Women's Health Tasmania

Talking to women about homelessness, Tasmania 2020

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Acknowledgement of country

Women's Health Tasmania's office is located, and this report was written in nipaluna/Hobart, part of the traditional lands of the muwinina people.

We acknowledge and pay respect to the Aboriginal community as the traditional and original owners of lutruwita/Tasmania. We pay respect to their elders, past and present, and to the young people who are their future leaders.

Background

In July – October 2020 we spoke with Tasmanian women about their experiences of homelessness. We wanted to talk to two different groups of women affected by homelessness who regularly contact our service.

We wanted to hear from women who were currently or had recently had direct experiences of homelessness. Collectively, their experiences of homelessness included rough sleeping, couch surfing, staying in women's shelters, staying in caravan parks and hotels and living in overcrowded dwellings. Some of these women have been homeless for lengthy periods.

We also wanted to talk to a new group emerging in the homeless population: older women, who, after a lifetime of housing security have unexpectedly experienced homelessness or are at risk of experiencing homelessness for the first time because of a change in their circumstances.

The way these two groups of women contact our service, and what they ask for from a service can be quite different. We wanted to learn more about their experiences and their insights into the service system.

We are presenting what we learned from these conversations separately, in two different sections of this report. In the end though, we realised that these seemingly different groups of women have a great deal in common, as we discuss in the conclusion.

The social determinants of health

To guide our work of listening to women talk about their health, we use a social determinants lens. This means we're attentive to the social and cultural factors, including the physical, economic and political environment in which women live. To this end we asked women what was working to keep women well and active in their communities, and what was making it hard for women to be well and active.

The social determinants of health are vital when we investigate issues around health and homelessness. Homelessness does have individual impacts, but it is a social and structural issue that requires the reorganising of resources so everyone, no matter their financial status, can be healthy and included.

The health experiences of women experiencing homelessness are different to the experiences of people who live in a safe, secure home. The women we spoke to told us about the impacts of homelessness on their health and how this related to income, access and the homelessness service sector.

Who did we talk to?

We talked to 10 women in individual interviews. Five were women talking about their experiences of homelessness. Five were women who were over 55 who were homeless or at risk of homelessness.

The women we spoke to live in the south, north and north-west of Tasmania. They ranged in age from 18 to 80 years of age. The women who were discussing direct homeless were aged between 18 and 54. The older women were aged between 55 and 80 years old.

The women were ethnically and culturally similar – all of them spoke English as a first language and none of them identified as Aboriginal or Torres Strait Islander. Some of the women identified as LGBTIQ.

Several of them reported that they had been diagnosed with a mental health condition. All of them reported that they were grappling with new mental health struggles or with an exacerbation of pre-existing conditions as a result of homelessness.

More than half the older women also indicated they live with a disability.

The majority of the interviewees met the criteria we applied for 'low income', that is, they held a Commonwealth Health Care Card or Pensioner Concession Card. Some of the older women were working but were struggling financially, with very low incomes after housing costs.

How did we reach them?

We reached participants who had experienced direct homelessness through the housing and homelessness sector. Information regarding the project was discussed and shared with workers from a range of services who let women know about the project and how to be involved.

We worked with Housing Connect Housing Workers, Magnolia Place Launceston Women's Shelter, Hobart Women's Shelter, McCombe House, Jireh House, Annie Kenney Young Women's Shelter and Mara House to spread the word about the project and connect with participants.

To reach older women with experiences of homelessness or housing insecurity we used the Women's Health Tasmania networks through our social media, e-news and newsletter. We also received promotional support from Anglicare, Hobart Women's Shelter, Hobart City Mission, Hobartians Facing Homelessness and 50+ Women Going Tiny Facebook pages.

We are very grateful to these organisations and Facebook groups for their support.

Limitations

The small numbers of participants means that this brief should be seen as a starting point for this conversation. Women had very different experiences and journeys into homelessness and housing insecurity.

We've focused on the similarities of experience across this diverse group of women. More work needs to be done to explore how women experience the responses of the health and homelessness sector to diversity and complexity.

What did we hear?

Homelessness is a health issue

Women told us about the very real impacts of homelessness on health. Health is determined by the social environment in which people live and the stories and experiences of the women we spoke to illustrated this.

Physical health

Many of the women reported feeling lucky that they had not been seriously ill while homeless, but also told us about a range of adverse health events that had gone untreated for some time or been exacerbated by an inability to get to a doctor quickly.

Often these health issues were impacted by layers of problems, for example, not having the money to go to the doctor alongside being unable to keep appointments because of transport issues, drug use or mental health factors.

"I contracted Hep C; I've got rid of that now.[1] I had a lot of chest infections all the time from running around the streets all the time. Other than that, I was quite lucky... I had an infection in my arm that I had to be operated on, so I did get a lot of infections. Just from being run down. It's all part and parcel of being homeless and doing drugs at the same time."

"I got a skin infection and [going to the doctor was] hard to do because I had to push myself out the door because I was suffering with the anxiety attacks but not, because I had to get there. I wanted to see [this GP] because she deals with the family..."

One woman also shared that her experience of needing complex and ongoing medical care brought a layer of complication to her experience of homelessness. Additional appointments and the cost of health care on top of caring for her mental health and seeking support with housing was a significant juggling act.

"The [health] thing affects me every day, it affects every part of [my] life and how I see my future. Being homeless affects me sometimes...[it's] hard; uncertainty about the future, trauma from my experiences of sexual assault make it hard to be healthy. It's not the homelessness just on it's own."

1 Since 2016, oral medications that can cure Hepatitis C have been available in Australia. For more information, see Hepatitis Australia, *A Cure For Hep C* (2020). https://www.hepatitisaustralia.com/hepatitis-c-cures

Mental health

All the women talked about the deep toll on mental health that happened because of homelessness. Experiencing homelessness could mean the beginning of new mental health struggles, or it could exacerbate pre-existing problems.

