Launch HOUSING IT'S TIME TO END HOMELESSNESS

LAUNCH HOUSING INSIGHTS 2024

# HOW TO END AN AVOIDABLE HOMELESSNESS AND HEALTH EMERGENCY

Breaking the cycle of homelessness

We acknowledge the Traditional Owners of the lands on which we live and work. As we create safe and welcoming homes, we honour the people of the Kulin nation and their enduring connection to their home we call Naarm, Melbourne.

We pay our respects to all First Nations Elders, past and present.

It is important that we acknowledge that the contemporary housing experience of Aboriginal and Torres Strait Islander people cannot be separated from their historical experience of dispossession and dislocation. Aboriginal Victorians are over represented in the homeless population, with census data confirming that Aboriginal Victorians experience homelessness at over five times the rate for non-Aboriginal people.

We support the development of a culturally fit Aboriginal housing and homelessness sector based on principles of self-determination and will continue to do what we can to help make this happen.

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# EXECUTIVE SUMMARY

## Why now?

**Homelessness in Australia has become a health emergency. People sleeping rough are dying — alarmingly younger than the general population and often from conditions that are easily treatable. They have higher rates of suicide and are more likely to have a mental health condition and post-traumatic stress disorder.**

We know that First Nations Australians are over-represented among people experiencing homelessness and poor health. The increase in people experiencing domestic or family violence presenting to homelessness services is deeply concerning.

Those with complex health and mental health needs are also more likely to experience homelessness for longer periods. They are often repeat users of homelessness and health crisis and immediate support services, putting strain on an already overburdened system.

The scale of the problem is difficult to accurately measure. The Government does not keep records of homelessness deaths, and the current gaps in the Victorian legislation mean that deaths in Victoria of people experiencing homelessness are not reported to the Coroner.

**Homelessness and health are inextricably interconnected.**

> **It's really important that we work together because they don't just have one need – they have a mixture of social, mental and physical needs and this requires a holistic team to address all these needs.**
>
> – Program Nurse

## Currently siloed health and homelessness systems need to come together

Stable housing coupled with integrated health support can end this avoidable homelessness and health crisis: there's proof both in Australia and overseas that an integrated model works. Evaluations consistently show significant health improvements, reduced interactions with emergency departments and other emergency services, better health outcomes for people experiencing homelessness, and cost savings for Government.

Research shows that it is cheaper to put someone into long-term accommodation than to leave them on the streets. For women and children escaping violence, safe housing and support leads to fewer instances of intimate partner violence, driving down health costs and interactions with police. Viv's Place shows how it can work.

Measures designed during the COVID-19 pandemic showed the impact of combining stable housing with health support. It both helped people out of chronic homelessness and improved the Government's bottom line. What was designed as an emergency measure turned out to be incredibly successful at getting people into long-term accommodation and offered proof of concept that stable housing combined with integrated health support can end this crisis.

**It's urgent that we act now. As a community we need to:**

1. **Invest in the true cost of implementing integrated health and homelessness programs**
2. **Invest in more trauma-informed long-term supportive housing**
3. **Reform the system to better reflect the interconnectedness of health and homelessness**

This paper puts forward in further detail why we need to act now to end homelessness and save lives.

# HOMELESSNESS IS KILLING AUSTRALIANS

## Homelessness and health are inextricably linked

Poor health is both a cause and a consequence of homelessness. People are caught in the ultimate Catch-22 — they are perilously unsafe and unable to access the healthcare and support they need without stable housing, and they cannot access or sustain housing without getting the support and healthcare they need. Those health problems escalate every night they live without a home.

79% of people experiencing homelessness reported having at least one diagnosed mental health condition such as schizophrenia, depression and anxiety,and over 40% reported experiences of post-traumatic stress, according to one **study that looked at 10 years' data from the Advance to Zero database**.

A study by the University of Western Australia found that the rate of multi-morbidity — two or more long-term health conditions — among people experiencing homelessness is alarmingly high. The study, which analysed the medical records of 2,068 patients of a homeless health service in Perth, found that 67.8% of patients had at least one chronic health condition, 67.5% had at least one mental health condition, and 61.6% had at least one AOD use disorder.[1] Nearly half had a dual diagnosis of mental health and AOD use issues, and over a third were tri-morbid (mental health, AOD and physical health condition).[2]

1 Vallesi S, et al (2021), Multimorbidity among people experiencing homelessness-Insights from primary care data, International Journal of Environmental Research and Public Health.

