Submission No 58

INQUIRY INTO HOMELESSNESS AMONGST OLDER PEOPLE AGED OVER 55 IN NEW SOUTH WALES

Organisation: St Vincent's Health Australia

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St Vincent's Health Australia

Submission to the NSW Legislative Council's Standing Committee on Social Issues' Inquiry into homelessness amongst older people aged over 55 in New South Wales

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1. Terms of reference

Inquiry into homelessness amongst older people aged over 55 in New South Wales

That the Standing Committee on Social Issues inquire into and report on homelessness amongst older people aged over 55 in New South Wales, and in particular:

(a) the rate of homelessness,

(b) factors affecting the incidence of homelessness,

(c) opportunities for early intervention to prevent homelessness,

(d) services to support older people who are homeless or at risk of homelessness, including housing assistance, social housing and specialist homelessness services,

(e) challenges that older people experience navigating homelessness services,

(f) examples of best-practice approaches in Australia and internationally to prevent and address homelessness amongst older people,

(g) options to better support older people to obtain and maintain secure accommodation and avoid homelessness,

(h) the adequacy of the collection of data on older people experiencing or at risk of homelessness and opportunities to improve such collection,

(i) the impact of homelessness on the health and wellbeing of older people and the related costs to the health system,

(j) the specific impact of homelessness, including the matters raised above, on older women,

(k) the impact of homelessness, including the increased risk of homelessness in the community, on older people in vulnerable groups, and

(l) any other related matter.

2. About St Vincent's Health Australia

With its origins dating back more than 180 years, St Vincent's Health Australia (SVHA) has been providing health care in Australia since its first hospital was established in Sydney in 1857 by the Sisters of Charity.

Today, SVHA is the nation's largest not-for-profit health and aged care provider. We operate six public hospitals, 10 private hospitals and 23 aged care facilities in Queensland, New South Wales and Victoria. Along with three co-located research institutes – the Victor Chang Cardiac Research Institute, the Garvan Institute of Medical Research, and St Vincent's Institute of Medical Research – we work in close partnership with other research bodies, universities, and health care providers.

We are a clinical and education leader with a national and international reputation in medical research. Our areas of expertise include heart lung transplantation; bone marrow

transplantation; cardiology; neurosurgery; cancer; clinical genomics; HIV medicine; palliative care; respiratory medicine; mental health; drug and alcohol services; aged psychiatry; homeless health; and prisoner health.

SVHA employs 22,000 staff and operates close to 5,000 hospital beds and residential aged care places across its organisation.

SVHA is committed to Inclusive Health[1], with people experiencing homelessness being a major focus of this commitment. Efforts to support and help address the needs of people experiencing homelessness across the organisation are guided by the organisation's *Health and Homeless Framework*[2].

This framework builds on existing SVHA services and models such as Prague House at St Vincent's Hospital Melbourne and Tierney House at St Vincent's Hospital Sydney which, along with a range of other homeless health services across both facilities, provide specialist care for people experiencing, or at risk of, homelessness, including people aged 55 and over who have unique needs which set them apart from others in the homeless community.

Work is ongoing across the Sydney and Melbourne public hospitals to define how the hospitals can enhance their supports for people experiencing homelessness.

SVHA's commitment to tackling homelessness is also reflected in the roles it and its hospitals play within the homelessness sector, which includes board membership of the End Street Sleeping Collaboration; membership of the NSW Premier's Council on Homelessness; the Sydney Intersectoral Homelessness Health Senior Collaborative Alliance; representation on the Melbourne CBD Service Coordination Project (City of Melbourne); the Specialist Homeless Services Network (Council for Homeless Persons); and membership of the leadership group of the Everybody's Home campaign to end homelessness and boost social housing in Australia.

SVHA's aged care division – delivered under the name St Vincent's Care Services (SVCS) – also gives the organisation a deep understanding of the issues facing older Australians and the changing environment in terms of providing high quality, resident-informed aged care.

SVCS is itself using the principles of inclusive health and guidance of the organisation's Homeless Health Framework to explore potential service offerings it could deliver for older people experiencing homelessness.

3. Introduction

Despite innovative partnerships among community-based homeless services, community housing providers, and health service organisations – and their continued best efforts – homelessness is on the rise in Australia and becoming more deeply entrenched.

Tens of thousands more Australians live in the shadow of homelessness as they struggle with a lack of affordable and secure housing and related challenges.

In recent years, we have seen more engagement, leadership and proactivity from state and territory governments to address the problem, which is welcome. The recent COVID-19 experience has proved that state and territory governments can find rapid solutions to better

[1] St Vincent's Health Australia. "Inclusive Health." Accessed 12 Mar 2021 (link)
[2] St Vincent's Health Australia, SVHA Health and Homeless Framework, 2019.

support people experiencing homelessness through the provision of housing and health care services.

Commonwealth-funded entities – such as the Primary Health Networks – are working closely with our hospitals in addressing homelessness, but in recent years, the Commonwealth Government has explicitly chosen not to play a leadership role in encouraging or investing in social housing, despite the major social and economic benefits such an effort could bring across Australia.

There is no shortage of research and evidence-based examples to show that ending homelessness can be achieved. What is ultimately missing in Australia is the political will to do so.

It is well known among governments and service providers alike that to end homelessness once and for all we need: significantly more social housing stock and quick access for those most vulnerable; accessible and individualised services – from health to social supports – that are 'wrapped around' people, when and where they are needed; help for people to maintain their tenancy and foster good health and healthy habits; employment and training opportunities; and a renewed focus on homelessness prevention among key demographics, including people aged 55 and over.

St Vincent's Health's hospitals – particularly St Vincent's public hospitals in Fitzroy, Melbourne and Darlinghurst, Sydney – have always been on the front line of tackling homelessness: it's a large part of why our organisation began; it's part of our DNA.

For example, among our efforts in healthcare for homeless persons, we operate two of Australia's only step up / step down services, providing residential short-stays and an opportunity for convalescence for people experiencing homelessness.

But like many homeless service providers – and as a leading aged care provider – we can see beyond funding and policy limitations to what else could be done or done better; how, the right partnerships and financial support, we could dramatically reduce homelessness.

With our combined health, homeless health, and aged care expertise, we have a unique perspective on the needs of older people experiencing homelessness or who are in insecure housing.

The conclusions and recommendations of this submission are grounded in our experience of housing-led models, patient and resident engagement with their own care, service agility and responsiveness, and strong service partnerships, all underlined by an emphasis on continuity of care with wrap-around support to ensure that the whole person can be sustained.

In order to be of most value to the Committee, this submission will focus strongly on two items within the inquiry's terms of reference: (g) options to better support older people to obtain and maintain secure accommodation and avoid homelessness; and (i) the impact of homelessness on the health and wellbeing of older people and the related costs to the health system.

SVHA has been engaged in a long-term process to consider best-practice specialist accommodation for this aged group. Part of that planning has included a series of consultations to gather the insights of people aged in their late 40s and 50s with a lived experience of

homelessness to better understand how such accommodation can best deliver positive health and wellbeing outcomes for them and their peers.

We have shared some of the general observations and outcomes of SVHA's discernment process in the body of this submission, along with the results of the 'lived experience' consultations at Appendix I.

We trust that this will be of value to the Committee, government, policymakers and other organisations as they consider the challenge of better supporting older Australians experiencing homelessness or insecure housing.

4. Problem definition and needs analysis

Key points

Homelessness is a broad and complex issue that affects more than 290,000 people across Australia. It results from a combination of system challenges, individual vulnerabilities, and trigger events. There is a spectrum of need that includes those at risk of homelessness (~152,000), living in unsuitable housing (~114,000), or sleeping rough (~25,000). There is a distinct shortage of long-term housing available for people experiencing or at-risk of homelessness, with over 70% of the 100,000 people who seek long-term housing each year unable to access it.

At least 24,000 older persons (aged over 55 years) are affected by homelessness across Australia. While they are not an overrepresented cohort, they experience similar issues and vulnerabilities to the broader cohort; this includes a shortage of long-term housing options for at least 9,000 older persons each year.

There is a diverse range of available services for people with experience of homelessness. The nature of these services for people experiencing homelessness varies due to differences in target outcomes and available funding, with aged-care services looking decidedly different because of their focus on permanent accommodation, rather than transition (to other services). Complex clients, as opposed to those with only financial needs, require dedicated facilities and service designs, often with specialised staff.

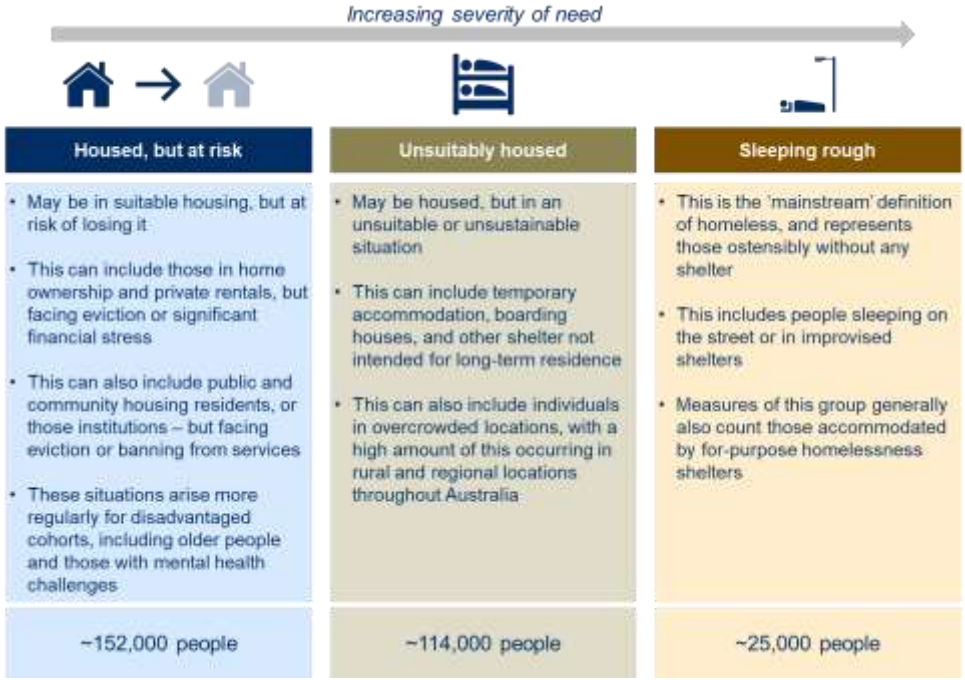
Based only on evidence of individuals *actively* seeking services (therefore being an underestimate) and not being able to access them, there is confirmed unmet demand for long-term accommodation services for older people with experience of homelessness across the key geographies where SVCS currently operates (Brisbane, Sydney, and Melbourne).

5. Homelessness in Australia

Homelessness in Australia is a significant and complex issue that impacts many Australians. *The Australian Institute of Health and Welfare* (AIHW) estimates at least 290,500 people in Australia are at risk of or experiencing homelessness.[3] This includes those that are currently housed but at risk of becoming homeless (~152,000[4]), those in unsuitable housing (~114,000[5]), and individuals that are sleeping rough (~25,000[6]). *Figure 1* describes the three categories of homelessness and estimates for the number of Australians experiencing them.

Additionally, as the core focus of this business case, older people are one of the cohorts most affected by homelessness, with the fastest growing cohort of homeless people being older women.[7] In 2019-20, 13,545 women over the age of 55 sought support from specialist homelessness services and this is expected to increase.[8]

Figure 1: Types of homelessness[9]

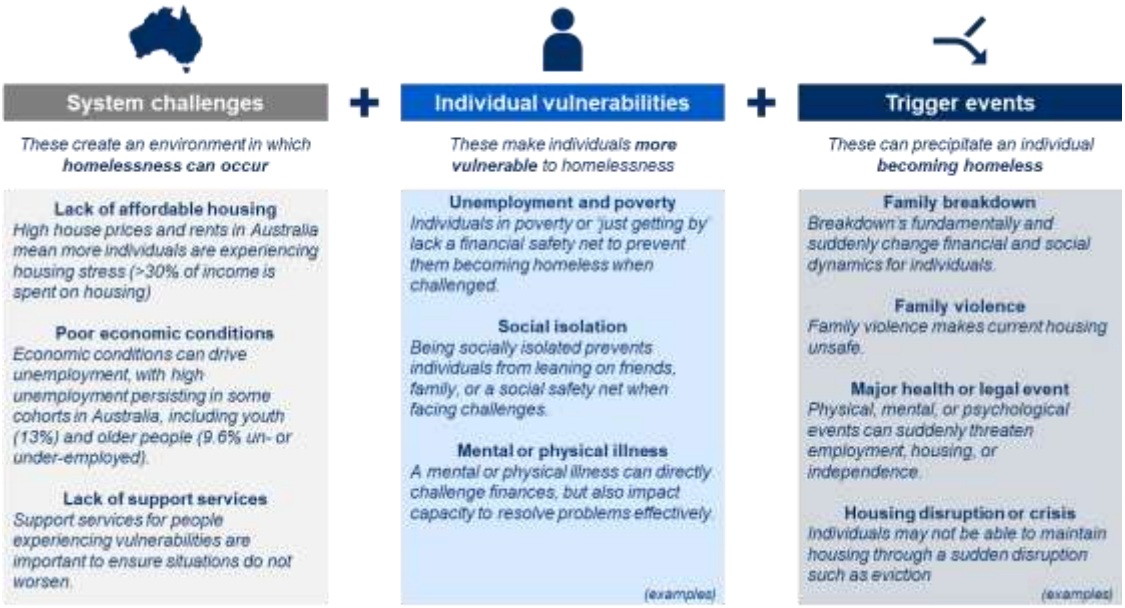


When considering solutions and policies to address the issue of homelessness in Australia, it is important to acknowledge that homelessness is a complex issue that most-often arises from a confluence of vulnerabilities and events for individuals.