Women told us the stigma and shame of homelessness could keep them isolated and make it difficult to access mental health services. Women also told us that mental health issues could make it very difficult to manage the appointments and obligations of temporary accommodation.

The women also identified how issues of grief, sexual trauma and family violence could impact their mental health but that the main feature of being homeless was having no safe, stable place to begin processing or healing. Women talked about having to put their mental wellbeing on hold out of necessity and that this had impacts on wellbeing.

"My main priority is finding a house and I've had to bury a lot of [grief] ... People forgetting what we've been through. I haven't dealt with emotional issues and I just have to keep going for the kids because I've got no choice. I've got to find them a home."

"It's taking its toll. And then the stress of housing. It gets to me. It makes me sometimes like 'Why? Why am I in this horrible world? Hasn't enough happened to me?' I've lost enough... what more do I have to lose?"

"Because we spend the majority of time on our own and not engaged in conversation, we've got no-one to bounce things off... there's no measuring stick with other people... so when I get in that room to talk to a worker, I haven't spoken any words to anyone and their pen is loaded with keys and access for me, so I have to be really careful because they can keep them closed... and it doesn't mean that I don't need help, but it becomes too risky."

"[I wish I could] stop my brain from overthinking and just let things be. I have anxiety and I over think things. Just wake up and just do me, but every day I wake up and I am so drained. Maybe things would be better. And the way I go about certain things. Sometimes I'm erratic."

What's working well?

Asking for help and knowing where to look for help

Many of the women we spoke to talked about asking for help as a being a crucial moment of change in their story of homelessness.

Many women talked about how shame and stigma played a role in preventing them seeking help around housing. Overcoming this shame and stigma enough to reach out was part of a process of recognising that what was happening to them was not ok.

Women talked about how being finally able to name their situations as ones where there was family violence, where drug use was an issue or where they had run out of options, was an important part of the reaching out process. Often workers and peers were a part of this journey, helping people know what support was available to them.

The positive impact of workers

Many of the women also named individual workers who had made a difference to their ability to access help and support, both in health settings and in the homelessness and family support sector.

Women talked about workers who were consistent in their support and who built rapport by demonstrating an authentic sense of care and concern for their situation. Workers who did this were trusted and respected.

The women told us that these workers were skilled in having positive conversations with women that maintained hope and a sense that the situation will change for the better. When workers acknowledged the strengths of women and positive steps and wins that women had made, this made a big difference to how women saw themselves and their future.

"I have a psychologist through a service, that calls me once a week and I can call her if anything comes up. And she will come and see me [do a home visit] when we get set up. This is a service that has been with me through the whole family violence journey."

"She said, 'you need to remember that this is only temporary' and that was big because it didn't feel like that. The words people say can absolutely make that difference, make that click, change things into a different gear."

"But now the shelter is pushing me, helping me, they have seen the positive changes that I have been making. [They have set] different rules and I've been given more responsibility and freedom."

"You need that niceness. Sometimes the world ain't nice, but if you've got someone being nice to you it's easy to be nice back. If you've got someone who's just answering the questions in a flat tone… it's like, 'I am even here anyway or am I non-existent to you as well?' It's an emotional rollercoaster."

Material aid

Women told us that material aid was vital in keeping them and their family healthy, both physically and mentally.

Women spoke about the importance of having access to free or inexpensive fresh produce. For women in shelters, the giving of free food hampers was highly valued. The role that community-based food programs that provided cheap vegetables and fruit and helped with delivery were also valued by women with families.

"You can feed your kids decent meals and that really helps because you're struggling paying bills… I've dropped down in pay, and I've always been on time [with bills] but you feel you can't because you want to feed your family. So those bloody hampers help!"

Resilience, strength and 'keeping going'

Women were able to name a range of ideas and strategies that kept them going and helped them stay healthy amid the chaos of homelessness.

For women who were caring for children, these family responsibilities were something that helped them keep trying. Women often described a strong sense of "having to keep going" for their family and children.[2] Women also talked about working hard to cultivate positive mindsets that could help them cope with the stress associated with homelessness.

Other women talked about how previous counselling, support and lived experience had taught them ways of planning for and coping with stressful experiences. For example, women talked about breathing exercises that they deployed when they felt a panic attack coming, or their expertise in setting achievable health goals.

Women also were clear that these mindsets, strategies and ways of getting through the stress of homelessness were not simple or easy. They took work, practice and time, and often worked best when bolstered by the support of workers, friends or family.

"The weight gain has really gotten to me, but I've just got to tell myself, don't worry about it, just keep going, so I've still got that positive spin on it."

"I was having anxiety attacks; I've never had them before...I feel it come and deep breath through it. I fought a couple of them, I had to deep breath through them. I realise how quick it could take someone over."

"I am trying. I've got these plans in my head, if I follow these steps then I am attempting to fix it... I've never done these things before in my life and this is what I say to people, I am starting my life again at 40. But it's going to be a better life this time."

2 While this was often talked about as something that helped women keep going, we also discuss it below as one of the things that could make it hard to maintain health of women as women often had to choose between meeting their own health needs and those of their children. We also discuss the exhaustion that women describe as a result of having to 'keep going' for extended periods of time.

The support of peers

The support of women peers was highly valued by women. Women told us that other women who had experienced homelessness could be key allies, supporters and expert advice givers.

Women talked about how the understanding and non-judgmental support that came from peers made a difference to their experience of homelessness. Women found that peers who knew what they were going through were able to help in different ways to workers. For instance, providing practical support (such as helping to move a load of possessions into a house) or having a level of expert knowledge at navigating systems and knowing what options were out there. These things helped women get their material and health needs met.

"It's because you understand each other... you might get some that you don't click with and others you do click with, But even so it's good to talk to different people and different experiences and what they've been through because sometimes you think you've had it bad. We love sitting around telling each other our problems and it helps."

"A lot of the girls in jail helped me. They had a lot of answers for me: 'do this or put your name down for this'... So yeah, if I had to put it down to anything it was more the females living in that life themselves [that helped me] and put me on the right path. There was no person in authority there to do that for me."