2 Vallesi S, et al (2021), Multimorbidity among people experiencing homelessness-Insights from primary care data, International Journal of Environmental Research and Public Health.

The number of people and households with complex health needs presenting to homelessness services is on the rise. In 2014 just under a quarter of households presenting for the first time reported mental health issues (23.4%) but this increased to a third (33.0%) by 2020, according to a **seven-year longitudinal study** of six entry points across Melbourne. The study also found the proportion of new households reporting medical issues and substance misuse problems doubled between 2014 and 2020, although both come off a low base.

## Homelessness is killing Australians prematurely

People sleeping rough are dying earlier than the general population. In Melbourne, one study at an inner-city public hospital in Melbourne found that people experiencing homelessness are dying 10 years earlier than the general population, at 66 years.[3]

In Sydney, people sleeping rough are dying at the average age of 55.9 years, with those living with schizophrenia dying even earlier, at the average age of 52 years.[4] In Queensland, the suicide rate of homeless people is almost two times higher than the general population, according to one study.[5]

A Guardian Australia investigation in 2024 found that people experiencing homelessness are dying more than **30 years prematurely**, at an average age of just 44.

Several international studies from Europe and Scandinavia also found rates of mortality to be greater among those who experienced homelessness than the general population.[6]

The scale of the problem in Victoria is difficult to accurately measure. The Government does not keep records of **homelessness deaths**, and the current gaps in the Victorian legislation means that deaths in Victoria of people experiencing homelessness are not reported to the Coroner. However, with what we do know, there is no doubt that people sleeping rough have a significantly lower life expectancy than the general population.

> **People need supportive communities to get the right help so they can feel like themselves again. Without community support, I wouldn't be here today. It was the people who never gave up on me, connecting me with the right services, that was the biggest help.**
>
> – Specialist Homelessness Services Client

3 Seastres R, et al (2020), Long-term effects of homelessness on mortality: a 15-year Australian cohort study, Australian and New Zealand Journal of Public Health.

4 Woodman L, et al (2023), Rates and causes of mortality among the homeless in Sydney. Australas Psychiatry. Cited in https://www.theguardian.com/australia-news/2024/feb/20/sydney-homeless-population-data-death-toll-early-health-concerns#:~:text=It's%20shocking%20%E2%80%93%20the%20number%20of,among%20those%20cases%20was%2044.

5 Arnautovska U, et al. (2013), What differentiates homeless persons who died by suicide from other suicides in Australia? A comparative analysis using a unique mortality register, Social Psychiatry and Psychiatric Epidemiology

6 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9943969/

# DIFFERENT GROUPS EXPERIENCE THE HEALTH IMPACTS OF HOMELESSNESS DIFFERENTLY

**Many factors can lead to a person experiencing homelessness. Once trapped in the cycle of homelessness, people can experience the health impacts of homelessness differently.**

Women and children escaping violence, First Nations Australians and people sleeping rough are among the most vulnerable groups experiencing homelessness and at risk of violence, health complications and premature death. Yet services for these groups are chronically overburdened and underfunded.

## Women and children escaping violence

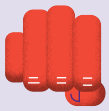
In Australia, the biggest driver of women experiencing homelessness is **family and domestic violence**.

Family and domestic violence (FDV) is a serious health concern. Each year, there are around **6,500 hospitalisations** for family and domestic violence related injuries. **A longitudinal study** looking at FDV related hospital stays between 2010-2011 to 2018-2019, found that around 29,000 people had at least one FDV hospital stay from 2010–11 to 2017–18 and most of these hospitalisations were for women (68%)[7].

The risk of homelessness can prevent women leaving a violent home, further entrenching the cycle of violence. If they leave into homelessness, health issues are exacerbated and costs to the health and homelessness system increase.

Pregnant women are even more at risk of violence. If violence already exists, it is likely to increase in severity during pregnancy. If they leave a violent home into homelessness, this insecurity and unpredictability interferes with the mother's ability to develop routines for their children and create a familiar environment in which children can learn and develop.[8]

The increase in women and children experiencing domestic violence and presenting to homelessness services in Melbourne is frightening.



