 HOMELESSNESS IN VICTORIA

The Australian Bureau of Statistics'(ABS) definition of homelessness encompasses the adequacy of the dwelling, security of tenure and space for social relations [5]. A person is considered 'homeless' in the following circumstances: when their current dwelling is inadequate, they lack tenure or their tenure is short and not extendable, or does not allow them to have control of or access to space for social relations, and they do not have suitable alternative accommodation [5]. Homeless people 'sleep rough', either in the open, in tents or in motor cars; or occupy emergency accommodation; or reside in supported accommodation for the homeless, or live in severely crowded dwellings [5].

Homeless persons are among the most marginalised people: the ABS noted a series of markers of extreme disadvantage and social exclusion that is disproportionately common among homeless people: low levels of education; serious health conditions; restrictive psychological disabilities; recent victim of violence; unemployment; reliance on government allowances and pensions; inability to pay bills; and missing meals due to a lack of money [5].

The rate of homelessness is rising In Victoria: from a rate of 38.9 per 10,000 persons in 2001 it reached 41.9 per 10,000 persons in 2016, the third highest rate of all the Australian states and territories [6]. A total of 24,815 Victorians was homeless on Census Night 2016, around one fifth of the total number in Australia [6]. According to the Council for Homeless People in Victoria homeless people explained their predicament was due to a lack of housing (40%), to escape violence (35%), a lack of money/finance (11%), relationship breakdown (5%), physical illness, mental illness and addiction (2%) [7]. These factors are not mutually exclusive because alcohol and other drug use is implicated in much family, intimate partner and domestic violence, as enunciated below.

The Specialist Homeless Services (SHS) provide accommodation and other services to those who are homeless or at risk of becoming homeless. The most recent published SHS data relates to the year 2018-2019 [2]. Of the 290,000 national clients registered with SHS, 28,000, or 10 per cent, had a co-existing alcohol and other drug problem [2]. Compared with SHS clients without an AOD problem, the data revealed clients with an AOD problem remain homeless for longer periods, have more serious health problems and face more challenging situations overall [2]. They draw on homeless services more often and for longer periods, are more likely to be homeless on presentation, are less likely to meet case management goals and are more likely to be homeless at the end of the period of support [2]. Over 40% of homeless people with an AOD problem report a concurrent mental health problem [2].

In Victoria in 2018-19 there were 112,000 clients of the SHS, a rate of 175 per 10,000 people, a higher proportion than the national rate of 116 per 10,000 people. Nearly one in ten Victorian SHS clients had a concurrent AOD problem, comparable to the national average [2]. The marginal status of SHS clients in Victoria was clear: few were employed (15%) while 40% were not employed and 45% did not participate in the labour force [8]. The main three reasons SHS clients gave for seeking assistance were family and domestic violence (44%), financial difficulties (44%) and a housing crisis (37%). However, the system in Victoria did not meet the demand as 105 requests for help that were received each day could not be addressed [8].

Problematic alcohol and drug use and dependence is disproportionately high within homeless populations: a meta-analysis of psychiatric disorders among homeless people produced estimates of 38% for alcohol dependence, 24% for drug dependence as well as 12.7% for psychotic disorders and 11.4% for major depression [3]. Alcohol and other drug (AOD) problems and mental illness are not only comorbid conditions but each independently contributes to and is a consequence of homelessness [3].

AOD problems compounds the marginalisation of homeless people because it results in them having less access to services and care as their drug use is interpreted as signifying that they are unable to benefit from help [4]. Housing services traditionally have demanded that drug dependent clients cease using substances before they are granted access to temporary and supported accommodation. The 'staircase' model of help has clients advancing to independent housing only after remaining compliant and abstinent during a period of supported accommodation; thus, clients who cannot achieve or sustain abstinence are locked out of help and remain homeless [4].

Recommendation 1: That the Committee recommends that homeless services account for and address the issue of severe alcohol and drug use among homeless people.