What's not working well and needs to stop?

Lack of options in private and public housing

Women told us that they felt pressure by the homelessness sector to be actively seeking private rentals.

Women told us how limited their options were in the private rental market and how the vast majority of their efforts did not result in securing a place to live.

Women had invested time, mental and physical energy, money for transport to view houses, only to experience repeated 'knock backs' from private rentals. Women also told us that there was 'nothing out there' in the private rental market that was suitable for their needs or within their budget.

"I've applied for 27 private rentals in the last month and a half, gone and viewed them so I pretty much view a house every 2-3 days and not one of them has gone through, so I've sort of given up on private."

The long waiting lists for public and social housing meant that women felt they were competing for a very small pool of affordable properties among themselves. This could cause perceptions among other women of unfairness when some women in shelters were offered social or public housing before others.

"I'm being pushed to go private, to look at private. And its money for fuel, and money for rent...but I've been told to wait because there's a house coming up for me... I'm not saying nothing. I just have to play the game... [other women who are homeless say] 'I've been here longer' but they don't realise the circumstances of others."

Women told us that this lack of meaningful housing options had a range of impacts, especially on women's mental health as they coped with the stress and uncertainty of being homeless.

Displacement and access to health services

The experience of homelessness often meant moving away from known areas, and displacement from community and support. Women had to go to wherever they could be temporarily accommodated. This meant going to a new area, potentially a vast distance from their family GP, regular services, and amenities that women were familiar with. These distances incurred additional cost and could be insurmountable when using public transport. The displacement and not having a safe place to be could also contribute to dependence on drugs and alcohol misuse.

"I couldn't go to the doctor... I had a referral for [my child's immunisations] but I never got that done because of the moving here to there. I was staying in the [outer suburbs of the eastern shore] but my doctor is in [inner northern suburbs] with no transport except public transport, three children, two of them babies in a pram when I've only got the one pram and the other one always wanting to be picked up... I was a single mum. It's hard, it's not easy, I didn't have support."

"It was just a horrible juggling act. The more I had to go from one place to another, the more I had to keep up with the drug taking. I don't know if I could have coped with the homelessness without the drugs, but then again maybe I could have seeked help earlier if I wasn't on drugs, I don't know..."

Support versus surveillance

"Everyone thinks they know what's best for you. And it's like, you haven't lived in these shoes so don't tell me you know what would be really good for me, because you'd be wrong."

Women identified that the homelessness support system could leave them disempowered and placed additional burdens on them. Women said that there were often a lot of appointments with homelessness sector workers and that these burdens came on top of other commitments and appointments.

Women identified that while they appreciated support, there were times when the 'support' they received felt like it was not directed by them or their needs but more like 'checking up on them'.

"The support is good when you need it, but I feel like I could do this on my own. I don't need someone to check up on me that I've gone to a property inspection, I don't need someone to get on the computer and show me the private rentals that I can look at on my phone and that I have previously looked at on my phone."

"It's draining being at the shelters because there are so many rules."

"You're always on your guard and wondering what people are thinking because that then leads to what resources, what's going to be accessible to me and what's not."

Thoughts of suicide and self-harm

Self-harm and suicidal ideation were common themes with this group of women and there was also a fear that sharing this would lead to a narrowing of housing and accommodation options based on risk. For some women, the disclosure of self-harm led to monitoring and the provision of support – however they still felt the pressure of being housed in temporary accommodation.

The legal, ethical and service landscape on which these issues play out is complex. Workers are bound to assess and take action where there is a disclosure of suicide risk or self-harm by mandatory reporting obligations and organisational procedures. As a result, women were strategic about how, when and to whom they talked about suicide and self-harm.

"...being in this horrible situation where I'm not knowing when or how, or how long it's going to take for me to get a house and being a mum every day... it's very overwhelming sometimes. Sometimes I think it would just be easier to [die]... Does another life have to be lost for someone to just do something about it?"

"Have been big impacts on my kids, the stress of moving and being between places. My daughter tried to take her life."

"I was self-harming recently when there was a downward spiral... being homeless is part of the downward spiral. I am fine, I am coping with it but it's hard. In some ways [being homeless and staying at the shelter is] good for me.. [it's] given me more structure and [a chance] find out about myself. But I struggle with being homeless, not having my own place.... I have my own unit [at the shelter]. I am monitored, there are restrictions, but don't know how long I can be there."

"If you answer questions too honestly, that takes you down another trajectory with people. Self-harm is the first thing that people will ask you and ... honesty is not a helpful thing, it's often detrimental... and then it's this thing where people think you're not being honest..."

Barriers in primary health care

"Financial [barriers are] way up front. If I don't have money I can't actually go [to the doctor] no matter what's going on."

The cost of primary health care was an issue that stopped women from visiting a GP.

Though some found they could access bulk billed and concession priced services, there were also concerns about the ways in which some GPs understood the needs of women experiencing homelessness. Women said that they struggled to communicate with their GP about their health issues.

For some women this was because they felt the attitude and conduct of the GP indicated that they were not a safe person to discuss their health concerns with. Women in this cohort told us they already feel shame, stigma and embarrassment at being homeless and so GPs who couldn't demonstrate an open and non-judgmental stance were avoided, even if they did bulk-bill.

"I don't really see a GP myself, unless something is awfully wrong and I don't know what it is. Only time I see a GP is for the children's needles or if they are sick... I don't have a good relationship with my GP. He scares me, he's really intimidating. I don't feel like I could go there and sort of talk to him... he does bulk bill."

"People say 'go to your GP and talk to them' but I don't know how I really go there and start...[to] open up this conversation and see where it leads. I'm too scared to dump my load of problems on them and for them to go 'we're not a counsellor'."

"[Discussion of Centrelink benefits] ..how do I go out to [that far to] see the doctor and then have to pay a concession rate of $66 and you know, you get the refund immediately of $30 so you're only out of pocket $36. So now I am looking at $400 rent, then the doctor $36, without travelling there."