Figure 2 (next page) includes one characterisation of these vulnerabilities and events, with categories including (i) system challenges, (ii) individual vulnerabilities, and (iii) trigger events that combine to result in homelessness.[10]

[3] Likely to be a significant underestimate as it only counts people who have sought assistance from specialist homelessness services.
[4] AIHW. *Specialist Homelessness Services Annual Report*. 2019-20
[5] *Ibid.*
[6] *Ibid.*
[7] AHRC. *Older Women's Risk of Homelessness: Background Paper*. April 2019
[8] AIHW. *Specialist Homelessness Services Annual Report*. 2019-20
[9] Sources: (1) AIHW. *Specialist Homelessness Services Annual Report*. 2019-20 (2) Homelessness Australia to assist with definitions
[10] *SVHA Homelessness Framework*

Figure 2: Drivers of homelessness



6. The health status of people experiencing homelessness

The link between homelessness and health is well-documented and people at risk of homelessness can be frequent users of hospital services. Clearly housing is a health issue.

Homeless patients generally have a range of complex needs that affect potential access to safe and affordable housing. Health issues among people who are homeless invariably cluster with, and are exacerbated by other social determinants of health, including trauma, poverty, unemployment and social disconnection. This challenges traditional clinical boundaries and health system responses.[11]

The key homeless cohorts are those with mental health and addiction issues, those escaping domestic violence or who have experienced significant trauma and people released from prison. Often those with acquired brain injury and intellectual disability are among the cohort.

People experiencing homelessness have more health problems, often struggling with a range of co-morbidities, and die earlier than the general population.

Physical health issues including respiratory tract infections, skin infections, poor oral and foot health, musculoskeletal disorders, and blood-borne viruses (e.g. hepatitis B, hepatitis C) are all common among people experiencing homelessness.[12] Much of this burden is thought to be related to the experience of homelessness itself, as homelessness is associated with poor nutrition, poorer access to health care, higher exposure to smoking and substance use, as well as challenges to adhering to medications and treatment.[13]

[11] Wood, L., Vallesi, S., Martin, K., Lester, L., Zaretzky, K., Flatau, P., Gazey, A (2017). St Vincent's Hospital Melbourne Homelessness Programs Evaluation Report. An evaluation of ALERT, CHOPS, The Cottage and Prague House. Centre for Social Impact: University of Western Australia, Perth, Western Australia.

[12] Hwang S, *Homelessness and health*. CMAJ. 2001 Jan 23; 164(2): 229–233.

[13] Hwang S, *Homelessness and health*. CMAJ. 2001 Jan 23; 164(2): 229–233.

People experiencing homelessness also exhibit high rates of mental disorder, alcohol and drug use, trauma, cognitive impairment, suicide and other premature deaths.[14] For example, a profile of chronically homeless people in Brisbane found more than one-third had asthma (compared to one-in-10 in general Australian population); one-in-five were diabetic (compared to one-in-20 in general Australian population); while one-third had heart disease; and one-quarter had liver disease.[15]

One of the more unique health problems experienced by many people experiencing long-term homelessness, but particularly those who are older, is poor oral health.

Homeless populations – including in inner Sydney and in the catchment area served by St Vincent's Hospital Sydney – are poorly served in terms of their oral health.

There is substantial evidence that poor oral health and an inability to access dental services for people experiencing homelessness and in insecure housing are significant contributors to broader ill health, reduced quality of life (including pain), and an inability to participate in work and in the community.

St Vincent's Health Australia believes state/territory and federal governments need a stronger focus on supporting and providing much needed dental services to vulnerable populations, including those who are experiencing homelessness. These services could be provided by a wide range of government and non-government organisations.

High quality, accessibly dental services need to be provided as part of any comprehensive health service to this marginalised cohort. Key elements of a good dental service should include:

- Tailored to individual needs
- Flexible (outreach and after-hours services)
- Accessible and timely (self-referral, sit and wait option)
- Consumer friendly (minimise registration red tape)
- Co-location of dental and welfare services
- Client and staff safety
- Monitoring and evaluation framework

The increased prevalence of chronic illness amongst homeless people has been recognised internationally. This will create a larger burden on the Australian healthcare system in years to come as there are increasing numbers of homeless people over 50 years of age.

Mortality in people experiencing homelessness is estimated to be 3-4 times the general population.[16] This rate appears to be constant across different countries, and to some extent time. A recently completed follow-up study of St Vincent's Hospital Melbourne patients verified this estimate in an Australian population. Most importantly, this study showed that all levels of homeless patients experienced this same increased rate of mortality however, this increased rate was not seen in those patients that were publicly housed with rental assistance.[17]

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[14] Teeson, M et al, Psychiatric disorders in homeless men and women in inner Sydney. Aust N Z J Psychiatry. 2004 Mar; 38(3):162-8.

[15] *Pathways Hospital Admissions and Discharge Pilot Project: Twelve Month Evaluation Report*, Jan 2015-Dec 2015, 2016

[16] O'Connell et al, A public health approach to reducing morbidity and mortality among homeless people in Boston, Journal of Public Health, Management and Practice, 2005

[17] R J Seastres, J Hutton, R Zordan, V Sundararajan, K Kiburg, J Mackelprang, G Moore, *Long-term health outcomes of homeless and non-homeless patients at an Australian metropolitan hospital: a 15-year cohort study* Poster presentation, SVHM Research Week 2018.

Significantly, people experiencing homelessness are disproportionately higher users of acute health services compared to non-homeless people, including more frequent emergency department visits and inpatient hospital admissions and longer hospital stays.[18]

A 2016 survey of rough-sleepers in Melbourne's CBD found that nearly three-quarters of respondents identified a hospital as their primary healthcare provider.[19]

Many don't access health services at all, or if they do, only after their issue has reached crisis point.

And the longer access to healthcare for a homeless person is delayed, the greater their need for acute care, longer hospital admission, and by extension, greater treatment costs.[20]

7. Homelessness and mainstream health services

Most mainstream health services are not configured to meet the needs of homeless people. The life complexities which contribute to their ill health are often not picked up or fully understood.

To begin with, the majority of hospitals aren't good at gathering information about a person's housing status, which means people are not necessarily identified as homeless and miss out on appropriate support.

A report by the Sydney Health Community Network[21] confirmed that homeless people were very likely to be undetected and undercounted by health services because of inconsistencies in the way information was gathered and the variety of systems used – with different data fields, some of which aren't mandatory for completion – meaning a person's homelessness status is often not captured.

A study at a metropolitan Melbourne hospital that used ED datasets identified 0.8% of attendees as homeless, whereas intensive manual screening identified 7.9% of ED attendees as homeless.[22]

This issue was brought into stark relief during the COVID-19 pandemic at one of SVHA's hospitals. It experienced a young Sudanese woman, a mother of five children and who was also six months pregnant, who was attempting to find emergency accommodation for herself and her children because of family violence.

While the woman was referred to emergency accommodation by authorities, she was unable to access the service until she had received a test for COVID-19. However, at the mainstream health service she attended, she was turned away from receiving a test because she did not have any symptoms.

It was only when the St Vincent's COVID-19 clinic encountered the young woman that her full predicament was understood and we were able to provide her with her test so she could access her emergency accommodation.

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[18] Fazel, S et al. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. Lancet, 2014 Oct 25; 384(9953): 1529–1540.
[19] Micah Projects Inc. *De-Identified Vulnerability Index-Service Prioritisation Decision Assistance Tool data for Melbourne 2010-2016.* Brisbane: Inc MP; 2017
[20] Wood, L., Gazey, A., Vallesi, S., Cumming, C., & Chapple, N. (2018). *Tackling health disparities among people experiencing homelessness - the impact of Homeless Healthcare: Evaluation Report October 2018*. Perth: The University of Western Australia.
[21] Sydney Health Community Network, *Enhancing primary health care services for people experiencing primary homelessness in the Central and Eastern Sydney Primary Health Network Region*, February 2018
[22] Lee et al, *Homeless status documentation at a metropolitan hospital emergency department*, Emergency Medicine Australasia, 2019.

For homeless people, accessing specialist care services is harder still.

For example, preparing your end-of-life plan when you have a terminal illness can be complicated enough, but add a lack of stable housing or the family connections to support the implementation of such a plan, along with a lack of access to medical services, and personal concerns about stigma and discrimination, it becomes close to impossible.

Hospital discharge can bring other serious challenges.

There is no independent source that reports on Australians exiting care into homelessness.

The available data on specialist homelessness services from the Australian Institute of Health and Welfare shows the number of people accessing such services after recently exiting care settings.[23]

However, this data does not give us the necessary insight to know whether some clients were proactively transferred by care settings as part of their discharge planning. Nor does it capture the many people who do not access specialist services but are at risk of, or experiencing, homelessness.

However, anecdotally we know the problem is a serious one. For example, due to the chronic shortage of affordable accommodation in Victoria, it's estimated over 500 people each year are discharged from acute mental health care into rooming houses, motels and other tertiary homeless situations.[24]

As Jenny Smith, CEO, Council to Homeless Persons has said: "Any gains made in hospital quickly unravel when people are discharged into homelessness or substandard accommodation, and many will find themselves back in hospital. It becomes an insidious cycle".[25]

All of the above presents a massive challenge for traditional clinical boundaries and health system responses.[26]

8. Homelessness for older persons in Australia

Homelessness remains a complex, major, and growing issue for older Australians. The *AIHW* estimates that over 24,000 older persons (defined as 55+) require support from specialist homelessness services.

The number of older people experiencing or at risk of homelessness, both long-term and first-time homelessness, is increasing. The proportion of women facing homelessness within that cohort is also increasing.[27] When combined with complex health needs, appropriate long-term care options remain limited.

[23] Australian Institute of Health and Welfare's *Specialist Homelessness Services (SHS) annual report, 2017–18*
[24] https://chp.org.au/five-reasons-why-victorias-mental-health-royal-commission-must-examine-the-role-of-housing-and-homelessness/
[25] https://vincentcare.org.au/stories/latest- news/352- from- hospital- into- homelessness, November 2018
[26] Wood, L., Vallesi, S., Martin, K., Lester, L., Zaretzky, K., Flatau, P., Gazey, A (2017). *St Vincent's Hospital Melbourne Homelessness Programs Evaluation Report. An evaluation of ALERT, CHOPS, The Cottage and Prague House*. Centre for Social Impact: University of Western Australia, Perth, Western Australia.
[27] *Designing residential aged care for people at risk of, or experiencing, homelessness: An exploratory Australian study*, Rowlands et al, Health and Social Care in the Community, April 2020

The older homeless population displays unique characteristics related to vulnerabilities, gender profile, and age profile.

An outline of key characteristics and vulnerabilities for older people experiencing or at risk of homelessness is included in

Table *1* and Table 2 below.

Table 1: Demographic characteristics of older persons (55+ yrs) experiencing homelessness[28]

Demographic Characteristic	Older homeless population (55+ yrs)	Comparison to general homeless population (aged 0-54 yrs)
Gender	55% female	60% female
	45% male	40% male
Living situation	60% living alone	30% living alone
Demographic Characteristic	**Older homeless population (55+ yrs)**	**Comparison to general population**[29]
Age	65% aged 55-64	42% aged 55-64
	35% aged 65+	58% aged 65+

Table 2: Vulnerability rates for older persons experiencing homelessness[30]

Vulnerability	Rate	General homeless population
Mental health issues	6.4%	9.7%
Behavioural challenges	8.1%	12.3%
Assistance for trauma	6.9%	12.8%
Family violence	17.4%	30.3%
Alcohol and other drug issues	1.7%	3.7%

The above tables highlight three important points for consideration: a) many older people experiencing homelessness require support for additional vulnerabilities, including mental health, trauma, and family violence, b) there is a larger number of older women experiencing homelessness than older men, c) people with an experience of homelessness generally experience mortality at a younger age compared to those without an experience of homelessness.[31]

[28] AIHW. *Specialist Homelessness Services Annual Report*. 2019-20
[29] ABS. *Australian Demographic Statistics*. Jun 2019
[30] *Ibid.*
[31] AIHW. *Health of people experiencing homelessness. 11 Dec. 2020.* (Accessed 26 Feb 2021)

Firstly, with regards to vulnerabilities, while there is a relatively small proportion of the older population suffering from the above-listed issues, when considering providing a range of supports and housing solutions for this cohort there are likely to be a number with complex mental health and alcohol and other drugs challenges along with behavioural issues and a lived experience of trauma. These vulnerabilities often require specialised support and will require staff working with this cohort to have additional experience relating to trauma-informed care and mental health support.