5.2 ALCOHOL, VIOLENCE AND HOMELESSNESS

Domestic, intimate partner and family violence is a leading cause of homelessness for women with children [9]. In 2016–17 around 72,000 women, 34,000 children and 9,000 men in Australia who sought help from homelessness services cited family and domestic violence as a cause or contributor to their homelessness [9]. Alcohol is implicated in the commission of early of all incidents of family and domestic violence (FDV) and alcoholic intoxication increases the severity of harms that result from that violence [10] [11].

When the World Health Organization summarised the evidence on the relationship between alcohol use and intimate partner violence it concluded:

- Alcohol use and intimate partner violence may both be linked to the same underlying factors (such as low socio-economic status or impulsive personality).
- Heavy alcohol use may cause or exacerbate relationship stress which increases the risk of conflict.

- Alcohol use affects cognitive and physical function, resulting in perpetrators of intimate partner violence using a violent resolution to relationship conflicts, rather than a non-violent resolution.
- Excessive drinking by at least one partner can aggravate existing relationship stressors such as financial problems, thus increasing the probability of violence.
- Alcohol use is often used by perpetrators as a justification to violence, or excuse for the violence.
- Experiencing intimate partner violence can result in increased alcohol consumption by the victim as a coping mechanism.
- Intergenerational effects may occur, with children who are witnesses to their parents' violence being more likely to have problematic drinking later in life [12].

A national study conducted for the National Drug Law Enforcement Fund examined the impact of alcohol and other drug use on family violence (FV) [13]. This study surveyed a national panel (n=5118) on AOD issues related to personal safety and retrospectively analysed jurisdictional police data on family violence (FV) and intimate partner violence (IPV) for the period January 2009-December 2013 [13].

According to the data reported by the national panel, alcohol was involved in 34 per cent of intimate partner violence incidents and 29 per cent of family violence incidents; and physical violence occurred in 57 per cent of IPV incidents and 52 per cent of FV incidents. The greater severity of alcohol related incidents was evident as IPV incidents that involved alcohol were more likely to include physical injury (34.4 per cent) or psychological injury (20.6 per cent) compared to incidents in which alcohol was not involved: 19.3 per cent for physical injury and 13.3 for psychological harm [13].

The national panel reported Illicit drug use was implicated in FDV, though at a lower level than alcohol: 12.7 per cent of intimate partner violence incidents and 12.0 per cent of FV incidents involved illicit drugs [13]. Drug-related IPV incidents were more likely to involve physical and psychological injury than non-drug incidents and police were more likely to attend IPV and FV incidents when drugs were involved [13].

Police data in Victoria for that same period provide evidence of the close association between FV and high alcohol levels. Between January 2009-December 2013 Victoria Police officers recorded 233,672 incidents of domestic violence and alcohol was recorded as being present in 44.2 per cent of those incidents. The reported rate rose over the period from 65.1 per 10,000 people to 102.9 per 10,000 people. Illicit drug use was reported as present in 28.0 per cent of cases; however, authors of this study warn that differences in reporting procedures in the states and territories for illicit drugs vary too much to allow a comparison between jurisdictions [13].

The majority of alcohol related offenders were male (77.5 per cent) and most victims were female (76.0 per cent) [13]. The rate of repeat offenders was high: most offenders were recidivists (63.8 per cent or 149, 672 individuals) while 36.2 per cent (n=84,380) were unique offenders; conversely 58.8 per cent of victims were repeat victims (n=137,500) and 41.2 per cent were unique victims (n=961,63) [13].

Recommendation 2: That the Committee acknowledge the role of dysfunctional drinking of alcohol by many recidivist perpetrators of family, domestic and intimate partner violence.

5.2.1 THE PSYCHO-PHARMACOLOGICAL EFFECT OF ALCOHOL

While the consumption of alcohol is not a necessary or sufficient cause of violence, the presence of alcohol increases the likelihood of aggression, assault and the severity of harms when violence does occur [14] [11] [15]. The psycho-pharmacological effect of alcohol is an important trigger for uninhibited behavior [16] [17]. As a central nervous system depressant, alcohol has a disinhibiting effect which can produce changed psychological, cognitive and emotional states: these include increased impulsivity and recklessness; a reduction in anxiety or fear regarding social or physical sanctions or danger;