'Don't look homeless' – poverty and class

Women identified that the way they presented to services made a difference in the kind of service they received. Women talked about walking a line between being in need and 'deserving' of support but not 'too needy' or complicated. Women often consciously had to moderate the way they spoke and took extra steps to appear grateful and 'deserving' of help.

Women told us that they felt people made negative judgements about them based on what they were wearing, how they spoke and their single mother status. They felt this could translate to less options being presented and less care and attention from workers.

Experiences of this kind of discrimination could lead women to stop asking for help.

"It's hard asking for help. I wasn't very well educated and so I don't know the right words to say sometimes or I come across a bit different to people because I'm loud so they think I'm yobbish. That's not the intent that I try and give. I guess at other times in the past I've come across as angry to some people, so they haven't wanted to help... it becomes a vicious cycle you're stuck in and even the years go by..."

"My situation has been different because I can articulate and because I have some capacity to control my frustration... and you can't lose your shit. As soon as you lose your shit you've lost everything. And the other thing is, don't look like you're homeless [because then] you're not one of the masses, the countless people that are coming in... You suddenly become somebody decent that something terrible happened to."

"If you don't appear to be appreciative then just forget it."

What hasn't begun but needs to start?

A stable, affordable home for everyone

Overwhelmingly, and unsurprisingly, women said that a stable, affordable, long term house would make a key difference to their mental health and the ability to focus on other health goals.

Three of the five women we had spoken to had been homeless for 12 months or more. One of these women had been homeless for six years. Providing more stable, long term options is key to improving the health of women and families experiencing homelessness.

Women were very clear that they valued short term housing options such as shelters and transitional accommodation, but in terms of mental health, the permanency of securing a *home* was something that allowed people the space to breathe, heal and move on.

"I've always been a fighter... I've fought all my life for people and it's draining. I just want to find a house that we can start healing in, and not let anybody in, and it will be our peace."

"I'm ok. The house has made me ok. I don't think you realise that until you get that [key] and you suddenly go [exhales deeply]."

It was also identified that the focus of support should be a stable, home of one's own. Most of the women had experiences of couch-surfing with friends and relatives or living in overcrowded accommodation but these were not healthy options. The women said that Government and NGO support for them needed to be focused on providing a real home for women, one that is their own, that is permanent, stable, and safe as distinct from having a place to sleep or be for a while.[3]

"That thing about whether you're homeless or at risk, I think we need to stop using that. It's not shelter-less, it's not couch-less, it's not roofless, it's not car-less, it's without a home and that's such a different thing."

More time to find a home

Women also said that something that needed to start is giving women in temporary accommodation more time to find a home. While women were grateful for the time in emergency accommodation and women's shelters, they also said that the short time frames for finding something permanent were not realistic and kept them in the cycle of moving around from place to place.

Longer stays in emergency accommodation and shelters would make a difference to the stress and worry women experienced because of homelessness and allow more time and space for accessing services.[4]

"And then hearing "8 weeks" of accommodation, you've got 8 weeks, you've got to find somewhere in 8 weeks. Each week I feel like I'm not getting any further... I'm stuck in this one little spot, and I'm not going back, I'm not going forward, I'm just swaying back and forth, in this one little spot. I don't know where I'm going to go."

3 The Tasmanian homelessness sector peak body, ShelterTas and its members are lobbying for this 'housing first' approach to homelessness. Housing first means providing safe and permanent housing as the priority for people experiencing homelessness. Once housing is secured, the support needs of people who have experienced homelessness can be addressed. ShelterTas is calling for increasing social housing stock from 5% to 10% of total dwellings in Tasmania. Enough affordable housing will mean that homelessness is "rare, brief and non-recurring".

4 The nature of shelters and transitional accommodation is that it is time limited and there are often reasons to do with Tasmanian Tenancy Law that longer timeframes are not offered. When there is sufficient affordable housing stock available, the temporary timeframes for shelters and transitional properties present less of an issue for women because they can find alternative, stable accommodation.

Listening to women's voices and needs

Women wanted their voices, ideas and needs to be listened to and respected by health workers and homelessness sector workers.

The context of homelessness is one of scarcity. Scarcity of houses, of accommodation options, of money. For those experiencing homelessness this scarcity can translate to a significant sense of being disempowered as they make decisions against a backdrop of narrow options.

Women often had stories where their personal power and autonomy had been eroded. They felt that it was very easy for this to continue when they did reach out for help to health workers or homelessness workers.

"It sort of has been my thing recently because I've got no choice but to... I don't feel like I've got a voice... my word matters, I'll say some things ... and they say, 'are you sure that's what you want to do?' it's like, I know what I want to do, and they make me feel like I have to agree with them."

More opportunities to connect with peers

Women said that more opportunities to engage with peers who had experienced homelessness would be beneficial. While some women found a community of peers informally, they suggested that structured programs or spaces could be useful for women who wanted to connect with others as a way to unpack the shame and stigma of homelessness with others who understood.

What did we hear?

The hidden women

Women aged over 55 are the fastest growing group of people vulnerable to homelessness in Australia. A dire shortage of housing, an ageing population, declining home ownership and the long term and cumulative financial inequities experienced as women, mean older women are experiencing, and are at risk of homelessness, at an increasing rate.

For this project we talked to women who were over 55 who had experienced homelessness or were at risk of becoming homeless. The women we talked to were all mothers and had spent time as single parents. Some had experienced homelessness in some cases for extended periods but are now settled in long-term secure housing or transitional housing. Others felt they were at risk of homelessness: they were living in rental properties with imminent risk of homelessness, they had a mortgage they could not afford, or they owned their home but needed to find more appropriate housing.

The women told us how in their later years a change in one or two life circumstances could very easily result in a woman being at risk of homelessness. They expressed shock at their situation and felt they did not meet the stereotype of homelessness. The women described themselves as literate, well-educated and were working or had participated in the workforce for most of their adult life. They had not had problems with addiction and were confident of their skills. Their homelessness experience had been triggered by marriage breakdown, ill-health, family violence, natural disaster, and financial insecurity due to employment interrupted by care giving responsibilities.