Secondly, it is important to note that there is an increasing overrepresentation of women in the homeless cohort, with 55% of older homeless people identifying as such. While there are a range of factors contributing to homelessness for older women, including family breakdown and domestic violence, part of the reason for this overrepresentation is current and historic system challenges affecting women's financial independence and security.[32]

Recent data from a Melbourne Institute study lays bare the financial difficulties many Australian women face at the dissolution of a long-term relationship, including an increased risk of poverty. The study found that in the first year of separation the risk of being poor more than doubled for women (increasing from 9 to 22 percentage points) and that while a breakup, on average, reduces a man's disposable household income by 5%, on average women's household income decreases by almost 30%.[33]

At retirement, single older women are more likely to rely on the age pension than single older men and about a third are living in income poverty.[34] Therefore, to some extent, the cause of homelessness for the older women cohort is different to the older men's cohort which is often more associated with complex experiences of trauma, addiction, and mental health. Older women experiencing homelessness, therefore, may have different and less complex support needs that may not require, for example, placement in a specialist residential aged care facility.

Finally, it should be noted that the figures listed in this section do not include individuals experiencing 'early onset aging', whereby people with a history of homelessness experiencing declining health, require aged care at earlier ages. This phenomenon has been identified in numerous studies, where homeless services support people requiring aged care as young as 45. This has implications for the delivery of any support for this cohort, as there may need to be a broader understanding of who can be included in any service.

Additionally, it will have implications for the term that residents spend in a specialist accommodation service. As the health of people experiencing homelessness who enter aged care may improve, residents could enter the facility in their younger years and live in the service for several years.

9. Royal Commission into Aged Care Quality and Safety

- The Royal Commission into Aged Care Quality and Safety issued its final report on 1 March, 2021. This report includes findings and recommendations relevant to providing care for the elderly homeless. Relevant findings and recommendations include:

[32] AHRC. *Older Women's Risk of Homelessness: Background Paper*. April 2019
[33] *From Partnered to Single: Financial Security Over a Lifetime*, The Melbourne Institute, Broadway, Kalb and Maheswaran, June 2022
[34] *Ibid.*

i) People from diverse backgrounds, including with an experience of homelessness, have difficulty accessing appropriate aged care services, and most services are not equipped to care for them. There is an associated recommendation that aged care programs be connected with State and Australian Government housing programs in order to provide more solutions for older people who are experiencing homelessness.

ii) Mental health services are generally inadequate and underprovided in aged care. There is an associated recommendation that older persons' mental health outreach services be funded for people receiving residential aged care.

iii) The report recommends no younger people reside in aged care, highlighting a specific target for no person under the age of 65 years to be living in residential aged care from 1 January 2025.

- The Commission's findings related to younger people in aged care are particularly relevant when considering the needs of people aged 45-65 who are experiencing "early-onset aging" (whereby residents exhibit symptoms of aging before age 65 due to life experiences), which the Commission's report does not explicitly discuss.

- These recommendations are likely to require providers of accommodation services to this particularly vulnerable group to give further consideration to the built form and their delivery model.

10. Unmet demand for long-term accommodation for older homeless people

The unmet demand for older Australians seeking long-term accommodation and support for mental health issues, family violence, and alcohol and other drug issues is substantial.

Specifically, over 6,000 older Australians per year seeking long-term accommodation have been unable to access it. SVHA's experience is in the capital cities of Brisbane, Sydney, and Melbourne where this issue is particularly pronounced.

In Brisbane, approximately 190 older people have an unmet need for long-term housing. In Sydney, there is approximately 900 older people with an unmet need. In Melbourne it is approximately 2,200 older people.[35,36] Meanwhile, in terms of existing supply of long-term accommodation for older people with an experience of homelessness, the situation varies across cities.

In Brisbane, there does not appear to be existing specialised long-term accommodation services for older people with an experience of homelessness[37] whereas in Sydney, there are a range of existing services including HammondCare Darlinghurst, and three services operated by Mission Australia. Meanwhile, in Melbourne, specialised services are provided by Prague House (St Vincent's Hospital Melbourne), Sacred Heart Community, and Wintringham, with others likely available.

[35]Unmet demand is estimated based on the homeless or at-risk population over 55 in metropolitan areas. These are likely significantly underestimated, because needs have been assumed to be met at same rates as general homeless/at-risk populations, and only people seeking actively seeking services have been captured in the data used (i.e. there is likely unmet demand not being captured).
[36] Note: Figures have been calculated based on the number of people accessing specialist homelessness services in each city, and subsequently not being provided the required long-term accommodation (this is how AIHW collects this data). Therefore, the estimated numbers are likely underestimates, as only people actively seeking services are captured in the data. Additionally, in areas such as Sydney and Melbourne where specialised services are available, there is likely to be a higher capture rate to Brisbane where such services are entirely unavailable.
[37] Finding based on desktop survey and interviews with relevant stakeholders in Brisbane including Micah Projects.

The implication of these findings is that, while there is a need for services in all three cities, Brisbane is unique in not having any of the specialised services available in Sydney and Melbourne. Meanwhile, in Sydney and Melbourne, despite a range of existing services, demand remains high and there is an ongoing need for high quality services providing comprehensive care.

11. Accommodation options for older homeless people

Key points

Models of care for older homeless people require a person-centred and trauma-informed approach, supported by peer workers and Aboriginal health workers, with in-reach support for mental health alcohol and other drugs. Residents are expected to have a younger age profile than are usually found in residential aged care, along with a higher proportion who require specialised supports. There is also expected to be an overrepresentation of Aboriginal and Torres Strait Islander residents.

To reflect these needs, any specialised accommodation for this cohort requires staffing that includes personal care assistants (PCAs) and registered nurses (RNs) with experience and training with working with people with a lived experience of homelessness, mental health, or addiction, and that these RNs and PCAs are supported by peer workers and Aboriginal Health Workers. In addition, service/s should engage high quality not-for-profit service providers to supply specialised homelessness services and support for mental health, alcohol, and other drug challenges.

To support the accommodation, a broad network of partners across the healthcare and homelessness services ecosystem will be required, and that can create referral pathways and strategically cooperate to ensure comprehensive care is available for residents. These partnerships may include existing specialist homeless services, public hospitals or clinics, and other providers of residential aged care in the facility's local area.

12. Benefits of stable housing and a 'housing first' approach – to individuals

The benefits of stable housing are well-understood across the homelessness, health and aged care sectors, including to address the specific challenges experienced by the cohort that is the focus of this inquiry. Prioritising accommodation as a key step to addressing complex challenges is often termed a 'housing first' approach.

When considering the impact of housing on health and mental illness, there are clear links between, stable housing and improved physical and mental health. A systematic review of evidence shows that people living in secure and well-maintained accommodation have reduced odds of depression, stress, and anxiety.[38]

For example, an evaluation of the *Housing and Accommodation Support Initiative* (HASI) in NSW – which provides housing to people experiencing a range of vulnerabilities including mental

[38] Singh. Et. al. *American Journal of Preventive Medicine*. "Housing Disadvantage and Poor Mental Health: A Systematic Review." 2019.

health, alcohol, and other drugs challenges – revealed substantial improvements in mental health outcomes resulting from the provision of stable accommodation. [39]

Further, alcohol and other drug issues, including addiction, can be addressed through a 'housing first' approach that also accommodates elements of harm minimisation. The same evaluation of the HASI program identified that some consumers ceased or reduced their substance use with support from the initiative. One consumer reported that due to having somewhere good to live with appropriate support, they were now 98% sober and it was the most well they had felt in years.[40]

Anecdotal evidence from existing services has indicated that similar significant outcomes can be achieved for incoming residents of aged care services for people with an experience of homelessness. Services have reported residents recovering from acquired brain injuries resulting from a reduction in consumption of alcohol or other drugs. Existing services have identified that health improvements are often significant and long-lasting, with St Vincent's Hospital Melbourne's Prague House noting residents have an average tenure of seven years compared to an average of two-and-a-half years for residents in mainstream aged care. [41, 42]

13. Benefits of stable housing and a 'housing first' approach – to society

Providing stable, long-term accommodation to the target cohort has benefits beyond the outcomes achieved for residents. These benefits include reducing government expenditure, allowing crisis and short-term services to meet the needs of more people, and facilitating residents' safe and sustainable participation in the community.

Net government expenditure on healthcare and other services for residents can be reduced because the needs of residents can be identified earlier, and prevention and early-intervention services can be provided.

Repeated studies have shown that by intervening early in the homelessness pathway – including by providing long-term sustainable accommodation – costs the community far less in terms of welfare, health, community service and justice costs. Conversely, to not do so, and to leave the problem unaddressed, not only ignores a major human cost but creates a significant drain on the public purse.

As noted earlier in this submission, people experiencing homelessness are disproportionately higher users of acute health services compared to non-homeless people, including more frequent emergency department visits and inpatient hospital admissions and longer hospital stays.[43] A 2016 survey of rough-sleepers in Melbourne's CBD found that nearly three-quarters of respondents identified a hospital as their primary healthcare provider[44].

Elsewhere, a new actuarial study by Taylor Fry as part of the NSW homeless strategy,[45] found people who use homelessness services cost governments $186,000 on average, nearly four times

[39] Social Policy Research Centre. *Evaluation of the Housing and Accommodation Support Initiative*: *Final Report*. September 2012
[40] *Ibid* (p. 68)
[41] Interviews with Tina Melrose, Prague House and Matt Larkin, Homeless Health Network
[42] AIHW. "People leaving aged care." Accessed 11 March 2021.
[43] Fazel, S et al. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. Lancet, 2014 Oct 25; 384(9953): 1529–1540.
[44] Micah Projects Inc. *De-Identified Vulnerability Index-Service Prioritisation Decision Assistance Tool data for Melbourne 2010-2016.* Brisbane: Inc MP; 2017
[45] NSW Department of Communities and Justice, Pathways to Homelessness final report, December 2021

more than the general NSW population, and only 9 per cent of costs – considered over six years – related to homelessness and housing services.

The research confirms people who are experiencing homelessness and who are accessing specialist homelessness services are significantly higher users of other government services than the broader population, often more than 10 times the rate.

The data study shows the 5 per cent (1500 people) with the highest cost had an average cost to government across six years of $706,000 per person, with 84 per cent of these costs attributable to NSW health and justice services.

In contrast, an evaluation of the *Housing and Accommodation Support Initiative* in NSW indicated that mental health inpatient admissions declined following the provision of housing to individuals.

Acknowledging the deleterious impacts of homelessness on health and the likelihood of patients returning otherwise, SVHA's hospitals and others pursue a "no discharge to homelessness" principle for their services. This includes the Royal Perth Hospital[46] that estimates savings of over $7,000 per person supported by the Royal Perth Hospital Homeless Team.

Further, residents can shift from perpetually accessing crisis and short-term services, freeing these services up to meet the acute needs of others. A review of increasing demand on public hospital beds in Australia highlighted that "potentially the biggest gains in reducing hospital demand will come from improved access to residential care, rehabilitation services, and domiciliary support as patients awaiting such services currently account for 70% of acute hospital bed-days."[47]

Furthermore, a study into the benefits of providing housing to formerly homeless people highlighted that "there were significant reductions in people presenting to emergency departments, people staying overnight in hospital, people presenting to ICU, people in psychiatric care, people accessing mental health services and people with prescriptions for opioid dependency treatment."[48]

14. A proposed service model

Providing accommodation for older people with experience of homelessness requires a specialised service model that differs from mainstream aged care services. Unlike mainstream aged care, a model of care for this specific group requires service and staffing costs that are not directly funded by the Aged Care Funding Instrument.

SVHA has developed a service model for older homeless people that is built around the three service principles of person centred-care, trauma-informed care, and strengths-based care.