Between 2014 and 2020, the proportion of households reporting domestic or family violence at their first presentation doubled, increasing from **7.5% to 15.8%**.[9]

7 https://www.aihw.gov.au/reports/family-domestic-and-sexual-violence/examination-of-hospital-stays-due-to-family-and-do/summary

8 Hogg et al., 2015.

9 Kavaarpuo G, et al (2024), Inside the front door: A seven-year longitudinal study of six high volume homelessness services in Melbourne, Unison Housing Research Lab and RMIT University.

Even in countries such as Finland where rates of homelessness is decreasing, women's homelessness has not decreased.[10]

Women sleeping rough report poorer physical and mental health, higher rates of chronic health issues and more AOD issues as a result of chronic homelessness than men.[11] Women also experience higher levels of violence and exploitation on the streets.

Family and domestic violence is a serious public health and social problem. The **Royal Commission into Family Violence** in 2014 shed light on the scale and magnitude of the issue, resulting in service reform and increase in funding. Despite this, the proportion of people experiencing family or domestic violence presenting to entry point services continues to grow.[12]

Family violence and homelessness are profoundly traumatic experiences that have a detrimental impact on healthy childhood development. Evidence shows that these adverse life events impact learning, behaviour, as well as physical and mental wellbeing.[13,14]

A 2013 study found that children experiencing homelessness and family and domestic violence face increased risk of low self-esteem and increased mental health problems, including depression, anxiety, and post-traumatic stress. It also identified that trauma related to homelessness can potentially change children's neurodevelopment.[15]

Yet despite the poorer health and safety outcomes, particularly for women and children fleeing family and domestic violence, there is little attention and resources given to building and scaling up appropriate housing solutions, let alone ensuring that appropriate healthcare is integrated into their support.

Poverty and family violence are constant pressures that push many women into the impossible position of raising a family without a stable home. Long-term solutions and investments are needed to break the cycle of intergenerational homelessness and give children a better start in life.

10 https://www.feantsa.org/download/a_home_of_your_own_lowres_spreads6069661816957790483.pdf

11 Box E, et al (2020), Women sleeping rough: The health, social and economic costs of homelessness, Health and Social Care Community.

12 Kavaarpuo G, et al (2024), Inside the front door. A seven-year longitudinal study of six high volume homelessness services in Melbourne, Unison Housing Research Lab and RMIT University.

13 Marci McCoy-Roth, Bonnie B. Mackintosh and David Murphey. (2012). When the Bough Breaks: The effects of homelessness on young children. Early Childhood Highlights. Volume 3, Issue 1. Child Trends, 11.

14 Justin Barker, Violet Kolar, Shelley Mallett, Morag McArthur. (2013) What works for children experiencing homelessness and/or family/domestic violence? Part 1: Literature Synthesis. Melbourne, Hanover Welfare Services, February.

15 Barker, J., Kolar, V., Mallet, S., & McArthur, M. (2013). What works for children experiencing homelessness and/or family/domestic violence? Part 1: Literature Synthesis. Melbourne: Hanover Welfare Services.

## First Nations Australians

There is a deep connection between health, culture, spiritual wellbeing, homelessness and dispossession that current systems do not adequately address for First Nations Australians.

The continuing legacy of colonisation on physical and mental wellbeing, coupled with the lack of appropriate housing options, are key factors underpinning experiences of **chronic homelessness among First Nations Australians**. Inadequate funding for culturally appropriate homelessness services, limited crisis and transitional housing and barriers to accessing housing also fails First Nations Australians.

These multiple systems failures are a major contributor to the over-representation of First Nations Australians among people experiencing homelessness and health disparities. First Nations Australians' life expectancy is 10 years lower than non-Indigenous Australians, have higher rates of chronic illnesses like diabetes, and are three times more likely to experience high levels of psychological distress.[16]

Roughly **28% of clients** accessing homelessness services across Australia are **Aboriginal and Torres Strait Islander people**,[17] and just under **one in six** Aboriginal Victorians experience homelessness each year.[18]

Some advocates state this is likely an undercount, given that many people are not comfortable identifying as Aboriginal when presenting to mainstream services.[19] Aboriginal Victorians experiencing homelessness have also reported racism as a barrier to seeking out health and housing services.[20]

## People sleeping rough

People sleeping rough often have multiple physical and mental health conditions that put them at greater risk of dying earlier than the general population. Chronic health, mental health issues and AOD use as a result of chronic homelessness are the most common health conditions experienced by people sleeping rough.