"I always had the idea those who were homeless were people who hadn't helped themselves, but I now know that's not the case. This experience has made me more understanding of others."

What's working well?

The positives of the pandemic response

The Job Keeper payments provided during COVID had positive impacts on the health and wellbeing of the women we talked to. Examples of the ways the increased payments had helped included being able to maintain a tenancy, to fund the move from supported accommodation to a housing unit and save for essential household items; to have choices and the comfort of knowing they could afford an occasional small treat – like a coffee out with friends. They reported that having choices and the ability to socialise were beneficial to their mental health.

While the isolation of the COVID lockdown was difficult for all the women interviewed, some of the women said it gave them more time to do things they know sustain their mental and physical health - like gardening, crafts, cooking and exercise.

"The lockdown has been good for my health. I have had time to rest and to get in the garden."

Social interaction

All participants spoke of the importance to their health and wellbeing of being able to spend time with family and friends. Women told us about a variety of social connections that sustained their emotional and mental wellbeing: arts activities, family connections, laughter, community and place were all highly valued.

Access to affordable group activities which enrich and/or improve physical and mental health and provide opportunities to connect with others and make friends was also seen as a key contributor to good health.

Gardening and outdoor space

The women placed a high value on access to green outdoor spaces. For some, gardening, and in particular the capacity to grow fresh vegetables, was important to their physical and mental health. Growing plants in the soil around a home was seen as a metaphor for putting down roots in a community.[5] Being able to walk on the beach or in the bush was vital, and fresh, clean air was valued.

Bulk billing

The women who lived close to services and had access to a bulk-billing doctor and medical procedures, identified these services as important in keeping them healthy. The increased bulk-billing during COVID was identified as having immediate benefits: it had enabled testing and treatment previously unaffordable. The government focus on health-related activities and maintaining health during COVID had also been beneficial.

"I used to put off going because I am working and had to pay for it. I don't earn a great deal. But now the doctor bulk bills me, I am more inclined to go when I am sick. Never used to, saved it up for when I had to go for medication."

5 A body of research has established the physical and mental health benefits of gardening and being in nature. See Soga M, Gaston KJ & Yamaura Y 2016, *Gardening is beneficial for health: A meta-analysis*, Science Direct.

What's not working well?

"Being in the land of uncertainty": the impact on mental health and general wellbeing

Women reported that the uncertainty of their housing situations was causing them high levels of stress and was impacting their mental health. Uncertainty was described as having the "biggest impact on my mental health" and of being a "driver of anxiety".

The women also reported that the uncertainty of their housing situations made it difficult to make longer-term plans to care for their health and wellbeing. It impacted on their ability to make plans for their lives. The women told us that uncertainty about where you will live, and when you will live there, made it impossible to make long term commitments such as study.

The women spoke of the effects of uncertainty, of not being able to see a way forward; a loss of confidence, of feeling overwhelmed, depressed, angry, without motivation and of dwelling on past events and past actions. Dwelling on the past, took them on a downward spiral of grief, trauma, regret and negative thinking which was detrimental to their mental health. It was something they wanted to stop, and tried hard to do but the necessity of meeting their most basic needs meant they had little energy left to change this behaviour. Isolation from family and friends made this more difficult and was magnified during the COVID lockdown.

"Fear it [my housing situation] could all change at any time."

The women told us that finding it hard to see a way forward and the feeling of constant struggle made it difficult to be motivated to look after their health and wellbeing. Women said their lack of motivation and depressed mood conspired against their best intentions to exercise or eat well, despite knowing it would help them feel better.

Women expressed a range of negative emotions linked to their shock at finding themselves homeless or at risk of homelessness. Some blamed themselves, even when they were aware their situation was due to circumstances beyond their control; some felt embarrassed by their situation and did not want to involve, or impose on, friends or family.

More than half of the older women interviewed currently lived with depression or described themselves as depressed. A majority had also experienced suicidal ideation.

Financial Insecurity

While the increase to Job Seeker and the Job Keeper payments helped a little in the short term, the women all knew this extra money would come to an end.

Financial insecurity was a constant source of concern for all the women we spoke with. All the women reported that their incomes were insufficient to adequately provide for all their basic needs and maintain or improve their health and wellbeing. Low incomes meant being unable to buy good quality, healthy food or to address their inadequate or inappropriate housing.

Housing costs were a major barrier to women's sense of stability and security. Women reported paying the bulk of their incomes on rent, 66% of income and above, and of drawing down on savings and superannuation. They were very aware they had few or no options for cheaper housing.

Most of the older women we interviewed work, and while some enjoyed this, others said that to stay housed they felt they had no option but to remain in jobs, despite the potential negative impact of working on their health.

Women also worried about their retirement incomes. The women we spoke to had very little superannuation to rely on in their retirement. Some had found it necessary to draw down on their superannuation to survive. Others had very little to begin with, due to time out of the paid workforce raising children. Women reported feeling anxious about being unable to pay housing costs on their retirement income.[6]

'Ageing in place': Homeowners in inadequate and inappropriate housing

Some of the older women interviewed had a mortgage or owned their own home, but they felt at risk of homelessness because their homes were not affordable, adequate or appropriate. These women felt they had no options but to try and remain in the house.

Women reported houses that were inaccessible due to age-related conditions, living conditions that were damaging their health, and houses that put them at risk of a fall.

"Lost my confidence, scared of falling again."

"I can't afford to sell it, pay it off and buy something else."

Women also reported living in inadequate accommodation without amenities such as running hot water or working toilets. Such inadequate living conditions became very taxing with age and ill health.

Service systems that overwhelm

The women reported that trying to secure a stable home is time-consuming, requiring determination and tenacity. All the women reported a sense of being 'overwhelmed' by the many tasks of securing a stable home.