These principles are supported by service elements based on the expected support needs of residents including high behavioural needs, mental health, alcohol, and other drugs challenges, and an overrepresentation of Aboriginal and Torres Strait Islander people. To support this specific cohort, it is proposed that specialised support is provided by experienced staff including peer workers and Aboriginal Health Workers who have the capacity to manage complex

[46] Gazey, A. et. al. *Royal Perth Hospital Homeless Team: Evaluation Report Summary*. February 2019.
[47] Scott, I. *Australian Health Review*. "Public hospital bed crisis: too few or too misused?" 2010.
[48] Wood, et. al. *Australia Housing and Urban Research Institute.* "What are the health, social, and economic benefits of providing public housing and support to formerly homeless people?" 2016.

behavioural and mental health challenges along with challenges resulting from addiction. Additionally, it is proposed that a range of partners are identified to support these efforts, both to ensure referral pathways for the people most in need of the proposed service and to provide specialised services/comprehensive delivery of care.

The proposed model has been developed to meet the specific needs of the expected resident cohort with the highest quality of care. However, it is recommended that any provider adopt a targeted and flexible approach to meeting the specific demands of the cohort. Additionally, providers will need to consider the specific needs of different genders and ensure specific protections are developed and in place for people who identify as women.

To arrive at the below recommendations, SVHA carried out consultations across the service sector with internal and external experts from residential aged care services for people with an experience of homelessness, providers of specialist homelessness services, and experts in residential aged care service design and delivery.

Additionally, 22 men and women with lived experience of long-term homelessness were engaged to inform the service design as part of a commissioned consultation process. Key themes and participant preferences from the consultations include:

- All services need to be underpinned by safety and trauma-informed practices.
- The service should provide comprehensive care and address all physical and mental health needs.
- Residents should feel connected to community, residents, and the staff through peer workers.
- Service location should be close to medical facilities and other services.

A draft SVHA Model of Care for Older Persons with Experience of Homelessness has been developed and is outlined briefly in ***Error! Reference source not found.*** below, with expanded details underneath.

The full report detailing lived experience consultations is available in Appendix I.

Table 3: SVHA Model of Care for Older Persons with an Experience of Homelessness

SVHA Model of Care for Older Persons with an Experience of Homelessness	
Service principles	Person-centred care - The service should be co-designed by service users and people with a lived experience of homelessness. Residents' wants and needs should always be the first priority. Trauma-informed care - Staff should have an understanding of the impact of trauma, and provide care that emphasises physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment. Strengths-based care - The capacity, skills, knowledge, and potential of residents should be respected and there should be a focus on ensuring cultural and holistic health needs are met.

Service elements	<u>Resident Characteristics</u> High behavioural needs - In general, residents are likely to be younger than usually found in residential aged care, with lower physical needs but higher behavioural needs due to their lived experience, trauma, mental health challenges and associated comorbidities. Mental health challenges - There is likely to be a high prevalence of severe and complex mental health challenges in the cohort. Substance use disorders - There is likely to be a high prevalence of ongoing substance use disorders and associated physical health impacts including acquired brain injuries. Aboriginal and Torres Strait Islander overrepresentation - There are likely to be residents in need of culturally-informed health and other services.
	<u>Service Requirements</u> Experienced and specialised staff - Staff should understand the cohort's unique challenges and be trained in a trauma-informed approach. On site mental health support – Clinical and non-clinical mental health support should be consistently available and behaviour management plans should be designed with psychiatrists and psychologists where appropriate. Harm minimisation approach - Residents should be supported to manage addiction challenges but may need to be allowed to consume alcohol and other drugs in reasonable quantities and settings. Peer workers and Aboriginal Health Workers - Staff with a lived experience should be available to provide encouragement and a sense of community. Aboriginal staff should be available to provide culturally-informed health services to Aboriginal clients
	<u>Partnerships</u> Referral partners - The model requires working with providers along the continuum of care, and with similar or related services, for which an aged care service may offer an exit point or enhancement of care to what is currently being provided. Service partners - Trusted providers of support services should be identified to meet resident needs, such as in-reach support for mental health, alcohol and other drugs.
Service format	Comprehensive care - Residents should have access to all of their support needs on-site including physical and mental health support, AOD support, specialist homelessness services, and access to community and culture. Culturally-informed - The site should acknowledge and pay respect to the traditional custodians of the land on which it sits and display Aboriginal and Torres Strait Islander art and culture. Access to the community - Within reason, residents should have the opportunity and flexibility to leave and return to the site at their free will.

14.1 Service principles

People with a lived experience of homelessness have often experienced trauma and marginalisation. To ensure residents' experiences are acknowledged and respected, the service model should adopt the following principles:

- Person-centred care: The service should be co-designed by service users and people with a lived experience of homelessness. The first priority of the service should be ensuring that residents' wants and needs are met. Staff should have experience and training working with people with experience of homelessness and there should be sufficient staff rostered on at any time to ensure residents receive the level of care they need. The service should continue to regularly consult residents and adapt as necessary to ensure the highest quality of care and support.

- Trauma-informed care: Staff should adopt a care framework grounded in an understanding of, and responsiveness to, the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.[49] The accommodation service should adopt six key principles of trauma-informed care (1) safety (2) trustworthiness and transparency (3) peer support (4) collaboration and mutuality (5) empowerment, voice, and choice (6) responsiveness to cultural, historical, and gender issues.[50]

- Strengths-based care: The capacity, skills, knowledge, and potential of residents should be respected and there should be a focus on ensuring a holistic method of planning and providing care whereby services form a support network around the client, based on individual needs and priorities.

14.2 Resident characteristics

There are several unique qualities of people experiencing homelessness and/or at risk of homelessness that the model of care should consider:

- The cohort is likely to be younger than is usually found in residential aged care, and have lower physical support needs but higher behavioural needs: people experiencing homelessness confront the challenges of ageing earlier than most people. This means the aged cohort for people experiencing homelessness is generally younger and has lower physical support needs. Notwithstanding, behavioural needs tend to be higher as people with an experience of homelessness have often experienced trauma and suffer from a range of other mental and physical challenges that can lead to challenging behaviour.

- There is a high prevalence of mental illness: people experiencing homelessness frequently suffer from moderate to severe mental health challenges. These challenges have often not been addressed and may require ongoing clinical and non-clinical intervention.

- There is a high prevalence of substance use disorders: There is likely to be a high prevalence of ongoing substance use disorders and associated physical health impacts such as acquired brain injuries.

[49] Vulnerable population groups such as those experiencing mental health, substance use, and homelessness, have a high prevalence of exposure to Trauma. The adoption of trauma-informed care improves patient experience, increases staff confidence, contribute to service efficiencies and creates safer environments. (SVHA. *Summarised proposal for the introduction of TIC@SVHA*. November 2019)
[50] SVHA. *Summarised proposal for the introduction of TIC@SVHA*. November 2019

- There is an overrepresentation of Aboriginal and Torres Strait Islander people: given the specific social and cultural needs of Aboriginal and Torres Strait Islander people, accommodation services for this cohort must employ Aboriginal Health Workers.

14.3 Service requirements

Given the above resident characteristics an accommodation service model should adopt a range of inclusions to ensure residents' needs are met:

- Ensure staff have experience and/or training working with people with a lived experience of homeless and/or mental health/substance use challenges. These unique resident characteristics require different skills and responses to mainstream residential aged care. Staff should have the experience and training necessary to understand how to respond to the unique challenges experienced by the cohort.

- Provide mental health support on-site: Given residents are likely to have high clinical and non-clinical mental health support needs it is proposed that these supports are provided on-location (where possible) and be consistently available. Partnerships may need to be developed with specialised providers of clinical and non-clinical support and the possibility of developing behaviour management plans with psychiatrists and psychologists could be considered where appropriate.

- Adopt a harm minimisation approach: Similar services and experts recommend the adoption of a harm minimisation approach for responding to substance use challenges amongst the resident cohort. A harm minimisation approach accepts that drug use, both licit and illicit, is inevitable, and occurs across a continuum ranging from occasional use to dependent use. There are a range of less severe and more severe harms associated with different patterns of AOD use and a range of approaches can be used to respond to these harms. These approaches often allow for controlled consumption of substances and have been adopted in other SVHA services including Prague House in Melbourne.

- Ensure residents have access to peer workers: It is increasingly acknowledged that providing peer support through the employment of trained support workers who harness their own experience of, homelessness, mental ill-health, and recovery to support others and foster a sense of hope can be effective for improving outcomes.

- Ensure residents have access to Aboriginal Health Workers: Given the overrepresentation of Aboriginal and Torres Strait Islander people, Aboriginal Health Workers who can provide flexible, holistic, and culturally sensitive health services to Aboriginal clients will be required.

14.4 Service format

In addition to the above, SVHA's accommodation service model has the following overarching characteristics embedded:

- Comprehensive care: Residents should have access to all of their support needs on-site including physical and mental health support, AOD support, specialist homelessness services, and access to community and culture. Additionally, where appropriate and desired by the resident, the service should allow for short-term respite stays and for long-term residents who have built capacity to transition out of the service into mainstream aged care or more independent living.

- Culturally appropriate environment: The site should acknowledge and pay respect to the traditional custodians of the land on which it sits and display Aboriginal and Torres Strait Islander art and culture.

- Access to the community: Within reason, residents should have the opportunity and flexibility to leave and return to the site at their free will.

14.5 Staffing

SVHA proposes a complementary staffing model to cater to residents with the specific needs outlined in the accommodation service model above. The model assumes staff will have experience and/or training working with people with a lived experience of homelessness, mental health, and/or addiction.

The proposed staff make-up is based on consultations with existing aged care providers and service delivery leadership at St Vincent's Care Services and would likely need to be adapted based on resident numbers and need.

The staffing model is as described below:

- Nursing and medical staff provided to the extent required to ensure safety and sufficient healthcare, in-line with mainstream residential aged care locations.
- Personal Care Assistants (PCAs), primarily to assist in caregiving, physical and health needs, in addition to behavioural supports.
- Peer / Lived Experience Workers, working alongside PCAs to enhance care and improve communication with residents and their comfort by openly using their lived experience of disadvantage or mental illness and recovery as part of their work.
- Aboriginal Health Workers, acknowledging the overrepresentation of First Nations people amongst people with experience of homelessness to provide flexible, holistic, and culturally sensitive health services to First Nations clients.
- Significant in-reach of specialist homelessness services, including from the SVHA operated Homeless Health Network and tenancy maintenance assistance or other similar services in Brisbane or Melbourne.
- Significant contracting of allied health providers, including physiotherapy, mental health, and AOD services.

15. Conclusion

There's no doubt that homelessness is a complex and 'wicked' challenge. But while there are no easy solutions, we do know – as a community – what is required to reduce the problem and that, with the right approach, that it is possible to end homelessness: both broadly and specifically among the cohort that is the focus of this inquiry: people aged 55 and over.

New South Wales – as with the rest of Australia – is at a crossroads in its fight against homelessness. Homelessness is increasing. Affordable housing is becoming harder and harder to access. There is a widespread shortage of social housing across the state and, as in other states and territories, there has been no concerted Commonwealth activity in this area to complement NSW Government efforts for close to a decade.

In this submission, SVHA has drawn on both its expertise as one of Australia's leading providers of homeless health services, and its experience providing residential aged care, to largely focus

its submission on addressing items (g) and (i) in the Inquiry's terms of reference relating to accommodation and health.

This submission both identifies the unique challenges facing vulnerable people in the 55 and over cohort who are either in insecure housing or experiencing homelessness, and puts forward a model of service that could successfully provide long-term and sustainable accommodation for this group.

We particularly draw Committee members' attention to the 'lived experience' consultation report which is included at Appendix I of this submission.

It involved a formal survey of 22 individuals in and around the age of 55 – all of whom were either experiencing or had experienced homelessness – as part of a co-design of a proposed model of accommodation.

Any discussion of housing and homelessness solutions – either in terms of accommodation or other supports – for any group, must be developed in concert with those same people as equal partners.

Appendix I

'A Place to Call Home'

A long-term residential service for older Australians experiencing homelessness – A co-design project

Gill, K. Hughes, J. (2020) *A Place to call home: A long-term residential service for older Australians experiencing homelessness. A co-design project*. St Vincent's Hospital Sydney, Homeless Health Service, Tierney House.

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The twenty-two individuals with experiences of homelessness, who gave up their time and shared their lived experience and expertise as part of the consultation and the co-design process.