In the Homelessness to a Home program (H2H) supporting people with a long-term history of sleeping rough into housing in Melbourne, 84% of clients had a dual diagnosis of AOD and mental health that impacted their life and housing situation. Additionally, 52% of these clients had tri-morbidity of AOD, mental health and chronic illness.[21]

An analysis of housing and support needs from three Advance to Zero Projects – Frankston, Port Phillip, and Dandenong between 2022 and 2023 – supporting people sleeping rough in those areas, demonstrate that 25% will require housing and support that was likely to be lifelong and on-site, that is supportive or disability housing or special residential services; double the number estimated in the AIHW analysis of 2018. Additionally, 12% also require multidisciplinary support similar to programs such as Melbourne Streets to Home (MS2H), H2H, and Journey to Social Inclusion (J2SI).[22]

> **My health overall is probably the best it's been in the last three or four years ... and my mental health is probably the best it's been in about ten years. I wasn't even aware of half the services they've been able to put me in contact with and they were invaluable.**
>
> – Launch Housing Client

16 https://www.health.vic.gov.au/your-health-report-of-the-chief-health-officer-victoria-2018/health-inequalities/aboriginal-and

17 AIHW 2022 via Pahor (2023), Launch Housing Better Health and Housing Program Evaluation.

18 Victorian Aboriginal and Torres Strait Islander Homelessness Factsheet (2022), Council to Homeless Person

19 Blueprint for an Aboriginal-specific homelessness system in Victoria, Aboriginal Housing Victoria Limited, available at https://vahhf.org.au/wp-content/uploads/2023/09/Blueprint.pdf

20 Aboriginal Housing and Homelessness Summit Report (2022), Victorian Aboriginal Housing and Homelessness Forum, available at https://vahhf.org.au/wp-content/uploads/2023/09/FINAL-AHHF-Summit-Report-2023_WEB.pdf

21 Launch Housing H2H client data.

22 LH0032_ZeroInMelbourne_NationalHousing_HomelessnessPlan_Submission_upload.pdf (nationbuilder.com)

Treating and managing complex health needs especially when sleeping rough is extremely challenging.  People sleeping rough often experience barriers to managing their health needs including:

- **Discrimination** by health services and emergency departments, contributing to inadequate prioritisation of care, leading to death on our streets.
- **Negative experiences with the health system**, leading to lack of trust in healthcare providers and the health system.
- **Challenges in navigating the health system**, for example difficulty in finding primary care such as a bulk billing general practitioner.
- **Lack of transport** to access care. This includes not being able to pay for public transport to attend appointments.
- **Having no mailing address**, means that people with no fixed address cannot be waitlisted for a catchment-based allocation of services.
- **Having no phone** limits people's ability to receive appointment reminders.
- **Unable to securely store medication** for diabetes, heart medication and cancer treatment for people in transient housing such as rough sleeping, couch surfing or short-term accommodation.[23]

23 https://www.aihw.gov.au/reports/australias-health/health-of-people-experiencing-homelessness#Barriers-to-accessing-health-care.

# THE CURRENT SILOED SYSTEMS ARE NOT WORKING

## The current siloed health and homelessness systems are failing to meet people's health and housing needs and adding strain on already overburdened systems that is costing the Government.

Siloed funding and budget processes at local, state and federal levels make it difficult for collaborative investment across homelessness and health services. The current funding systems don't acknowledge the interdependent relationship between homelessness and health systems and thereby the true costs of a holistic response. The need to remove these siloes were also highlighted in the **Royal Commission into Victoria's Mental Health System**.

Siloed funding streams make it difficult for service providers to deliver what we know works. Operating with limited resources, service providers face challenges in allocating resources, including funding multidisciplinary teams, specialist training for staff interacting with people with complex needs, and monitoring and evaluating programs.

Frontline staff play a crucial role in bridging the gap between siloed services, but this can often lead to staff bearing the burden of joining disconnected services together. With different governance, reporting and information sharing mechanisms across the systems, staff work as navigators, ensuring that people receive comprehensive support from a complex service system that would otherwise be impenetrable to many.

Staff see how complex and separate systems impact every person experiencing homelessness. Achieving outcomes for people is based heavily on building trust and relationships, which takes a long time. Funding cuts to programs can lead to losing momentum with clients and losing relationships that have taken time to build.

The burden on staff is also contributing to burnout and staff leaving the sector. High caseloads and vicarious trauma are contributing to people leaving the homelessness and health sectors.