The women who had experienced homelessness described their days as filled by appointments with service providers, health professionals and Centrelink, having to regularly repeat their story to different service providers and workers. For some this was re-traumatising.

"Dependent on services for basic needs so have to keep meeting their requirements. Fearful of not meeting them or missing something."

Centrelink was not viewed as a user-friendly, client-focused service. Women reported finding Centrelink overwhelming and frustrating; they described how filling out Centrelink forms was complicated and caused them distress.

"A letter from Centrelink will be enough to knock me sideways for a day or two. Worried about being able to follow through the steps and be confident with how I am responding and gathering information."

The feeling over being overwhelmed was at times so consuming it made them unable to act.

6 According to research from Industry Super Australia, on average women retire with just over half the superannuation savings of men – on current averages, with about $90,000 less than men. And 23% of women retire with no superannuation at all.

Poor access to technology

Women said that applying for support from government agencies often requires filling in and submitting online forms and uploading documents. This can be extremely difficult, even impossible to do if you only have a mobile phone. For women with a prepaid mobile and/or internet dongle, the expenses involved can be prohibitive. Women who are homelessness or living in transitional housing might not have access to a computer or printer - items often necessary when dealing with government agencies.

"There is an assumption you have access to all the technology. When you are homeless, you don't. So, you can't upload documents or print things out. Things people take for granted, you lose when you move into homelessness."

"There is no NBN in my unit [transitional housing], so had to go and buy portable WiFi which costs more... to be able to even access the web on the laptop."

Public transport

"Anywhere you go in Tassie you are dependent on having your own car, you have to drive there. There is a lack of accessible transport."

The accessibility of homes to services and public transport routes was important for older women especially as they began to limit their driving. The women said public transport is either not easily accessible where they live, or infrequent and unreliable. They said that when transport is unaffordable or involves too much effort, they became further socially isolated and unable to access services, including medical appointments.

"The effort to go to the doctor for minor things might stop me from going."

Pets

Women also said that having animals in their lives provided important companionship but finding a rental property when you have one is difficult.

"Having pets makes you vulnerable; you are not houseable."

What hasn't begun but needs to start?

Increased supply of affordable housing

All the women raised the need for more affordable, appropriate housing in Tasmania. They felt government needs to invest in more community and social housing projects, to ensure the health and wellbeing of its citizens.

The women also wanted the housing to be energy efficient; to reduce electricity bills and increase the comfort of occupants.

Adequate income support

Access to adequate income to maintain a home, feed and clothe oneself, access to health care and health promotion activities, the ability to create and socialise, were all described by the women as being vitally important for health and wellbeing. Lack of money can mean being forced to choose between going to the doctors or paying the rent. Ways forward suggested included increasing government income support permanently, to COVID levels or higher or introducing universal basic income.

"An adequate income gives you real choices."

Affordable health promotion activities

All the women talked about wanting to participate in activities to improve their physical and/or mental health. They wanted to eat healthier foods, to get moving and to exercise.

The women also discussed wanting to increase their social circle and friends, as something they would like to begin to improve their well-being.

They felt there is a need for more free or affordable health promotion activities in their local areas and suggested what is available could be better advertised. The women we talked to who had stabilised their housing had taken the opportunity to participate in these kinds of programs.

"I would like to join a social walking group, something locally. There is not much locally."

Access to bulk billed primary health care

The women we spoke with felt they benefitted from the increase in bulk billed services and the government focus on health and wellbeing during COVID. They wished to see continued access to bulk-billed appointments, tests and treatments maintained. Having access to affordable, or free, allied health professionals like physiotherapy and massage was also mentioned by the women.

Women also said that the current number of sessions allowed annually on a chronic or mental health plan is often insufficient and may only allow for one issue to be addressed when there can be multiple.

Conclusion

When we began this project, we organised two separate conversations: one was with women with direct experiences of homelessness, the other was with women who were older and were experiencing it for the first time. In the process we talked to women who did and didn't meet the stereotypes of homelessness, and who were the first to point this out. We thought the women would have quite different stories, but we were struck by how much they had in common. All the women talked about the mental load of being homeless, or of fearing becoming homeless soon; a heavy weight of anxiety, powerlessness and vulnerability to other people's judgements and decision making. They talked about the trauma of being homeless when you had responsibility for children. They told us about the shame, stigma and fear that accompanied being homeless. They talked about the pressure the support system of NGOs and Government agencies put them under, forcing them to engage in the days and weeks of 'busy work' of looking at rental properties they could not afford and would never be given the opportunity to rent. They talked about the devastating impact on their physical and mental health of not having a home.

The women all wanted the same things – a community which supported its people when they experienced hardship, in which people had access to homes, decent food, services and an adequate income. And they were willing to play their part to see this happen. One of the universal things we heard from them was that they wanted their story to make a difference to the experience of others who were experiencing homelessness.

Homelessness is a health issue and its greatest toll is on mental health. We want to acknowledge the bravery and resilience of the women we spoke to.

We can change the situation in lutruwita/Tasmania and we owe it to our communities to do it.

Appendix

Our data

Many of the statistics in this section draw from the 2019-20 report of the Specialist Homelessness Services Collection (SHSC): an Australia data set provided by homelessness services in every state and territory. SHSC data includes clients who are at risk of homelessness and those currently experiencing homelessness. This data provides us with a measure of service response. It does not necessarily provide information about how many people are experiencing homelessness/at risk of homelessness in Australia, but it does tell us about who is seeking support because of housing and homelessness.

We also draw on data from the 2016 Australian Bureau of Statistics data from the Australian Census. The next Australian Census will happen in August 2021. The true extent of homelessness is difficult to determine and ABS data and SHS data are not directly comparable.

What is homelessness?