Jennifer Hughes: Peer Support Worker, Homeless Health Service, St Vincent's Hospital Sydney NSW 2001, Australia

Lola Sheenagh: Peer Support Worker, Tierney House Homeless Health Service St Vincent's Hospital Sydney NSW 2001, Australia

Matthew Larkin Manager, Homeless Health Service St Vincent's Hospital Sydney NSW 2001, Australia

Cameron French: Manager, Tierney House Homeless Health Service St Vincent's Hospital Sydney NSW 2001 Australia

Erin Longbottom: Nurse Unit Manager, Homeless Outreach Team Homeless Health Service St Vincent's Hospital Sydney NSW 2001 Australia

St Vincent's Hospital Homeless Health Team (HHS) is a multi-disciplinary service that aims to support people experiencing or at risk of homelessness to engage in and access health services of their choice. Utilising a strengths-based, harm minimisation approach the service partners with local services to provide assessment, treatment, education, support and referral. The team includes Nurses, Doctors, Allied Health Staff, Health Educators, Aboriginal Health Workers and Peer Support Workers (https://www.svhs.org.au/our-services/list-of-services/homeless-health-service).

Tierney House (St Vincent's Hospital) is a 12-bed residential facility operates as a step-up/step-down model to deliver sub-acute health care to homeless people. The objective of Tierney House is to stabilise health conditions and improve the functional health status of homeless persons. (https://www.catholicweekly.com.au/charity-begins-at-tierney-house/ + https://www.abc.net.au/7.30/breaking-the-hospital-homeless-cycle/8333772)

Social Ventures Australia (SVA) is a not-for-profit organisation that partners with others with the aim of influencing systems to move towards enhanced social outcomes for people by learning about what works in communities, assisting organisations and advocating for change (https://www.socialventures.com.au).

2 EXECUTIVE SUMMARY

This paper reports 'lived experience' consultation outcomes by Dr Katherine Gill (Lived Experience Partner, St Vincent's Hospital, Sydney), consultant to Social Ventures Australia, and Jen Hughes (Peer Support Worker Homeless Health Service, St Vincent's Hospital Sydney).

This project harnesses the lived experience voice of people who have experienced long-term homelessness, to inform the potential design of a residential facility for this population.

A focus group and individual interviews were run by a consumer researcher and two peer workers from the Homeless Health Service, St Vincent's Hospital Sydney. Twenty-two people experiencing long term homelessness were recruited to participate in the consultation. The data was coded and themed. Key themes and participant preferences included:

1. A preference for a location that is close to medical facilities and other services.
2. A one-stop shop that addressed all their basic needs, physical and mental health wellbeing needs, including drug and alcohol support needs.
3. That all services needed to be underpinned by safety and trauma-informed practices, with a client-centred focus, that understood the trauma needs of people who have been homeless.
4. Connectedness was vital to feelings of safety. This included connectedness with peer workers, other residents, and to nature and animals.
5. People wanted therapeutic activities to keep them busy and give them a sense of purpose, including therapeutic and life skill groups, physical activities, and creative activities such as music and art groups.

Participants in the consultation highly valued the peer worker role, and wanted staff who had 'walked in their shoes', and who could relate to their needs. People also wanted to give back to the community and be involved in assisting others, such as a mentoring or a 'buddy' program. They reported this would give them a sense of purpose and meaning. Participants reported needing staff who were kind and understanding, who would support the implementation of rules that created safety for all, and who met their needs in a trauma-informed manner.

The design and layout of the building was reported to be critical to help create a sense of safety and connectedness. People articulated the importance of outdoor areas where they could gather and talk to others, but also having the opportunity for privacy and solitude in their own space that they could make their own. The building needs to be designed to accommodate vision, mobility and cognitive disability, and to be a place that felt like a home and a community.

Figure 1: Themes identified by participants – Co-design of a residential facility for older people experiencing homelessness

3 BACKGROUND

Homelessness is defined by the Australian Bureau of Statistics (ABS) as being when a person's living arrangement is in a dwelling that is inadequate or unsuitable, has no tenure, if their tenure is short and not extendable, or does not allow them to have control of, and access to, space and social relations (Homelessness Australia 2016).

Although there is no internationally agreed upon definition of homelessness, Mackenzie and Chamberlain's (1992) definition of homelessness is often used in the Homelessness Sector and includes three categories:

Primary homelessness-people without standard accommodation (e.g. sleeping rough/improvised dwellings)

Secondary homelessness-people moving often from one temporary shelter to another (e.g. emergency accommodation/refuges/ "couch surfing")

Tertiary homelessness-people in accommodation below minimum community standards (e.g. boarding houses/caravan parks).

Homelessness in Australia is an increasing concern. Results from the Australian Bureau of Statistics (ABS) Census of Housing and Population and the Australian Institute of Health and Welfare (AIHW) Specialist Homeless Services Data showed that in five years the rate of homelessness increased by 8% from 89,728 (2011) to 105,237 (2016) (ABS Census of Housing and Population 2011/2016).

The number of older people experiencing or at risk of homelessness, both long-term and first-time homelessness, is increasing. The proportion of women facing homelessness within that cohort is also increasing (Rowlands, 2020). When combined with complex health needs, appropriate long-term care options remain limited.

Increasing numbers of older women face homelessness due to insufficient affordable housing, relationship breakdown, chronic illness and job loss (Patterson, Proft, & Maxwell, 2019; Petersen & Parsell, 2014). In the 2011 Australian Census, one in 20 Indigenous people were considered homeless, which was 14 times the rate for non-Indigenous people.

The 2016 Census identified that in the Australian homelessness context:

- 116,427 people were counted as being homeless on Census night (up from 102,439 in 2011)
- 50 out of every 10,000 people are homeless - up 5% from 48 persons in 2011
- 58% were male and 42% were female
- 20% (23,437) are Aboriginal and Torres Strait Islander Australians (down from 26% in 2011)
- 30% are born overseas

People were staying in improvised dwellings, tents or sleeping out 7% (8,200), supported accommodation 18% (21,235), staying with other households 15% (17,725), boarding houses 15% (17,503), other temporary lodging 1% (678), overcrowded dwellings 44% (51,088).

Age breakdown included:

- under 12 14% (15,872) +11% since 2011,
- 12-18 10% (10,913)
- 19-24 15% (15,325),
- 25-34 18% (19,312)
- 35-44 14% (14,484),
- 45-54 12% (12,507),
- **55-64 8% (8,649),**
- **65-74 4% (4,174),**
- **75 and over 2% (2,028)**

Significantly, in the over 55 age bracket, there has been a 28% increase in people experiencing homelessness. (ABS Census of Housing and Population/AIHW Specialist Homeless Services Data 2016).

In considering location requirements, census data reveals that NSW has the highest numbers of chronically homeless people.

Australian Homelessness Statistics-State Breakdown (Source: Homelessness Australia 2016)

- **NSW 37,715 (50.4 people per 10,000) +37% since 2011**
- VIC 24,817 (41.9 people per 10,000) +11% since 2011
- QLD 21,671 (46.1 people per 10,000) +14% since 2011
- SA 6,224 (37.1 people per 10,000) +7% since 2011
- WA 9,005 (36.4 people per 10,000) -2% since 2011
- TAS 1,622 (31.8 people per 10,000) +6% since 2011
- NT 13,717 (599.4 people per 10,000) +11% since 2011
- ACT 1,596 (40.2 people per 10,000) -8% since 2011

Being homeless is associated with poorer health outcomes, including higher rates of preventable acute and chronic medical conditions, traumatic injuries and assaults, serious psychiatric disorders and mental health issues, and disability. Homelessness has been strongly associated with emergency department (ED) presentations involving a primary psychiatric or drug/alcohol diagnosis. Homeless individuals are more likely to present to the ED, and to have a greater number of ED presentations and representations compared to the general population (Doran et al., 2013; Moore, Gerdtz, Hepworth, & Manias, 2011).

4 HOMELESS PERSONS RESIDENTIAL FACILITY CO-DESIGN PROJECT

Dr Katherine Gill (St Vincent's Hospital, Sydney) was approached to explore potential design and operational features for a permanent care, residential facility addressing the needs of people, over 55, experiencing long-term homelessness. To facilitate an effective co-design process, peer workers from St Vincent's Homeless Health services, supported the recruitment of the target population and contributed to the design of the questions, the interviews and focus group.

5 OBJECTIVES

This project aimed to harness the lived experience voice of people who have faced long-term homelessness, to assist in the co-design of a specialist permanent care, residential facility for people over the age of 55 years, experiencing, or at risk of experiencing homeless.

To gain an understanding of the needs of this population, consultation with community stakeholders was undertaken, and a focus group and individual interviews with people who have experienced long term homelessness were conducted.

6 RATIONALE

There is a close link between homelessness and health. Homelessness is associated with poorer health outcomes, higher rates of preventable, curable, and chronic medical conditions, traumatic injuries, assaults, psychiatric, alcohol and other drug use issues and disability (Doran et al., 2013). In Australia, housing with insecure tenure has been associated with worse physical and mental health (Baker et al., 2011). Long term homelessness is also associated with an increased risk of premature mortality (Seastres et al., 2020). It is reported that mortality risk was reduced over a period of six years among formerly homeless individuals who attained stable accommodation (Henwood, Byrne, & Scriber, 2015).

The aims of the Sustainable Development Goals in Australia are for people to have safe, adequate and affordable housing for all and access to services, for all, by 2030 (Sustainable Development Goals, cited in Seastres et.al 2020).

Over the past 20 years in the human services sector, there has been an increase in understanding and general move towards providing more person-centred, trauma-informed and consumer driven, models of care to people. The drive towards more holistic and less institutionalised models of care has been in highlighted in policy documents, in Australia since the 1980s, with the release of the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (Richmond Report, 1983) and the National Enquiry into the Human Rights of People with Mental Illness, Burkedin, 1993).

When considering the higher-than-average incidence of static developmental and fluid lifetime traumatic experiences, incidence of mental health and substance use disorders, chronic health care needs and premature mortality commonly seen in this population (Doran et al., 2013), it is crucial to consider the specific needs of this vulnerable, but often resourceful and resilient population, in the design of any permanent care facility. Housing strongly influences health.

7 SCOPE

The project scope encompassed the St Vincent's Hospital Homelessness Health Service, Sydney; people with experiences of long-term homelessness, aged 55 years and over, and peer workers from St Vincent's Hospital Homelessness Health Service.

8 METHODOLOGY

Peer workers assisted in recruiting people experiencing long-term homelessness, to participate in interviews or a focus group. Due to this population often being transient (even if only within their city and surrounding suburbs), people were interviewed in the community where they frequently

reside and typically spend their time, such as relevant community services or the park opposite St Vincent's Hospital Sydney (Green Park).

Participants were recruited via word-of-mouth, utilising the peer worker's known network from her lived experience of homelessness, and current role as Peer Worker with the Homeless Health Team at St Vincent's Hospital Sydney. It was intended to seek a diverse population experiencing long-term homelessness as possible.

Interviews took place at sites in the community including in Green Park near St Vincent's Hospital Sydney where homeless people gather in the day; on the street outside the hospital; in a nearby café; and at a Sydney community day service, the Wayside Chapel, that assists homeless people. A focus group was also conducted at Tierney House, a 12 bed sub-acute medical facility attached to St Vincent's Hospital Sydney's Homeless Health Service. Interviews and focus groups were held between Tuesday 04 May 2021 and Friday 07 May 2021.

Eligibility criteria included that participants had to be experiencing long-term homelessness (over one year) and ideally, people over the age of 55 years were targeted.

A few factors influenced the rationale for the methodological approach and format. Long-term homeless people often have complex and ongoing health needs and experience competing daily priorities, to meet personal basic needs. For example, higher incidences of physical health, mental health, and substance use issues, can influence how well a person might be functioning and feeling on any given day. Seeking food, shelter, safety, and substances, daily, can be fatiguing, so a brief survey of seven questions was designed to elicit conversation and invite expansion around the topic. Participants were provided with a paper copy of the questionnaire and a brief welfare check ice-breaker conversation was had, before the study aim was introduced.

To communicate to respondents that their sharing of themselves, their time, and their insights were valuable, a $50 Aldi Voucher was offered to each respondent.

Interviewee responses were written down and when consent was provided the interviews were audio recorded and transcribed verbatim.

A semi-structured focus group or interview addressed the following questions:

UNDERSTANDING THE PERSON WHO IS ACCESSING THE SERVICE

1. Who is most likely to access this service?

WHAT AND THE PERSONS IMMEDIATE NEEDS AND HOW DO WE MEET THE PERSON'S NEEDS?

2. What is / are the person's immediate need/s when they access long term residential housing?

3. Are there location requirements? If so, what are they?

4. What medical services do people need access to?

5. What amenities/facilities/community services would people like access to?

HOW DO WE CREATE A QUALITY OF LIFE AND ADD VALUE TO IMPROVE THE PERSON'S WELL-BEING?

6. Do other aspects of the service design influence appeal size/staffing model/design of building?

7. When considering the facility will be the person's permanent home, what sorts of things may not be helpful?

9 RESULTS

Six participants [M=4, F=2] engaged in the focus group at Tierney House. These participants were past or current residents of Tierney House. Sixteen people were interviewed at Green Park, Wayside Chapel, or outside St Vincent's Hospital Sydney.