Despite health and homelessness being inextricably linked, the systems and processes around data collection and sharing between health and homelessness service providers are siloed, burdensome and inefficient. This results in "the invisibility of clients that the systems are working separately to support".[24] A study by Launch Housing and St Vincent's Hospital found a significant overlap between clients frequently accessing certain services across the two organisations. The report highlighted the need for enhanced data collection and sharing systems to identify these individuals early and provide integrated care.

Finally, lack of integration across the health and homelessness systems has flow on effects impacting the justice system, which also incurs costs through interactions with ambulance services, child protection, police (as both victim and offender), appearances in court and nights in custody.

Not only are the siloed systems failing people, but it's wasting Government money.

## Systems failures have a significant cost to Government

Lack of access to primary healthcare means people experiencing homelessness don't get the care they need when they need it. This is pushing people into emergency departments.

In NSW, one study found that the Government spends a median cost of **$81,481** in health service for every person experiencing homelessness.[25] The study followed 2,155 clients of a homeless hostel clinic who were hospitalised in NSW. Between 2008 and 2021, there were 27,466 hospital admissions, with a median cost of **$81,481** per person, and a total cost of **$548.2 million**.

Homelessness has a significant cost on other Government services and systems. A study commissioned by the **NSW Department of Communities and Justice** found that the Government spends **$186,000** on each person who uses homelessness services, nearly **four times higher** than the general NSW population. Only 9% of that cost relate to homelessness and housing — most costs are spent across the health and justice sectors.

Violence against women and children cost Australia **$22 billion** in 2015-16, according to a report commissioned by the **Department of Social Services**.

These costs are associated with the psychological and physical health and premature mortality of victims, costs associated with damaged property and moving, lost wages and potential earnings, police and court systems costs, social welfare payments, public and private health system costs and child protection.

Many people who access homelessness services also access family violence support. The **NSW Government**-commissioned study found that family violence support was the most commonly required specialist support for people using homelessness services (23%). The study also found that people accessing homelessness services are:

- 24 times more likely to be in AOD treatment
- 20 times more likely to have been in custody
- 16 times more likely to be receiving private rental assistance
- 13 times more likely to access Legal Aid
- 10 times more likely to have a court appearance.

Research by **Unison and RMIT** shows similar trends in Victoria — a very high rate of family and domestic violence among repeat users of specialist homelessness services.

The current siloed health and homelessness systems are not just failing people. They are overburdening many other Government funded services.

24 Howard R, et al (2020), Data linkage highlights shortcomings for integrated health and housing responses; Parity 2020

25 Mitchell R, et al (2022), Health service use and predictors of high health service use among adults experiencing homelessness: a retrospective cohort study, Australian and New Zealand Journal of Public Health.

## These costs to Government can be avoided

It is cheaper to support people with complex health and wellbeing needs into stable housing, than let them cycle through the service system and experience chronic homelessness.

Integrated health and housing solutions for women escaping family and domestic violence shows how the Government can save costs. The costs savings of Viv's Place, a world-leading social housing program in Melbourne aimed at providing long-term housing and support for women and families leaving family violence and homelessness situations, are incredible. Early indications point to significant cost savings from reduced health costs from lower rates of intimate partner violence.

> The costs savings of Viv's Place, a **world-leading social housing program** in Melbourne ...has projected **savings of $49,173 per year** to families and communities.

An additional **$274,267 annual saving to state Government** is anticipated from Viv's Place's trauma-informed model.[26] This includes healthcare cost savings associated with a 50% reduction in intimate partner violence and reduced costs of treating mental health conditions. There are also anticipated reductions in costs of unresolved trauma for children.

Similar supportive housing models have also demonstrated cost savings. Brisbane Common Ground showed a cost saving to the Queensland Government of almost **$13,000 per person per year**. This included savings across health ($832,335), homelessness services ($169,364) and criminal justice ($122,904) generated as tenants experienced fewer mental health episodes and interactions with hospitals, as an admitted patient and at emergency departments, as well as fewer interactions with police.

Evaluations of other integrated programs like Melbourne Street to Home showed similar benefits. There was a significant improvement in people's physical and mental health in the first 12 months of the program. The number of people admitted to hospital in the three months before exiting the program had declined from 32% at the first interview to 11% at the final interview. The number of people using an emergency department in the three months before exiting the program fell from 42% at the first interview to 18% at the final interview.