heightened emotionality; and narrowing of the perceptual field [18] [19]. This effect undermines the drinker's ability to assess and resist risks and situations they might avoid when not affected by alcohol. These effects are dose related, so as the drinker consumes a progressively greater volume of alcohol they are progressively more liable to act on impulse, to misinterpret words and actions, to respond with emotion rather than thought, and to respond and act aggressively. In short, acute alcohol intoxication is predictive of aggressive responses and violence [18] [20]. A study of violent offenders incarcerated within the USA correctional system showed 40% had been drinking prior to committing the offence for which they were punished [21]. Some estimates have suggested that up to 50% of violent offenders had consumed alcohol prior to their offence [19].

6 Reducing family-related violence via alcohol policy

Changes in the consumption of alcohol due to changes in supply of alcohol or demand for alcohol are shown to influence the rate of domestic, family and intimate partner violence. When the supply of alcohol dropped by 10-15% in Norway due to a workers' strike among government-run retail liquor stores, police reported a 25% decline in "home quarrels" [22]. An Australian example occurred in 2008 when the rate and severity of family and community violence declined after the types of beverages and the times when alcohol was sold by retail stores in Fitzroy Valley, Western Australia, was subject to strict controls. A formal evaluation found reductions in alcohol consumption were followed by reductions in the severity of family violence and street violence, as well as improvements in the care of children [23].

The incidence of alcohol related harm, including all forms of violence, can be moderated by public policies that act to reduce the level of alcoholic intoxication. A reduction in intoxication reduces the risk and prevalence of alcohol-fuelled reckless and criminal behavior.

One such policy is the setting of a minimum price for alcohol.

6.1 MINIMUM PRICE OF ALCOHOL

A minimum unit price (MUP) for alcohol beverages, otherwise known as a floor price, establishes a price per standard drink below which alcohol cannot be sold. Controls on price are identified by the World Health Organization as the most effective measure that governments can implement to reduce the harm caused by alcohol [24]. Unlike an increase in tax, a MUP cannot be circumvented by discounting, loss-leading or below-cost selling.

A minimum price is applicable to packaged liquor only, as alcohol sold for immediate consumption on licensed premises is sold at a premium price. Lowering the price is a key marketing strategy for retailers of packaged liquor which includes promotions such as discounted prices, two-for-one deals, docket deals, etc. Packaged alcohol is available for as little as 23 cents per standard drink and off-premises sales accounts for 80% of alcohol sold in Australia.

International research indicates a strong link between alcohol price, consumption and alcohol related harms. Typically, when prices increase, alcohol consumption and harms decrease. This effect is seen in overall consumption as well as in measures of heavy or problematic drinking, and in the level of harms experienced by the drinker as well as to others, including family members [25] [26] [27]. A higher price for alcohol most affects the heaviest drinkers [28], who are most at risk of chronic alcohol related problems, including dependency, and acute adverse consequences due to intoxication that include aggression and violence. The heaviest drinkers account for a large fraction of alcohol sales: 3% of drinkers consume 20% of alcohol and 10% of drinkers consume 40% of the alcohol sold in Australia [29].

While differences in the specific price effects can occur across societies, in general, a price increase of 10% will reduce consumption by an average of 5% [30] [31]. In Saskatchewan, Canada, a 10% increase

in the minimum price per standard drink resulted in an overall decline in consumption of 8.4% [32] and was associated with an 8.0 per cent decrease in night-time alcohol-related traffic offences in men, and a 19.7 per cent reduction in observed violent offences at four months) [33]. Similarly, In British Columbia, a 10 per cent increase in the floor price was associated with a 3.4 per cent reduction in consumption; an 8.9 per cent reduction in acute alcohol attributable hospital admissions; a 9.2 per cent reduction in chronic alcohol-attributable admissions two years later [34]; and a 31.7 per cent reduction in wholly alcohol-attributable deaths [35].

The Northern Territory government introduced a minimum price of $1.30 per standard drink in 2018 among a range of other policies designed to lower alcohol related harms. Recent modelling has indicated that the impact of the NT minimum price could reduce alcohol consumption by heavy drinkers of 12 standard drinks per week [28]. That result would likely lower the incidence of intoxication as well as the levels of intoxication experienced by a high-risk population. Early indications of the NT reforms are positive, with a reduction in alcohol-related assaults, emergency department presentations and domestic violence in key centres across the Territory after twelve months [36].