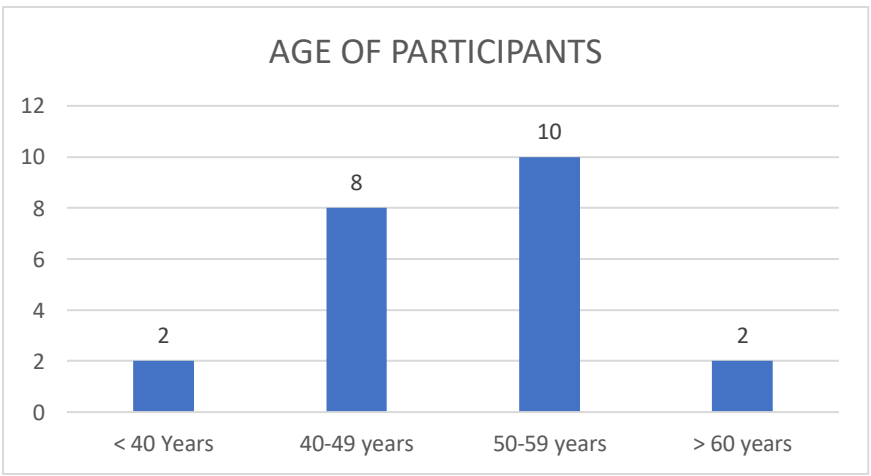
Twelve participants were aged greater than 50 years, with 64% of participants identified as male; 9% [n=2] transgender and 27% female. Two males identified as gay, and one female as lesbian.

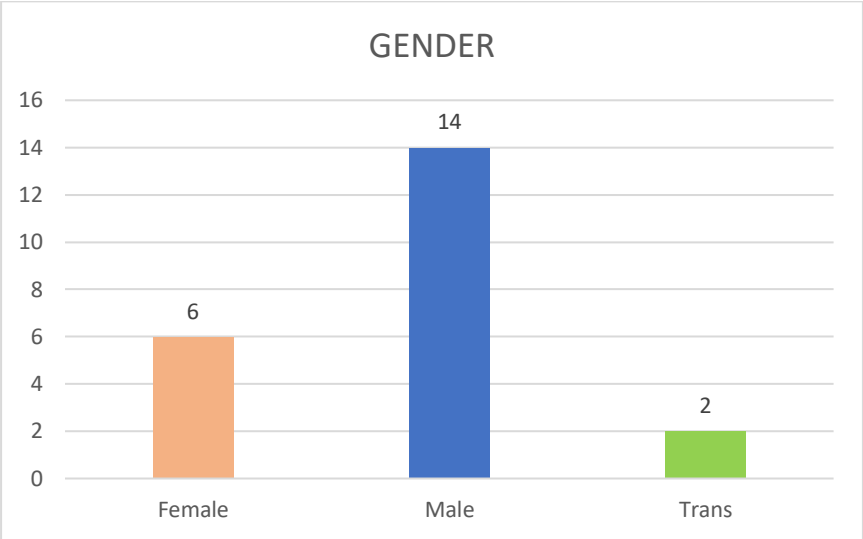
One participant was vision impaired (22); two participants had cognitive problems secondary to a traumatic brain injury (6, 13) and all participants had mental health conditions including post-traumatic stress disorder and alcohol and drug dependencies. Five participants [23%] identified as being of Indigenous background (6, 10, 12, 19 and 22).

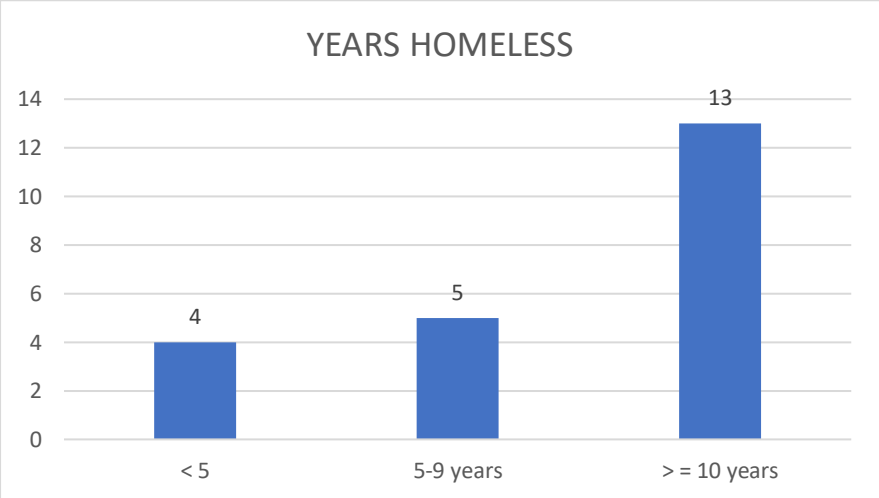
The participants had past or current experience of long-term homelessness with 82% having experienced homelessness for five years or greater and 59% having been homeless for 10 years or longer.

Participant	Gender	Age	Years Homeless	Place Interviewed
S 1	M	51	10+	Tierney House-Focus Group
S 5	M	53	10+	Tierney House-Focus Group
S 6	M	45	2	Tierney House-Focus Group
S 7	M	57	15	Green Park-Darlinghurst
S 8	M	56	5	Green Park-Darlinghurst
S 9	M	55	10	Green Park-Darlinghurst
S10	M	50+	10	Green Park-Darlinghurst
S 11	M	45+	20	Victoria St-Darlinghurst
S 12	M	49	10	Victoria St-Darlinghurst

S 13	M	43	5	Victoria St-Darlinghurst
S 14	M	63	5	Victoria St-Darlinghurst
S 15	F	50	5	St Vincent's Hospital
S 16	F	47	10	Café-Surry Hills
S 17	F	28	13	Café-Surry Hills
S 18	F	65	1	Tierney House-Focus Group
S 19	M	46	10+	Tierney House-Focus Group
S 20	M	45	2	Tierney House-Focus Group
S 21	Trans F	52	13	Wayside Chapel-King's Cross
S 22	F	50+	10+	Wayside Chapel-King's Cross
S 23	M	50+	10+	Wayside Chapel-King's Cross
S 24	Trans M	38	7	Wayside Chapel-King's Cross
S 25	F	40	3	Wayside Chapel-King's Cross







9.1 UNDERSTANDING THE PERSON WHO IS ACCESSING THE SERVICE

All participants who were interviewed or who engaged in the focus group, universally reported that those who would reside in a facility targeting older Australians experiencing, or at risk of homelessness, would have a *history of trauma, mental health concerns and problems with drugs and alcohol*. The experience of *domestic violence* was also commonly reported. It was reported that people accessing this service are also likely to have *physical health problems*, and possibly injuries and wounds.

Participants identified that those experiencing homelessness and accessing the proposed service are likely to have experienced marginalisation and multiple acts of discrimination, in addition to complex and/or adult trauma. They may have been incarcerated, identify as LGBTIQA+, have disabilities and/or identify as being of Aboriginal or Torres Strait Islander origin. They may have '*experienced discrimination and hate crimes because of sexuality'*. People who have experienced long-term homelessness, may have little to no education. Those accessing the services are likely to have *financial concerns*, and/or they may have *legal issues*. People may be dealing with relationship and family breakups, have lost parents or partners, or they may have had lifelong family problems.

> *1 'People from broken families as children who never had fathers to show them how to be men or what was the right way to behave' (10)*

It was reported that many residents may be smokers, and some may be '*long-term drug users who may never be abstinent (10)'.* Those accessing the service after experiencing long-term homelessness may be:

> *2 'Addicts and mental health people who have lost touch with society, who don't trust society, find it hard to ask for help, a lot of people like this, vulnerable people escaping domestic violence'. (S16)*
>
> *3 'people who have disconnected from mainstream society' (15)*

9.2 MEETING BASIC NEEDS

Participants reported that it was necessary for people entering the service to get their basic needs met. They reported needing a *warm bed, bedding, clothes, toiletries, and furniture*. People identified needing *food, a fridge, and a shower*. They reported that people entering the service would need *financial assistance, and possibly legal aid*. That they might need assistance applying for welfare benefits and support to access *identity documents*.

9.3 FINANCES

Financial concerns were commonly listed, and people reported concerns about the cost of the service: that they needed enough funds for cigarettes and that it couldn't take all their benefits. *'Need money to live on, that it doesn't cost all of your benefit to live there'.*

> *4 'Don't leave people with not even enough money each fortnight to smoke, not 85% of pension' (10)*

9.4 SAFETY

The *sense of safety* was a paramount theme throughout the interviews and focus group. People need the place to *feel safe*. They reported needing *staff to be understanding and kind*, and they need to *feel safe from other residents*. People wanted *privacy*; their own room, they wanted a locker where they could store their valuables; they did not want people engaging in crime to be housed on site, and they did not want the environment to feel like a jail.

> *5 'Safe place and safe people, don't want predators, good to have duress buttons, intercom, or security with big bollocks.' (17)*

6 *'Keep it as safe as possible, staff need to be people who care and know how to react when people have been traumatised.' (25)*

7 *'Each person should have a card key, so it is safe, a swipe for the room, and fire doors, to make you feel safe, a lockable cabinet in room, so no stealing, stealing is a big one.' (focus group)*

8 *It was reported that the facility 'would only be accepted if the environment was safe and the people were kind, or I would run back to wherever or shut down and play the game and never engage in a way that was conducive to resolution of anything.' (15)*

One participant reported that he would rather be homeless than live in a facility where there was violence and drug use. He reported being in a place where he felt unsafe; that he had got himself clean in rehab and he did not want to turn back, but the violence and drug use on the property made the facility unsuitable and unsafe for him to stay.

9.5 LOCATION REQUIREMENTS

Both the interviewees and the attendees at the focus group strongly preferenced a *city location* for the residential facility over a suburban location. The strong preference for a city location, may be related to the fact that participants were recruited from an inner-city location. A couple of the interviewees indicated a country retreat might be helpful to reduce access to drugs, but not ideal for a long-term residential facility.

There was a strong preference for the facility to be close to public transport and shops. It was essential that any service be close to medical services, hospitals, methadone clinics and drug and alcohol services.

9 *'More homeless people in the city' (12)*

10 *'As close to the hospital as possible' (13)*

11 *'Walking distance to major hospital' (23)*

12 *'In the city between Surry Hills up to Darlinghurst' (14)*

13 *'In the city near a teaching hospital, if you are out in the sticks somewhere you are not close to these places, people need to be near the medical supports.' (Focus Group Participant)*

14 *'One here [city] and one in the suburbs so the person has a choice whether to live in the suburbs or in the city. A lot of homelessness people like being in the*

city, also more specialised health care in the city than in the suburbs; needs to be near shops and transport facilities.There are more services in the city.' (Focus Group Participant)

15 'One in the country and one in the city. Cater to different needs and different services; the city in terms of access to services, and the country is good to reduce access to drugs' (25).

9.6 MEDICAL AND HEALTH CARE SERVICES

Participants in the consultation indicated that the residents would require a *comprehensive health check* on arrival, and that residents are likely to *experience significant physical health, mental health, drug and alcohol problems*. They may also have *chronic liver disease, respiratory disease or cancer (FG).*

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16 'Need a doctor's check-up. I have never had these as I feel not worthy of it and I am gonna die anyway.' (16).

17 'People coming in off the street need chronic wound care, diabetes clinics, treatment for cellulitis, wounds, and ulcers; a primary health clinic, needs to be a one stop shop.' (Focus Group Participant)

It was universally reported that the residents will require access to *trauma-informed counselling* or *psychology services*, and *peer support services* were highly valued.

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18 'Peer workers are essential they help things make sense' (24).

19 'Makes a difference if someone has a similar shared experience, someone who is friendly who has been there themselves is so much better than a textbook learner. Someone who has been an ex user, drinker, comes from domestic violence, they know where you are coming from. The worst thing is when you sit there and talk to someone and they don't understand; reading case studies just does not cut it.' (Focus Group Participant)

20 'Need a peer support worker, someone who understands and has been through it and can relate to the people; people who have been there.' (Focus Group Participant)

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21 'They need peer staff; people who have already been there; people who are clean and who are the ones who have already worn those shoes; they are the ones who can help the most.' (16).

22 'You don't want to talk to someone who has got it out of a textbook – you want to talk to someone who has been there, to know there is hope for people, it is a big thing, hope and strength and faith.' (17)

23 'Need a mix of medical people and peer people' (Focus Group Participant)

It was universally reported that people will need assistance with drugs and alcohol, and that they might need to access *methadone clinics and 'needle and syringe' programs*. It was reported that people might be Hep C or HIV positive.

People wanted access to health services on-site.