It is hard to know the true extent of homelessness,[i] and women's homelessness can be 'invisible' to the broader community.[ii]

Mackenzie and Chamberlain's (1992) definition of homelessness includes three categories in recognition of the diversity of the experience:

- **Primary homelessness** is experienced by people without conventional accommodation (e.g. sleeping rough or in improvised dwellings, including tents).
- **Secondary homelessness** is experienced by people who frequently move from one temporary shelter to another (e.g. emergency accommodation, youth refuge/shelter, "couch-surfing").
- **Tertiary homelessness** is experienced by people staying in accommodation that falls below minimum community standards (e.g. boarding houses and caravan parks)."[iii]

Being at risk of homelessness is considered by Specialist Homelessness Services (SHS) as when a person is at "risk of losing their accommodation or they are experiencing one or more of a range of factors or triggers that can contribute to homelessness."[iv] This includes situations where there is rent is unaffordable, financial crisis, overcrowding and family and domestic violence.[v]

Homelessness in Australia

In the 2016 National Census 116,427 people identified as being homeless on census night.[vi] 58% of these people identified as male and 42% as female.[vii]

2019-2020 data shows that 290,462 people presented to homelessness services for support.[viii] This was an overall increase of the numbers of people presenting to homelessness services in the 2014-15 period (279,196 people).[ix] However the rate of homelessness per 10,000 people has decreased over time.[x]

People living in severely overcrowded dwellings make up 44% of the homeless population.[xi] 18% are living in specialist homelessness supported accommodation and 7% are identified as sleeping rough.[xii]

Homelessness in Tasmania

The 2016 census shows that the total number of people experiencing homelessness in Tasmania was 1,622 (up from 1,145 people in 2006 and 1,537 people in 2011). Tasmania has the third highest rate of SHS clients (after the Northern Territory and Victoria).[xiii]

This 2016 data shows that most of the State's homelessness is concentrated in the Hobart region and South East (57% of people), while Launceston and the North East accounted for 23% and the West and North West coast 20%.[xiv]

SHS data shows that in Tasmania one in 83 people received homelessness assistance, higher than the national rate of one in 87 people. The Tasmanian SHS data[xv] shows that the most common reasons for Tasmanians to seek assistance were:

- housing crisis (50%, compared with 34% nationally)
- financial difficulties (45%, compared with 41% nationally)
- housing affordability stress (44% compared with 29% nationally).

Tasmanian housing experts point out that a major cause of homelessness, and obstacle to a way out of it, is the chronic shortage of affordable rental housing in this state.[xvi]

Gender and homelessness

National data from the 2019-2020 period shows that 60% of those seeking assistance from SHS were women.[xvii] This equates to "1 in 73 females in the Australian population [receiving] support in 2019–20 compared with 1 in 109 males."[xviii] Among the adults seeking assistance, the biggest group were people aged 25 to 35 years old: almost 1 in 5 clients (18%).[xix] The majority of this age group were women.[xx]

In Tasmania, in the 2019-2020 period 56% of SHS clients were women.[xxi] Nearly a third of all people seeking support in Tasmania had experienced family or domestic violence and the majority of adults experiencing family violence were women.[xxii]

Given the differences between ABS data and SHS data around gender, it is difficult to know with certainty what the gender differences are amongst Australian and Tasmanian people experiencing homelessness.[xxiii] What we do know is that domestic and family violence is a leading cause of homelessness for women and children[xxiv] and that women experienced greater economic disadvantage than men.[xxv] As a consequence the Australian Human Rights Commission has warned:

"In the context of a shortage of affordable housing, an ageing population, declining home ownership levels, and continued and accumulative economic disadvantage experienced by women, the number of women experiencing and at risk of homelessness is expected to continue to increase."[xxvi]

Homelessness and health

Homelessness is a health issue. Experiencing homelessness has impacts on physical health, mental health and the ability to access health care. Women experiencing, or are at risk of, homelessness have poorer outcomes across a variety of areas, including physical and mental health, emotional wellbeing, relationships, nutritional consequences, employment outcomes and long-term economic well-being.[xxvii]

Health issues can also contribute to people becoming at risk of or experiencing homelessness.[xxviii] Around 1 in 10 (11%) SHS clients presenting as homeless identified medical issues as a reason for seeking assistance.[xxix] For example, a health issue that means someone is unable to undertake work or access work that is sufficiently secure and well paid[xxx]

People with at least one experience of homelessness are more likely to also report a health condition or disability.[xxxi] People who have experienced homelessness are more likely to report having "a mental health condition or a long-term health condition, with depression, back pain or back problems, anxiety and asthma the most commonly reported long-term conditions."[xxxii]

Homelessness also makes it difficult to address pre-existing health problems.[xxxiii] People who've experienced homelessness are more likely to report finding barriers to accessing health care (13% of those who had experienced homelessness compared with 4.4% of those who had not experienced homelessness).[xxxiv] Such barriers include "financial hardship; lack of transportation to medical facilities; lack of identification or Medicare Card; and difficulty maintaining appointments or treatment regimes."[xxxv] The fear of stigma and discrimination in health settings may also stop people from accessing primary health services.[xxxvi]

The kind of homelessness that someone experiences will have different health impacts. For example, rough sleeping is often associated with impacts such as poor nutrition and a greater likelihood of encountering violence.[xxxvii]

Overcrowding is the most prevalent kind of homelessness in Australia.[xxxviii] Overcrowding can mean more pressure on communal amenities such as kitchens, toilets, bathrooms and sewage systems. Overcrowding can also mean that infectious diseases can affect everyone in the house and be unpleasant and stressful places to live.[xxxix]

International research suggests that people who experience homelessness have shorter lifespans than those who do not experience homelessness[xl]

Homelessness and mental health

30% of SHS clients in Australia reported a current mental health issue.[xli] Women were more likely than men to report a current mental health issue (61% of women).[xlii]

Over half (51%) of Tasmanian SHS clients report a current mental health issue.[xliii] Tasmania has the highest rate of SHS clients reporting a current mental health issue of all the states and territories: 61 people per 10 000.[xliv]