An evaluation of the Better Health and Housing Program (BHHP) – an integrated health and homelessness step-down partnership between Homes Victoria, Launch Housing, St Vincent's Hospital Melbourne and the Brotherhood of St Laurence – is showing improvements in healthcare service utilisation for residents who had a planned exit from BHHP. Further, 74% of residents identified improvements in the management or resolution of health issues, with 37% noting improved management of mental health issues.

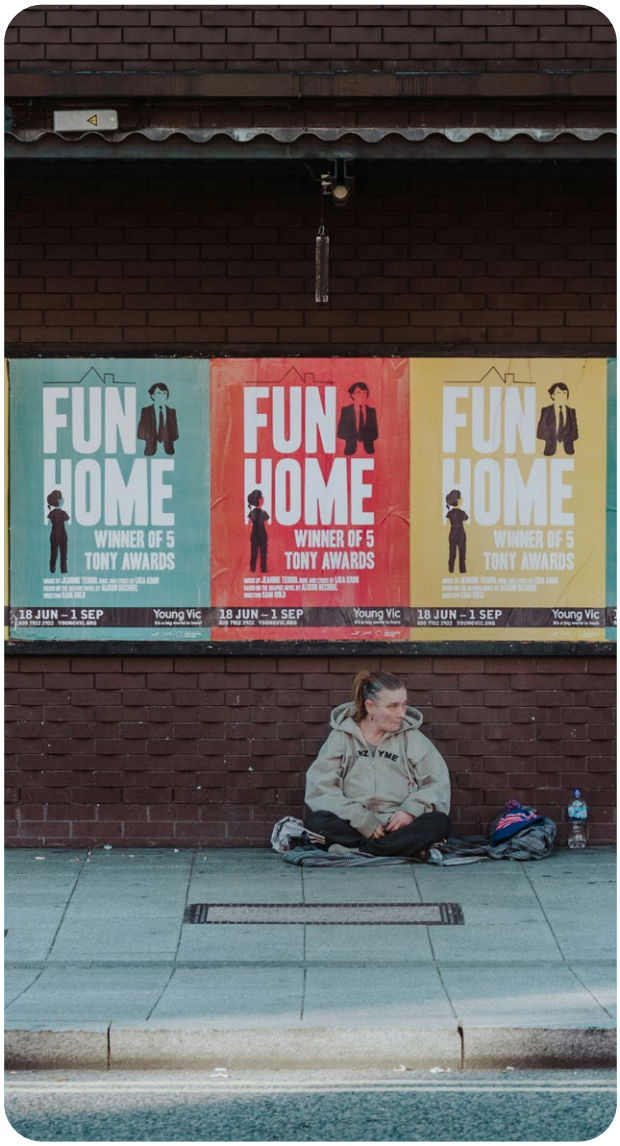
Launch Housing commissioned Nous Group to develop a cost-benefit analysis framework that shows that integrated homelessness health responses produce cost savings to Government. There are cost savings in avoided ambulance callouts, avoided emergency department presentations, avoided hospital admissions and reduced stays.[27]

An evaluation of a nurses program at Launch Housing's crisis accommodation in Southbank showed that having a nurse onsite working alongside homelessness service providers contributed to improved access to primary and community health care, and easing of pressure on hospitals.[28] Recent data from Southbank is demonstrating continued benefits of this approach, including avoiding 22 ambulance callouts, and nurse responding to 11 critical incidents, 88 acute injuries and health events on site, including 1 potential life saved.

Solutions that address homelessness and health in an integrated way saves lives and saves the Government money.

26 Launch Housing Submission to Issues Paper, National Housing and Homelessness Plan (2023).
27 Expanded Health Program Cost-Benefit Framework Literature Review (2022); Nous Group (2022).
28 Launch Housing Evaluation of Shine-on Nurses Program (2023).

# THE SOLUTION IS INTEGRATING HEALTH AND HOMELESSNESS SUPPORT




**Housing is good healthcare. Stable housing has positive impacts on a person's physical and mental health and wellbeing. Not only does integrating health and housing supports deliver significant benefits for people experiencing homelessness, it has cost savings for Government; a solution that we know works.**

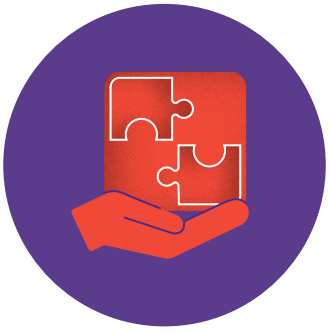
## A blueprint for Victoria

Integrated health and housing support means greater merging of services, teams and resources across the health and homelessness sectors.