Recommendation 3: That the Committee recommend the government investigate the impact on family domestic and intimate partner violence of the introduction of a minimum price for alcohol in Victoria.

6.2 REDUCING RECIDIVISM BY VIOLENT OFFENDERS

Purposive interventions have demonstrated that violent offending by recidivist offenders, including the reduction of domestic and family assaults, can be reduced when the offenders' use of psychoactive substances is controlled. Two examples are the Sobriety 24/7 program in South Dakota and the HOPE program in Hawaii.

6.2.1 SOUTH DAKOTA'S SOBRIETY 24/7 PROGRAM

A successful drink drive program in South Dakota (USA) indicates how reducing the demand for alcohol, and subsequently reducing problematic drinking among high risk populations reduces family related violence. The 24/7 Sobriety Program offers recidivist drink-drivers an incentive to abstain from alcohol: recidivists avoid further sanctions, when they agree either to be breath tested twice per day or wear a bracelet that continuously monitors the presence of alcohol. If they breach the agreement or reoffend they are subject to immediate penalties, including incarceration. In addition to a 12 per cent reduction in drink driving, an evaluation of 24/7 Sobriety found a nine per cent reduction in arrests for intimate partner violence after the program was implemented [37].

6.2.2 HAWAII'S OPPORTUNITY PROBATION WITH ENFORCEMENT

Hawaii's Opportunity Probation with Enforcement (HOPE) program has improved the compliance of individuals on probation through a strict behavioural contract [38]. Probationers on the HOPE program are required to provide a drug test specimen on any day without notice and face an immediate penalty if they fail that or any other probationary requirement e.g. failing to attend meetings or failure to comply with treatment. A breach of the contract is subject to a swift and certain penalty—a short stay in jail (on weekends to preserve employment opportunities). Among a group of probationers with a history of methamphetamine use the proportion of failed drug tests under HOPE declined by 80%; for a group of 685 probationers the rate of missed appointments dropped from 13.3 to 2.6 and failed drug tests fell from 49.3 percent to 6.5 per cent [38].

The key tenets of the program are based on a body of literature that indicates that sanctions alone (without concern for swiftness or certainty) have little deterrent effect and may be criminogenic. The governing principle of HOPE is that sanctions are delivered swiftly, with certainty, and that the penalty should be proportionate to the particular violation of the agreement [39]. A similar program in Texas,

USA, the Supervision with Intensive Enforcement (SWIFT) program has produced similar results. When compared to a matched comparison group, SWIFT participants were significantly less likely to breach their probation, half as likely to have probation revoked, and half as likely to be convicted for new criminal offences. In a pre-post study, subjects in SWIFT reduced their general technical violations by a fifth and their positive drug tests by a quarter, but the probability of a jail sanction as well as the average number of jail days increased [39].

Recommendation 4: That the Committee recommend that he 24/7 Sobriety Program and the HOPE project should be utilised as models for the testing of the approach with recidivist violent offenders in Victoria.

7 Housing the chronic homeless

Housing schemes known as Housing First have achieved success in enabling chronically homeless people to gain access to and maintain long term accommodation. The Housing First model originated in New York and its positive outcomes have led to the approach being trialled and adapted in many countries across the western world in North America, Europe and Australia [40] [41] [4] [42].

7.1 HOUSING FIRST

Housing First (HF) is an approach to remedying the housing problem for chronically homeless people who usually have a serious mental health condition and often a comorbid substance use disorder [4] [43] [44] [45] [46]. Core principles of HF include the understanding that a secure and habitable dwelling is a human right that is owed homeless people; that homeless people should be supported to exercise some choice in their living arrangements; that offers of housing are not conditional on the client changing their behavior; and that the commitment to the client extends beyond the issue of housing and seeks to help the client function in an optimal manner. [40]

The Housing First approach is to place and maintain homeless people in housing by providing intensive personal support and offering a range of housing and social services to help them maintain their equilibrium [47] [42]. Unlike traditional housing services that employ the 'continuum of care' model and requires the client to be drug free and comply with psychiatric care [44] HF does not demand abstinence or compliance with medical treatment [3]. Apart from delivering sustained accommodation, HF seeks to promote the client's general health, wellbeing and social integration, which entails their involvement in the community and access to meaningful and productive activity.