Severe and complex mental health issues can contribute to becoming and staying homeless in the long term.[xlv] Research has found higher rates than the general population of alcohol and drug dependence disorders, severe psychiatric illnesses and major depression in people experiencing homelessness.[xlvi] Other research has highlighted the prevalence of trauma in the lives of people experiencing homelessness and a correlation with mental health conditions.[xlvii]

Homelessness, family violence and health

A leading cause of homelessness for women in Australia is family violence.[xlviii] In the 2019-20 SHS data set, domestic or family violence was the main reason for seeking assistance for almost 1 in 3 clients.[xlix] Domestic and family violence affected 9 out of 10 women who were 18 years and over.[l] Half (51%) of all younger SHS clients (aged under 18) had experienced family and domestic violence.[li]

There are direct health consequences of experiencing family and domestic violence. Violence can mean women experience physical injuries, permanent disability[lii] and violence and control can result in trauma and other impacts on mental health.[liii] There can also be factors that limit women's financial resources to take care of their health such as being subject to financial control or abuse.

For women who are leaving violent situations a lack of affordable housing options creates a significant barrier.[liv] Income inequality, the cost of living and the low rate of government income support payments bring additional barriers to stable housing and meeting health needs.[lv]

Women who have experienced family violence can also face discrimination in the private rental market because of perceptions and stigma around family violence.[lvi]

COVID-19 and homelessness

The COVID-19 pandemic shone a light on the relationship between housing and health. March 2020 saw Australian borders close, social distancing requirements begin and the closure of 'non-essential services'.[lvii] Against this backdrop, governments implemented interventions for people experiencing homelessness.[lviii] The Tasmanian state government introduced a Housing and Homelessness Support Package to assist people in housing stress and at risk of homelessness in response to COVID-19.[lix]

This intervention included uncapped brokerage funds which meant those without somewhere to stay could be accommodated in hotels, hostels and caravan parks. It also gave funding for 'Safe Spaces'. These 24/7 services are run in Hobart and Launceston by Hobart City Mission and in Burnie by Salvation Army. They provide a safe place for those without accommodation to stay, sleep and access essential services.

Other health interventions at this time, such as bulkbilled telehealth appointments meant that people could access a GP for free if they had a phone or access to video conferencing.

The addition of a Coronavirus Supplement payment of $550 per fortnight to some Centrelink payments effectively doubled the JobSeeker payment. The Supplement made a significant difference to housing stress and poverty.[lx] The original $550 supplement resulted in a decrease in the numbers of Australians living in poverty by 32%.[lxi] The supplement had a particular impact on single parents on JobSeeker payments. Prior to COVID 20.2% percent of single parent families fall below the poverty line. With the advent of the $550 stimulus this dropped to 7.6%.[lxii]

In terms of housing stress, the increase in JobSeeker payments by $550 had a "demonstrable positive impact on the Australian population."[lxiii] However, the Australian Government has reduced the supplement to $250 and it has dropped to $150 as of December 2020.

This is significant because poverty and housing affordability are key reasons why people are at risk of homelessness and poorer health outcomes.

'The hidden homeless': women over 55 years of age

In Australia, women over 55 years of age are the fastest-growing group of people vulnerable to homelessness.[lxiv] The 2016 Census estimated 6866 older Australian women were homeless and a further 5820 were living in marginal housing and may be at risk of homelessness.[lxv] There had been a 30% rise in numbers of older women in Australia experiencing, or at risk of homelessness, in just five years.[lxvi] In Tasmania, 115 women 55+ were estimated as homeless on census night and 43% of them were temporarily staying with friends. It is acknowledged that given the hidden nature of older women's homelessness the figures obtainable may not represent the full extent of the issue.[lxvii]

Older women are more likely than men to experience, or be at risk of, homelessness for the first time later in life.[lxviii] Risk factors for homelessness for them include relationship breakdown, death of a partner, loss of income, ill health, rent increase, eviction notice, trauma, abuse and/or substance addiction. Other risk factors include ethnicity, reluctance to seek formal support, social isolation and/or providing housing to family.[lxix]

These risk factors are exacerbated by financial disadvantage flowing from inequality in superannuation, job security and wages, and caregiving expectations.[lxx] At retirement superannuation is on average $157,050 for women compared to $270,710 for men:[lxxi] Further, superannuation is only mentioned as the main income source for 10% of retiring women in comparison to 25% of men.[lxxii]

Anglicare's Rental Affordability Snapshot (outlining the percentage of available housing for different cohorts) reveals the low and declining amount of rental housing affordable for older single women. In 2018 less than 2% of rental housing was affordable and appropriate for a single person on an Age Pension[lxxiii]. In 2020 it is less than 1%.[lxxiv] Jobseeker payments are lower. Even with the COVID supplements older single women on Jobseeker would have access to less than 1% of the housing stock. When these were cut on 1st December 2020, 0% of the housing stock was affordable.[lxxv]

Homelessness services do not always respond appropriately to older women experiencing homelessness for the first time in later life. Women may not relate to the word 'homeless' - particularly if they are living in a caravan, a car, inadequate housing or with family or friends. The may not feel comfortable to seek help or even know where to begin to find it.[lxxvi]

Some people are more at risk

Across Australia, Aboriginal and Torres Strait Islander people are disproportionately represented - across all age groups and genders - among the populations of people experiencing, or at risk of, homelessness. This is particularly the case in remote areas, where they often live in severely overcrowded dwellings.[lxxvii]

Another group likely to be over-represented in the numbers of people experiencing, or at risk of, homelessness is LGBTIQ+ people - due to both the complexity of their experiences and difficulty accessing services.[lxxviii] Older LGBTIQ+ people may refrain from revealing their queer identity when accessing services, due to fears of discrimination and/or abuse.[lxxix]

The risk factors for homelessness are also more prevalent among women who live with a disability.[lxxx] The issues listed here: additional costs of living with a disability – medications, physical aids and home modifications; discrimination; safety/location; deinstitutionalisation and lack of accurate data further compound the risk of homelessness for women living with a disability.[lxxxi]

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