We have a proposed a blueprint for integrating health and homelessness support in Victoria. A client-centred and trauma-informed approach embedded across all programs and supports, which allows us to be responsive to people's individual needs.

> **I think the nurse is doing an awesome job. They go above and beyond, and I would ... highly recommend every community or crisis housing centre, to have nurses on staff because they are an absolutely invaluable tool.**
>
> – Launch Housing Client

# Pillar 1: Service integration

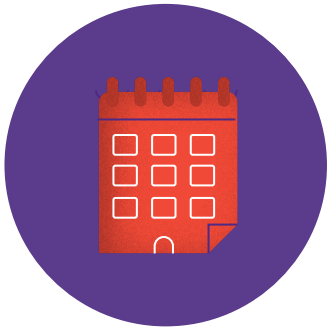


## Teams and organisations across both the health and homelessness sectors working together means timely and better access to care.

### What this looks like in practice:

- **Embedded nurses.** Nurse Practitioners embedded within programs ensures better access to care for people experiencing homelessness where they need it, when they need it. Nurses embedded in outreach teams, at crisis sites, and long-term housing sites can provide more holistic housing and healthcare support. Elizabeth Street Common Ground shows how on-site nurses can improve the health of residents. Melbourne Street to Home shows how nurses embedded in outreach teams can bring healthcare to people sleeping rough.
- **Multidisciplinary teams**. Teams comprising of healthcare workers, AOD supports, case coordinators and culturally appropriate support are able to solve problems together quickly and in a coordinated way. It also removes barriers for clients accessing services. Multidisciplinary teams at sites like Launch Housing's Southbank Crisis Accommodation, Sacred Heart Mission's J2SI program and the Victorian Government's Homelessness to a Home deliver case management, healthcare and crisis support for people in need of shelter and care. Programs delivered by the Victorian Aboriginal Community Services Association Ltd (VACSAL) include multidisciplinary teams and culturally appropriate supports.
- **'Step down' programs.** When people are in our hospitals and emergency departments, we can prevent them going back onto the streets when leaving hospital. Step down programs provide holistic care, addressing people's health and wellbeing needs while connecting them to housing. Programs like the Better Health and Housing Program, Homeless Healthcare's Medical Respite Centre and The Cottage show how step down programs can be delivered effectively.
- **By-Name Lists.** A shared By-Name List (BNL) recognises every person sleeping rough in a specific area so that their names and needs are known. Relevant partners across multiple services and systems in a local area then work together with the purpose of supporting that person into housing and helping them access other relevant community services. This has proven to work in multiple local Government areas in Melbourne and across Australia. Advance to Zero's assertive outreach approach finds and engages with people sleeping rough in a local area and adds their names to the BNL. The BNL is a strong foundation that enables coordinated wrap-around support and housing outcomes for people experiencing chronic homelessness.

# Pillar 2:
# Long-term supportive housing



**Building more appropriate long-term supportive housing will help people better access support and stay out of homelessness.**

## What this looks like in practice:

- **Trauma-informed long-term supportive housing.** Long-term supportive housing models with onsite supports ensure health care and other services are accessible and people have a stable home.
- **Flexible and individualised supports onsite.** This provides people the opportunity to access flexible and individualised supports including AOD, healthcare, case management and practical assistance such as budgeting and managing a tenancy. Examples include Brisbane Common Ground, Ozanam House, Elizabeth Street Common Ground, the Cornelia Program for pregnant women and Viv's Place which is a purpose-built, trauma-informed long-term supportive housing model, helping women and children escaping family and domestic violence.