7.1.1 HOUSING FIRST IN NORTH AMERICA

Tsembris *et al* reported on an early Housing First project in New York in which a total of 225 chronically homeless people with a psychiatric disorder were allocated either to an HF project (n=99) or to a traditional Continuum of Care (CoC) approach (n=126) [43]. The experimental HF group gained immediate access to housing and had round the clock support from a multi-disciplinary Assertive Community Treatment team (ACT) which could provide mental health and drug treatment, and other services, if required. The HF clients did not need to maintain sobriety or comply with mental health advice, whereas clients of the CoC programs needed to do so.

At two year follow up, 80% of the HF group remained in residence; they reported faster access to housing, more time in stable housing, and higher levels of autonomy than the control group. There was not a significant difference between the groups in substance use or in psychiatric symptoms. The result was interpreted as evidence that HF was more effective than the traditional approach which required the vulnerable to 'earn' their place by negotiating prior drug and mental health treatments [43].

Numerous studies have repeated the finding that HF approach leads to better housing outcomes for long term homeless people including earlier (i.e. rapid) access to housing, greater choice in housing options, and greater stability and longer occupation of housing [43] [47] [48]. Other reported improvements included HF clients having a greater sense of autonomy and control [45], making fewer visits to hospital emergency rooms and hospital admissions [3], having less contact with the criminal justice system [49] [50], and making less use of community services [45]. Results for substance use was mixed as some studies found showed substance use declined, [41] some found an increase, some reported no change [3] and one reported reduced alcohol use but no change in use of illicit drugs [48].

In Canada in 2008 the Mental Health Commission established the At Home/Chez Sois project (AHCS) within five cities to compare the effectiveness of HF and Treatment as Usual (TAU) for homeless clients who were diagnosed with a mental illness [51]. Final results for the AHCS showed the HF intervention had substantially better gains in housing stability over TAU and modest improvements in community integration and quality of life; however, client mental health and substance use problems improved in both HF and TAU approaches with no advantage for HF [3].

Another analysis compared the outcomes for clients with a Substance Use Dependency (SUD) with the clients without a drug dependency. This analysis confirmed HF was superior to TAU in meeting the primary aim of providing housing and that it was equally effective with drug dependent and non-drug dependent clients [3]. The study concluded "…large gains in the time spent in housing were generally achieved and maintained over 2 years regardless of SUD status at baseline" (p143) [3]. However, those with a drug dependency were slightly less likely to be housed at the end of the project [3]. Both HF and TAU clients with a SUD improved on measures related to their community functioning and quality of life [3].

7.1.2 HOUSING FIRST IN EUROPE

The Housing First approach was formally tested in five cities across Europe (Copenhagen, Lisbon, Amsterdam, Glasgow and Budapest) between 2011-13 where sustained housing was sought for long-term homeless [52]. Clients at all locations had high levels of substance abuse – mainly alcohol at four of the sites while heroin dependence was common in Glasgow. A positive housing result was found overall as a retention rate of 80-90% obtained at four of the five sites; the exception was Budapest, which had the least fidelity to the HF model. The study concluded that people with severe needs were capable of sustaining a permanent tenancy when they have access to high levels of support, such as provided by the Assertive Community Treatment teams. Results for the secondary aims of HF were mixed: there was an overall improvement, including a reduction in substance use for many clients, though drug use increased for some people. Most of the more than one-third of the clients (39%) who were diagnosed with a mental health problem had improved mental health; however, the results for paid employment, managing financial security and social integration were less positive. The author suggested future HF programs should be informed by the understanding that sustained funding would be required, especially for clients with the most complex needs for whom future paid employment is not a feasible option. Finally, the study concluded that the Housing First approach was successful and should be promoted by all levels of government, while further studies of its cost-effectiveness were desirable [52].