24 'Would be good to have on site so they know the people are there to help with their whole general wellbeing, and to move on in life. Can't do anything without health, health needs to be addressed and needs to be onsite, and they are all here and it is all free, and then people will be willing to do it.' (25)

25 'Build place where everything is close to each other because it is hard to get from one appointment to another; all in the one building is a great start.' (16)

26 'Need Hep C treatment because a lot of people use, and they probably have Hep C, if you have a bad liver; …people need physical health and general wellbeing stuff. They need community services, mental health, psychiatric help, and skin health if they have ulcers. I have seen a lot of people that use, and they have big ulcers and need help with that. People also need NSP services'. (16)

Participants recognised that residents would need access to *nurses, doctors*, assistance with *pharmaceuticals* as well as access to *dental care and dieticians*. Case managers and social workers were identified as important to assist people in managing their health, welfare, and other concerns.

9.7 SOMETHING TO DO – 'PEOPLE NEED PURPOSE'

Participants in the consultation indicated that residents would require therapeutic groups and activities that support connection, skill building, health and wellbeing. Activities should be targeted to the specific needs and preferences of the residents but could include activities such as: '*writing, poetry, crochet, knitting, cooking, gardening, meditation, colouring in therapy, origami,*

activities that keep your mind busy, such as crosswords, also trips to the beach, and a minibus that can drive people around for outings, to the beach and country.' (Focus Group Participant).

Creative groups were strongly referenced by focus group participants and interviewees. People reported wanting art and music groups.

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27 'Music therapy, art therapy - things they have never been able to do, never had the option to do, teaching things they have never seen before. Feeling free to ask for it, being given it and not being turned away.' (16)

They also wanted therapeutic groups such as wellness groups, recovery groups, emotional regulation and distress tolerance groups, sensory activities and group support addressing harm minimisation. Interviewees reported the need for anger management groups, PTSD groups, and AA / NA meetings on site.

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28 'Harm minimisation and distress tolerance groups as different emotions will come up when now housed and clean. It doesn't mean we will just snap right in; they need to understand it is not bad to relapse. To have someone they can tell that it doesn't matter, don't turn around and walk away, just pick back up'. (16)

Living skills activities were also identified as important, especially for people who have been incarcerated or been on the street for a while. People need *skill building in budgeting, cooking, shopping, healthy eating and vocational skills.*

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29 'You can't expect people to come off the street and be a house-trained dog.' (11)

30 'People get out of jail and don't even know how to buy a bus ticket.' (14)

31 'People get used to sleeping rough' (16).

Physical activities and gentle relaxation groups were also discussed. People spoke about the value of *yoga and Tai Chi*; they wanted a *gym, swimming pool / hydrotherapy and a table tennis table*.

9.8 PETS and PARTNERS

Several interviewees and focus group participants reported how important pets are, and that many *homeless people had dogs* and would rather remain homeless than give up their pet. Participants in the consultation reported that pets should be allowed, and in addition the facility should have animals and *pet therapy*.

32 'People do have their pets, need pet therapy, one dog for all the residents in addition to people with their own dogs. Pet therapy is powerful – people don't want to give up their pets.' (Focus Group Participant)

33 'Dogs are our company' (14)

Another barrier identified was that for *couples* who were homeless. It was reported that most facilities only catered to homeless individuals and not couples. Participants requested that a few rooms be made available for couples who presented.

34 'Need couple rooms – there are no places for people who are in couples, especially if you are an older couple, most facilities don't accept couples – never seen a place for homeless couples.' (Focus Group Participant)

35 'There are no places for people who don't fit into the box.' (Focus Group Participant)

9.9 BUILDING DESIGN AND LAYOUT

OWN PRIVATE SPACE: Participants in the consultation all reported that residents require their own private living space / bedroom, bathroom, and kitchenette. They wanted privacy and an option to be able to eat meals in their room. They wanted a table and a locker to store their valuables, as well as a room that can be locked. People wanted their own courtyard, balcony, or garden and a TV in their room.

36 'How buildings feel is important, the colour, layout, have pastel colour walls, so that it is peaceful, and has a non-clinical feel. Have a nice bed, you would have a closet to put your clothes in, side tables, like a hotel – put your own stuff on the wall, a little table so they can eat in their room, make it homely, with not everyone having the same thing, and the freedom to put things on the wall in the room.' (Focus Group Participant)

37 'Colours and design are important, like a big mural. Have a big bedroom, and not having to share with people. It is nice to have our own single room, and to be independent, have our own little kitchen, and don't have a shared bathroom.' (17)

38 'An oasis in the city - it is the spirit of the place that makes the difference.' (15)

OPPORTUNITIES FOR CONNECTEDNESS TO PEOPLE AND NATURE: Participants described the need for *open spaces and communal areas* where they could get together for company and conversations. They wanted areas *connected to nature, a garden, a waterfall, a courtyard*, and some comfortable outdoor lounges where they could sleep outside, if people were struggling to settle in their private room. Connection to nature was important, they wanted a *green area and trees*.

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39 'Need an open living plan, where people can sleep outside in the courtyard. I couldn't be inside for a while'. (Focus Group Participant)

40 'Want it to look homely, not clinical, like a semi-circle around a courtyard, with a nice garden, and a community in the courtyard where everyone can meet out in the courtyard.' (Focus Group Participant)

41 'This is my space and my room, and the courtyard is where I go to meet with others'. (Focus Group Participant).

42 'Needs to feel like it is your own home, some people want to be by themselves and some people want to talk.' (Focus Group Participant)

43 'Want friendliness, want people to mix, everyone wants to talk to somebody, needs to feel like a community where you belong, and realise you are not alone, everyone is going through similar things although different.' (Focus Group Participant)

44 'The outdoors area can have a BBQ area where we can have Christmas parties, run groups, and cooking groups.' (Focus Group Participant)

PEACEFUL: Interviewees and focus group participants wanted the building to promote a *relaxed and soothing* retreat style feeling. They wanted opportunities where they could *connect with others*, where they could mix and feel like the facility represented *a community of like-minded people*.

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45 'The symbol of Buddhism is so peaceful. Have water features, the sound of water, fish in the pond. Water is a great balancer, especially the sound of running water.' (Focus Group Participant)

46 'Want friendliness, want people to mix, everyone wants to talk to somebody, feels like a community, you belong, realise you are not alone.' (Focus Group Participant)

DISABILITY FRIENDLY: People reported that the building needed to *cater to people with disabilities*, including people with vision and motor problems, especially the needs of older residents. If it was a multi-storey facility it needed to have *lifts*, there needed to be appropriate *disability grab rails,* and it needed to cater to the needs of people who are vision impaired or experience cognitive challenges.

SAFETY: High rise buildings were not desired, single story dwellings were preferred for safety reasons.

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47 'Consider needs if people are suicidal. Building should only be ground level or one level. Not too high, so people can't jump. Also need lifts need to cater for people who can't walk upstairs.' (Focus Group Participant)

The building needed to be homely; people didn't want bars on windows or sealed windows. People wanted '*windows that opened and balcony doors where the breeze can come through*'. (FG) People didn't want environments that retriggered their trauma, such as being in jail (14).

9.10 OPERATIONAL MANAGEMENT

STAFF QUALITIES: Participants in the consultation spoke to the importance of staff being kind, understanding and tolerant, and to take the time to listen to residents.

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48 'Staff need to be friendly, open minded, ideally someone who has been through it. Don't want staff who stand over people and are intimidating'. (11)

49 'No judgements and assumptions from staff' (16)

50 'Staff need to know how to talk to people, to be with people. They need to have a sense of compassion and energy….. Staff need to be people who care and know how to react when people have been traumatised' (25)

RESIDENTS – BUDDY AND MENTORING: Participants in the consultation wanted the opportunity to be able to help other residents and to provide support and mentoring to help others.

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51 'Need people to check on others. People die because of loneliness, people go back to alcoholism, because of loneliness. People need someone to talk to – 'are you alright, do you want to go and have a coffee?' Loneliness is the killer.' (Focus Group Participant)

52 'A place where people check in on others: 'Are you OK?' with a smile on their face, keep reaching out and keep the hope.' (17)

53 'Longer term residents should support newer residents…they will help each other and help them to feel at home.' (Focus Group Participant)

54 'The vast majority of people just want a mate and a lending ear. Some people don't want to swap war stories, they just want to be heard. A lot of

people get intimidated by staff and they don't talk to staff, but they do to other residents. The older residents can talk to newer people and put them at ease.' (Focus Group Participant)

People valued the opportunity to contribute and to help others.

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55 'People living there can evolve to contribute…gives them motivation to be clean and to show others how it can be done. Makes them feel wanted and needed and helpful. I would feel great if I could help one person. People could work their way up in steps and they can be like peer friendships, like they do in the AA, a sponsor something like that. And then maybe they could get a little bit of pay for it…it doesn't have to be financial...like a goal people might want, a computer for their room. One of the major triggers of an addict is having money.' (16)

CREATING ORDER AND CALM - RULES AND REGULATIONS: Participants wanted rules and guidelines to assist in creating a safe environment. People who had worked hard to come off drugs and alcohol did not want to be exposed to drugs and alcohol. Participants wanted residents to get on with each other and any issues to be dealt with, as they arise.

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56 'Alcohol is always a bad thing no matter where you are. Need to have a rule that you can't have alcohol; no drugs, no alcohol as that creates dramas and resentment.' (Focus Group Participant)

57 'Rules without jail, without anarchy, without being punitive. Rules need to be monitored or will be chaotic.' (Focus Group Participant)

58 'Unresolved issues can really disrupt a house, need to have house meetings to resolve issues, otherwise it has a ripple effect and divides a place. Need to stamp it out before it escalates. Need to have staff to help with conflict management before it explodes. Have a meeting once a week, sit down and talk about. Meetings need to be compulsory, and to come to an agreement but not a punitive contract. Most people are interested in what is going on, need to give people an opportunity to have a say. No stand over tactics, no aggressive behaviours of residents or staff, no bullying, and the freedom to talk.' (Focus Group Participant)

Others understood that people may struggle with some rules and they should not be punished but supported to get back on track.

59 'Need to have rules, but no getting kicked out for being themselves. People must know that the rules are society rules and can't have illegal stuff going on. Got to have rules and boundaries but need to know that just because they have faltered, people need to know they will not be kicked out and punished. To be truthful is better, let people be truthful and then it is better. If it is not truthful then they have to hide again and all the shit that comes from that, they feel guilty.'

60 'Rules are rules and they are set for a reason, everyone breaks rules no matter who they are, or where they are from, everyone feels bad if they break a rule, they need to know they won't be booted out, obviously within reason, if there is violence etc. But just need to pick themselves up and keep going again. Also, if people have relapsed, they can still come home, and be truthful about it, without being shunned. Once you have broken a rule just pick yourself up and keep going'. (16)

10 DISCUSSION

The participants who engaged in the consultation had pathways into homelessness consistent with the reported literature. Research identifies risk factors for homelessness among people aged 50 years and older include male gender, childhood trauma, prior imprisonment, substance abuse, history of mental illness and psychiatric hospitalisation, presence of cognitive deficits, presence of physical illness and history of victimisation, (Cohen, 1999), along with family breakdown, domestic violence (Shinn et al., 2007). The participants in the consultation were people who had been exposed to childhood trauma, who had experiences of domestic violence, some who had lived conventional lives before ending up homeless, people who had had family breakdowns and people who experienced injury, disability and/or had been incarcerated. All participants had a history of mental illness, in particular PTSD and complex PTSD, and the majority had experienced dependencies on alcohol and other drugs.

10.1 MEDICAL NEEDS

Research has found elevated levels of *physical health problems, mental illness and substance use* among adults, and significantly more chronic disease and functional disability among homeless adults aged over 50 years compared to younger homeless people (Shinn et al., 2007). Homeless people over the age of 50 years are reported to resemble the general population over the age of 65 years (Cohen, 1999). Residential facilities targeting the needs of long-term homeless people over the age of 50 need to consider the physical health and disability needs of this population, alongside the complex trauma and mental health needs of residents.

Participants spoke to the lack of self-care and feelings of unworthiness that had impacted on their ability to address their physical health. Participants in the consultation identified that people coming into the facility are likely to have significant physical and mental health needs that needed to be addressed under the one roof. There was a strong expressed need to be near hospitals and services addressing drug and alcohol addictions. Participants were recruited in the inner-city area

around the hospital, and overwhelming expressed the desire for the facility to be in the inner-city area near hospitals and other services, including close to shops and public transport.

10.2 THERAPEUTIC ACTIVITIES

Participants spoke to the importance of therapeutic groups and interventions to address their trauma, to support recovery and wellbeing, and to build life skills that had either been lost or that they have never had an opportunity to develop. People wanted to engage in creative and physical activities to support their wellbeing. They wanted opportunities to connect with others and do activities with others, such as art, craft, music and cooking groups.