> **Building the trust and explaining things really well to people – getting that rapport – if you don't get that initially, you can lose them. A lot of them are quite reluctant to go to general health services as they feel they are being discriminated against.**
>
> – Program Nurse

# Pillar 3:
# A specialist workforce

**Retaining and scaling up a specialist workforce will ensure the health and homelessness sectors have the people, skills and expertise needed to meet growing demand.**

## What this looks like in practice:

- **Retaining a specialist workforce.** Recurrent funding to retain a multidisciplinary workforce will ensure specialist knowledge and learnings remain in the sector, and the sector can better manage staff burnout. Ongoing and adequate funding that acknowledges the true demand will mean that staff are not overloaded.
- **Scaling up a specialist workforce.** Demand for services across the homelessness and health sectors is increasing. Too often our teams are inundated and do not have the capacity to support everyone in need of specialist care. Scaling up our specialist workforce will ensure our teams can meet demand. This includes scaling up First Nations lived expertise as a key part of a specialist workforce.
- **Cross-sector training.** A specialist set of skills is required for teams supporting people with complex health and wellbeing needs into housing. Providing training to workers across the health, homelessness and other related sectors ensures care is better coordinated and delivered. For instance, in hospitals, accurately identifying and referring people experiencing homelessness at the emergency department could lead to targeted interventions that could save lives and end a person's cycle of chronic homelessness. The Frankston Zero project initiative with Peninsula Health is an example of cross-sector training that covers topics on how hospital staff can ask patients about homelessness, better understanding the specialist homelessness service system and how to access specialist services at Peninsular Health for complex clients.

# Pillar 4: Coordinated health and homelessness function

## Government, funding and information siloes are broken down to enable better cross-sector ways of working.

### What this looks like in practice:

- **Cross-function accountability.** Having a coordinated homelessness and health function within a Government department will help increase accountability and promote shared responsibility. Victoria's H2H program and NSW's Together Home program showed how multi-agency approaches to homelessness can deliver effective health and housing responses. Finland's national plan to end homelessness is a close collaboration between its Ministry of the Environment and Ministry of Social Affairs and Health and shows how cross-departmental collaboration can end homelessness.
- **Service quality-driven funding arrangements.** More diverse funding structures will allow greater flexibility for services to better meet clients' complex needs. Funding arrangements between Victorian Government departments and service providers should better consider outcomes-based service goals when commissioning homelessness services, rather than output-based service delivery. This includes additional subsidies for individuals with more complex needs. This was a recommendation that came out of Victoria's inquiry into homelessness.
- **Information sharing.** Data sharing benefits clients, service providers and Government. For clients, it means they are not subjected to the same or repeat information and questioning. For service providers, it means building a holistic understanding of client needs quickly and developing targeted interventions. For Government, it means cost savings, better policies and planning to meet service demand.
- **Shared monitoring and evaluation function.** Collaborative monitoring and evaluation efforts across health and homelessness systems ensures services are effective and accountable. Insights drive service improvements and ensures decision making is evidence-based.

More diverse funding structures will allow **greater flexibility** for services to better **meet clients' complex needs**.

# OUR CALLS TO ACTION

## Action 1:

### Invest in the true cost of implementing integrated health and homelessness programs

- Invest in culturally appropriate, safe and integrated health and housing models for First Nations clients.
- Invest in 'step down' programs such as the Better Health and Housing Program to support people exiting hospitals to find appropriate housing and the care they need to sustain housing.
- Embed nurse practitioners in outreach teams and at every site that supports people experiencing homelessness.
- Prioritise people sleeping rough into housing, including prioritising access for people sleeping rough on the Victorian Housing Register and through programs like Advance to Zero.
- Provide ongoing funding to hire, retain and train social services staff to meet the demands of integrated health and homelessness support programs.
- Provide funding for ongoing monitoring and evaluation of integrated health and homelessness programs.

## Action 2:

### Invest in more trauma-informed long-term supportive housing

- Build more long-term supportive housing for women and children escaping family and domestic violence such as Viv's Place.
- Build more long-term supportive housing models such as Common Grounds for singles and couples.

## Action 3:

### Reform the system to better reflect the interconnectedness of health and homelessness

- Commit to reporting street deaths to the Coroner so there is better understanding of the scale of the problem and we have the data we need to effectively address it.
- Establish a coordinated health and homelessness function within the Department of Families, Fairness and Housing. This includes ensuring there is collaborative investment, reporting and monitoring mechanisms across health and homelessness.
- Better harmonise information collection and sharing systems between Government agencies and the broader housing and health sectors to improve efficiencies and cost-savings across systems.

## Inclusivity at Launch Housing

We are proud to be an inclusive organisation and support all efforts to build a more equal world, where individuals can live and work free from discrimination.

## Child safety

Launch Housing is a Child Safe Organisation. We prioritise the health, safety and wellbeing of children and young people, and have a zero-tolerance approach to child abuse.

Launch HOUSING IT'S TIME TO END HOMELESSNESS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