7.1.3 HOUSING FIRST IN AUSTRALIA

A study in Sydney compared the impact of two HF modes on criminal justice outcomes, quality of life and social connectedness for a small group of participants (n=63) drawn from the long term homeless [53]. In this case, the HF participants were living either in a private rental-market dwelling, (n=37), known as a 'scattered site' (SS), or in public housing on a single site, (n=26), known as a 'congregated site' (CS). Over half the sample had been sleeping rough for five years, most had a cognitive impairment, they reported a median of two mental health disorders and 45% had a substance dependency.

Engagement with the criminal justice system was assessed as being stopped by police, held in custody overnight, attended court on a criminal matter, incarceration in an adult prison, supervision by a parole officer. From baseline to the follow-up at 12 months, contacts with the criminal justice system among SS clients decreased from 1.4 to 0.9, while among CS clients they increased from 0.9 to 1.3. In addition, the likelihood of CS clients attending court increased during the period while the SS CS clients' likelihood of attending court declined. On the matters of quality of life and social connections there was not a significant distinction between the groups, although SS participants had reduced contact with their case manager whereas the CS residents maintained regular contact with their case manager. Other non-significant changes included more SS clients feeling bored over time (up from 56% to 70%), while the proportion of CS clients who reported losing their temper dropped from 61% to 33%.

Recommendation 5: That the Committee acknowledge the success of the Housing First approach to providing accommodation for homeless people.

Recommendation 6: That the Committee recommend the Housing First principles be adopted by homeless housing projects in Victoria.

8 Effective harm reduction support for drug dependent homeless

The Australian 2016 Illicit Drug Reporting System report revealed high levels of homelessness among people who inject drugs regularly: 86% of Victorian respondents had a lifetime experience of homelessness; 31% were currently homeless; 10% had been homeless for 1-2 years, 17% for 2-5 years and 26% for more than five years [54]. The most common form of lifetime and current homelessness was 'sleeping rough' for 26% and 25% respectively [54]. Drug overdose has been ascribed as the most common source of death among the homeless [55] and it is reported as contributing to a mortality rate for homeless youth that is ten times that of housed youth [56].

8.1 DRUG CONSUMPTION ROOMS

'Drug consumption rooms' are designed to protect marginalised drug users, especially those who are homeless or whose housing is insecure, and who use drugs on the streets or in other hazardous conditions [57] [58] They are most likely to use drugs daily, to experience overdose, and to endure other bodily harms and infections due to injection practices.

DCRs have operated in Europe for over thirty years and in Canada and Australia (i.e. the Sydney Medically Supervised Injection Centre) for nearly two decades [59] While the major goals are to reduce morbidity and mortality, and to reduce drug use in public and improve public amenity surrounding urban drug markets, DCRs also promote drug users' access to social, health and drug treatment facilities [58].

A survey of regular injecting drug users in 2019 in Victoria revealed their marginal status: 90% were unemployed; 45% had experienced an injection-related health problem in the previous month and 26% had experienced an overdose in the previous twelve months, In addition 42% had a mental health problem in the previous six months but only half (54%) had sought assistance from a health professional. For the last episode of injection, nearly half (45%) had not injected in a private home [60].

Prior to the establishment of a two year trial of a medically supervised injection centre in North Richmond in 2019, [61] the Victorian Coroner acknowledged that supervised injecting facilities present an opportunity to engage with drug users who do not usually seek assistance [62]. DCRs maintain contact with high risk drug users who may have no other contact with support resources [63] Findings from the Sydney MSIC report that 80% of frequent clients have accepted a referral for dependence treatment

[64]. Similarly, a report into Vancouver's *Insite* showed a 30% increase in the rate of long term treatment for drug dependence amongst those regularly involved in SIFs [65]. Further research supports that clients frequently attending SIFs are more likely than other injecting users to report engaging with treatment services [63].

While the two-year trial of a medically supervised injection centre in North Richmond is yet to conclude, the international evidence suggests DCRs are a positive service for the marginal homeless people with a drug dependency. No person has died of an overdose in a DCR worldwide, there is no evidence they increase drug use or frequency of injecting, and there is evidence that they facilitate rather than delay entry to treatment.