10.3 ENVIRONMENTAL DESIGN

The *physical environment* was identified as important in supporting feelings of safety, inclusion, and connectedness, to provide opportunities for people to connect with one another and with nature. The importance of the physical environment in promoting wellbeing has been recognised and reported, with high-quality physical environments required to support the older people in care facilities with cognitive and physical frailties (Nordin, McKee, Wijk, & Elf, 2017). High quality physical environments have been found to promote psychological and social wellbeing of older people living in residential care facilities (Nordin et al., 2017). Environmental design can compensate for decreasing competencies and enhance resident's wellbeing.

The layout, sound levels and access to outdoor areas can improve sleep, orientation, activity, and overall well-being (Joseph, 2006). Contact with *nature* is reported to increase well-being among residents (Bengtsson, 2015), and nature was identified as an important element in the design of the facility by those who participated in the consultation. Participants reported green areas, trees, nature, and water features were important design features to support wellbeing.

Participants in the consultation reported that the facility needed to accommodate disability needs, reduced cognition and reduced physical capacity in the *physical design*. The design needed to accommodate for people unable to manage stairs. Other safety aspects such as flooring, handrails and adequate lighting are also reported to support mobility (Brawley, 2001). Floor plan design and environmental cues such as signage and colours can assist navigation and orientation for people with cognition challenges (Marquardt, 2011) and will be important for older residents who have faced long-term homelessness and may be dealing with reduced cognitive function due to alcohol and physical-related brain injury.

Participants reported the need for the facility to *feel like a home and a community*, rather than an institutional facility. They wanted *private rooms* where they could place their own belongings and pictures on the wall. The importance of familiar belongings with a home-like, non-institutional design, for supporting older people, has been recognised previously and found that it supports residents' behaviour, reducing agitation, anxiety, apathy and aggressiveness (Joseph, Choi, & Quan, 2016; Zeisel, 2013).

The value of home-like and small-scale environments is central in a person-centred care approach and can contribute to older peoples' autonomy, social interactions and sense of privacy (Zeisel, 2013).

10.4 TRAUMA-INFORMED APPROACHES TO CARE

Consistent with this consultation, another Australian study exploring the care needs of older people at risk of homelessness, also reported the importance of a trauma-informed approach to care, that needs to be consistently applied by all staff to all processes. The trauma history of older people experiencing homelessness necessitates a trauma-informed framework to deliver the best outcomes and avoid re-traumatisations (Rowlands et al., 2020; Song et al., 2018). Care needs to be relationship-based, providing long-term commitment, understanding of the complexities of needs, an emphasis on safety, harm minimisation philosophies, respect for cultural diversity, and opportunities to rebuild control in a strength-based approach (Rowlands et al., 2020; Song et al., 2018). A persons' participation in care, and the relationship between the person and healthcare staff, have been identified as core aspects of person-centred care (Kitson, Marshall, Bassett, & Zeitz, 2013), which is essential in providing a trauma-informed approach.

Participants reported the need for understanding, kind and compassionate staff, who understood the trauma background and history of drug and alcohol of people who have experienced long-term homelessness. Participants reported that people don't immediately fit right in after they are housed, '*people get used to sleeping rough'* and *'[you] can't expect people to come in off the street and be a house-trained dog*'. It is recognised that evolution into long-term homelessness involves an enculturation process in which the individual learns to adapt and survive in the world of shelters or streets (Cohen, 1999). The behaviours used to survive on the streets cannot necessarily be turned on and off at will, and accommodations and support will be required as residents adapt to the new environment. For example, it was reported that some people struggled sleeping indoors initially and this could be accommodated by having comfortable lounges outside in a courtyard area. People also wanted reassurance that they would not be kicked out of the facility if they had slip-ups in the use of drugs and alcohol.

High-quality care is dependent on the organisational structure and care values including the knowledge and skills of care staff and support from management (McCormack, Dewing, & Mccance, 2011). Participants reported wanting a flat management structure whereby they could have a say in the running of the facility, and address any issues as they arise.

The rate of homelessness for Indigenous people per 10,000 population aged 55 and over, is reported to be 16 times the rate for non-Indigenous people (Australian Institute of Health & Welfare, 2018). One-in-five of those in the consultation reported to have an Indigenous background. Indigenous people experience greater levels of intragenerational trauma, childhood and adult trauma, and have a greater level of risk factors for homelessness. Given the high rate of older Indigenous homeless people, the care offered in, and the design of, the facility should be sensitive and inclusive to the needs of Indigenous older Australians, and should also include co-design of artwork and murals.

10.5 CONNECTEDNESS

Throughout the interviews and focus groups participants reported a strong need for connectedness with people who understand. Connectedness is a key recovery principle, and social interaction and the sense of community was strongly desired by those who participated in the consultation. Peer work was highly valued by the participants. Participants in the consultation were recruited by St Vincent's Hospital Sydney's Homeless Health Service peer workers, so participants had experience working with peer workers and had an opportunity to experience the value of peer work. Participants had a sense of trust and feelings of safety with the peer workers, which was essential as part of recruiting people into this study.

Research studies have indicated the effectiveness of peer work for improving recovery outcomes, including improvement in quality of life, reduction of symptoms and distress, and reducing hospital admissions (King & Simmons, 2018; Lloyd-Evans et al., 2014; Pitt et al., 2013). In homeless health services, intentional peer support involving mutual understanding, empathy, social support and role modelling, along with shared experiences are noted as having a significant impact on the homeless client's overall quality of life by reducing alcohol/drug use, improving mental/physical health, and increasing social support (Barker & Maguire, 2017). People who have experienced homelessness, are reported to experience a 'different world' of isolation and neglect, and peers who have experiential knowledge of this world, are able to genuinely empathise and connect with the client (Barker & Maguire, 2017).

Peer support was found to significantly increase feelings of belonging, to reduce isolation and increase social relationships and social support in the homeless population (Barker, Maguire, Bishop, & Stopa, 2018). Peer workers in homeless health have been found to result in significantly improved positive outcomes in reductions in drug and alcohol use and reducing relapse rates (Barker & Maguire, 2017). Improvements in physical and mental health was found with peer interventions as a result of increased health promoting behaviours resulting from peer interventions (Stewart, Reutter, Letourneau, & Makwarimba, 2009). Peer workers are able to access 'hard to reach' people with experiences of homelessness and to increase engagement (Barker et al., 2018)

Participants in the consultation study saw themselves as giving back to the community that had supported them, and they wanted to be able to assist other people. They identified the benefit of being able to make a difference in someone's life, they wanted to support other people and grow through the experience. Participants wanted to have a sense of purpose, and to add meaning to their life. They desired opportunities to give back and be recognised for the work they did, through some reward or point system.

11. CONCLUSION

Peer workers from St Vincent's Hospital Homeless Health Service were pivotal in recruiting people who have experienced long term homelessness, to participate in this consultation. Peer workers who have experienced homelessness have connections, know where people experiencing homelessness gather, and are able to talk the language of people experiencing homelessness. Peer workers are recognised as safe and trustworthy, by the homeless population.

People recruited to the consultation were keen to have a voice and contribute their perspectives to the design of the proposed facility. The experiences of homelessness and the outcomes of this study are consistent with national and international literature, in relation to pathways into homelessness; and the physical design of facilities targeting older people with experiences of homelessness. The medical and social needs of people identified in this study are also consistent with that reported in the national and international literature. The importance and value of peer work was strongly recognised by participants, along with a desire for pathways that they might have in the future, to be able to assist others. People wanted a sense of purpose, and the opportunity to grow and develop through helping others.

There was a strong need for a sense of connectedness with others, alongside opportunities for privacy. It was reported that the design of the facility was critical in creating feelings of safety, and providing opportunities where people can gather and connect with others. Overarching all needs that were identified, was the need for the facility to be trauma-informed in all aspects of design,

service and operation. All activities, including those that met their physical and mental wellbeing, along with skill building and creative groups, needed to be underpinned by trauma informed processes and ensure safety for all. Participants recognised that safety meant that there needed to be rules and regulations, including rules around use of alcohol, to ensure the facility was safe for all.

In conclusion, this project has highlighted the specific needs of this population when designing a permanent care residential facility for older Australians experiencing homelessness. The information collated may contribute to the understanding of long-term homeless people's needs, and facilitate the development of a specialised facility where people want to stay. A place where people could feel at home, and develop a life with meaning and purpose.

12. APPENDIX

12.1 QUESTIONS FOR SEMI-STRUCTURED INTERVIEW AND FOCUS GROUP

CO-DESIGNING A LONG-TERM RESIDENTIAL FACILITY FOR PEOPLE > 55 YEARS AT RISK OF HOMELESSNESS

This project aims to harness the lived experience of people > 50 years to contribute to the model of care and design features of a specialist permanent care residential facility intended to meet the needs of people > 55 years experiencing, or at risk of homelessness.

UNDERSTANDING THE PERSON WHO IS ACCESSING THE SERVICE

The service will be open to:

GENDER: Male / Female / Other
AGE: > 55 years

1. Who is most likely to access this service?

e.g:

- ✓ EDUCATION / LITERACY LEVEL
- ✓ HEALTH / DISABILITY NEEDS
- ✓ TRAUMA BACKGROUND
- ✓ CULTURAL / INDIGENOUS BACKGROUND

_____
_____
_____
_____

2. What is / are the person's immediate need/s when they access long term residential housing?
e.g: health / medical / disability / financial / psychological / social

_____
_____
_____
_____
_____

3. Are there location requirements? If so, what are they?
e.g. near hospital, medical services, city, suburbia, access to public transport, shops

_____
_____
_____
_____

4. What medical services do people need access to?
[e.g. hospital, GPs, AOD/mental health services, peer workers, psychologists, social workers]

_____
_____
_____
_____

5. What amenities/facilities/community services would people like access to?

[Harm reduction services, trauma informed care services, social, sporting, community type services. Access to art, music, sensory, distress tolerance and innovative type interventions.]

_____
_____
_____
_____

HOW DO WE CREATE A QUALITY OF LIFE AND IMPROVE THE PERSON'S WELLBEING?

6) Do other aspects of the service design influence appeal?
e.g. size, design of building, building facilities, staff experience / training, staffing model?

_____
_____
_____
_____

7) What should be avoided / what is not helpful?

_____
_____
_____
_____

_____Thank You ____

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Harnessing the lived expertise of older Australians who have experienced homelessness; to contribute to the design and service model, of a long-term residential facility.

(1) What is this consultation about?

You are invited to take part in a consultation that explores the needs and preferences of older Australians with a history of homelessness. This consultation aims to understand how a long-term residential service, can best meet the needs of older Australians, at risk of homelessness.

Participation in this research study is voluntary. By giving consent you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the consultation as outlined below.
- ✓ Agree to the use of your personal information as described.

(2) Who is running the consultation?

The consultation is being run by Dr Katherine Gill. Dr Gill is working in collaboration with the peer workers from Tierney House, who are assisting with the consultation.

(3) What will the study involve for me?

If you agree to participate in this consultation, you will be asked to take part in an interview, or focus group. If you agree, the interview / focus group will be audio recorded, to assist with noting your input and feedback. The recordings will be deleted after transcription.

(4) How much of my time will the study take?

The time required to participate in interviews or the focus group will depend on how much you have to share. You do not have to prepare for the interview or the focus group.

(5) Do I have to be involved in the consultation?

The consultation is completely voluntary and you do not have to take part. Your decision whether or not to participate, will not affect your current or future relationship with St Vincent's or Tierney House. You are free to withdraw at any time. There are no consequences for withdrawing. You may also refuse to answer any questions that you do not wish to answer.

(6) Are there any risks or costs associated with being in the study?

Aside from giving up your time, there is a small risk that the questions might bring up some emotions, related to your lived experience of homelessness. You can stop at any time.

(7) Are there any benefits associated with being in the study?

We cannot guarantee that you will receive any direct benefits from participating. Possible benefits may include satisfaction by contributing to the project which may benefit others in the future. A $50 voucher will be provided for your contribution to the project.

(8) What will happen to information about me that is collected during the study?

By participating in interviews and/or focus group, you are agreeing to us collecting personal information from you for the purposes of this consultation. Your information will only be used for the purpose of the consultation. Your information will be stored securely and your identity/information will not be disclosed.

(9) Can I tell other people about the study?

Yes, you are welcome to tell other people about the study.

(10) What if I would like further information about the study?

Please feel free to contact Dr Katherine Gill, via the Peer Workers at Tierney House.

++

Do you understand the information provided above? ☐ YES ☐ NO

Do you agree to participate in the consultation, as described above? ☐ YES ☐ NO

Do you consent to your interview / focus group being audio-recorded? ☐ YES ☐ NO

NAME: _____

SIGNATURE: _____

DATE: _____

WITNESS NAME: _____

WITNESS SIGNATURE: _____

DATE: _____

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