While DCRs emerged to protect and support people who inject drugs, DCRs in Europe now allow for people to smoke or inhale their substances [66]. This development allows for changes in the clients' drug preference and method of ingestion and it is health promoting because it encourages less hazardous forms of drug administration.

8.2 WET ROOMS

The 'wet room' is an early version of a DCR, a setting in which homeless alcohol dependent people, for whom alcohol treatment is neither a possible nor realistic option, are provided with or permitted to consume alcohol as a harm reduction exercise. Wet rooms have been implemented in Britain since the 1970s, in Canada since 1995 and the Netherlands more recently [67] [68] [69].

In Ottawa, a formal study of a Managed Alcohol Project (MAP) involved the dispensation of alcohol to 17 'chronically alcoholic homeless clients' who were accommodated in a homeless shelter [68]. The participants had been homeless for at least two years prior to the study, had decades-long histories of heavy drinking, most had at least one psychiatric diagnosis and sturdy records of contact with police and emergency health services. The MAP provided them with housing, health care and alcohol on demand as the pparticipants could request a maximum of 140 mL of wine or 90 mL of sherry each hour, from 0700– 2200, seven days per week. Medical care was provided 24 hours per day by nurses and two physicians. Over the 24 months of the project, three clients died from diseases common to homeless and alcohol dependent people. Of 11surviving clients, for whom full data was available, the average number of daily drinks consumed dropped from 46 to eight; encounters with police dropped by 51% and visits to hospital emergency rooms declined by 36%.

In the Netherlands wet rooms that aim to prevent street crime and nuisance by alcohol dependent homeless people operate in 20 cities; in some limits are placed on the type and amount of alcohol that can be consumed by the client in a given period of time while in others alcohol is supplied by the institution; some rooms require the client to be breath tested to gauge blood alcohol concentration on entry. Health workers value the wet room because it allows regular contact with a marginalised population and most of the centres offer basic care, attempt to stabilise the client's drinking and encourage them to consider alcohol treatment [69].

Dug consumption rooms and wet rooms offer a range of health and social services for homeless people who are vulnerable to a host of problems including ill-health, substance related disease, violence

Recommendation 7: That the Committee recommend that Victoria continue to utilise drug consumption rooms to protect homeless clients from preventable disease and to strengthen their connection to drug treatment and other health and housing services.

Recommendation 8: That the Committee recommend that the medically supervised injection centre in North Richmond allow clients to use other methods of administration than intravenous injection.

Recommendation 9: That the Committee recommend Victoria undertake a trial of wet rooms to provide protection for alcohol dependent homeless people and to strengthen their connection to alcohol treatment and other health and housing services.

9 Recommendations

Recommendation 1: That the Committee recommends that homeless services account for and address the issue of severe alcohol and drug use among homeless people.

Recommendation 2: That the Committee acknowledge the role of dysfunctional drinking of alcohol by many recidivist perpetrators of family, domestic and intimate partner violence.

Recommendation 3: That the Committee recommend the government investigate the impact on family domestic and intimate partner violence of the introduction of a minimum price for alcohol in Victoria.

Recommendation 4: That the Committee recommend that the 24/7 Sobriety Program and the HOPE project should be utilised as models for the testing of the approach with recidivist violent offenders in Victoria.

Recommendation 5: That the Committee acknowledge the success of the Housing First approach to providing accommodation for homeless people.

Recommendation 6: That the Committee recommend the Housing First principles be adopted by homeless housing projects in Victoria.

Recommendation 7: That the Committee recommend that Victoria continue to utilise drug consumption rooms to protect homeless clients from preventable disease and to strengthen their connection to drug treatment and other health and housing services.

Recommendation 8: That the Committee recommend that the medically supervised injection centre in North Richmond allow clients to use other methods of administration than intravenous injection.

Recommendation 9: That the Committee recommend Victoria undertake a trial of wet rooms to provide protection for alcohol dependent homeless people and to strengthen their connection to alcohol treatment and other health and housing services.

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