T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into the Redevelopment of Melbourne's Public Housing Towers

Melbourne – Tuesday 5 August 2025

MEMBERS

Joe McCracken – Chair
Michael Galea – Deputy Chair
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Anasina Gray-Barberio
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WITNESSES

Delaram Ansari, Research, Advocacy and Policy Manager, and

Arundhathi Lekshmi, Research, Advocacy and Policy Officer, Multicultural Centre for Women's Health.

The CHAIR: Welcome back to the next session of Legal and Social Issues Committee inquiry into the redevelopment of public housing towers. I am Joe McCracken, Chair of the inquiry, and we are going to go around and introduce the rest of the members of the committee.

Anasina GRAY-BARBERIO: Good afternoon. Anasina Gray-Barberio, Northern Metro.

Aiv PUGLIELLI: Hi, Aiv Puglielli, Member for North-Eastern Metro.

Rachel PAYNE: I am Rachel Payne, from South-Eastern Metropolitan Region.

Ryan BATCHELOR: Ryan Batchelor, from the Southern Metropolitan Region.

The CHAIR: And online we have –

Michael GALEA: Michael, from the South-Eastern Metropolitan region.

The CHAIR: Thanks very much. All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information you provide during the hearing is protected by law. You are protected against any action for what you say during the hearing, but if you go elsewhere and say the same thing, you will not be protected by that same privilege.

Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament, and all evidence is being recorded. You will be provided with a proof version of the transcript. That transcript will ultimately be made public and put on the website. Just for the Hansard record, can you just say your name and any organisation that you are appearing on behalf of, please?

Arundhathi LEKSHMI: Yes, sure. I am Arundhathi Lekshmi. I am a Research, Advocacy and Policy Officer with the Multicultural Centre for Women's Health.

Delaram ANSARI: I am Delaram Ansari, and I am the Research, Advocacy and Policy Manager at the Multicultural Centre for Women's Health.

The CHAIR: Perfect. Thanks so much. Now, we have got about 5 minutes for a bit of an opening statement, so I will hand it over to you guys, and then we will go to questions.

Arundhathi LEKSHMI: Brilliant. Thanks so much to the committee for the invitation as well. To introduce us, the Multicultural Centre for Women's Health is a Victorian-based national organisation led by and for migrant and refugee women and gender-diverse people to advocate for the health, wellbeing, safety and leadership of migrant and refugee women. More specifically, for over 47 years we have been providing health education to migrant and refugee women in their language, including directly to residents in Melbourne's public housing towers during the 2020 COVID-19 lockdowns.

During the lockdowns many residents were left afraid and concerned because they lacked access to timely and evidence-based information on how they could stay safe from COVID-19. This was made worse by being locked inside their homes without notice and with little information other than that a dangerous virus was spreading around them. MCWH responded by providing health education directly to residents in their own languages over the phone, and we had over 900 conversations. Through this we got to know residents. Many were older women who did not speak English, many were mothers who had young children and many had multiple health conditions and were impacted by the trauma of war and displacement.

We know that 55 per cent of public housing residents are women, and almost half of all migrants in public housing are refugees on humanitarian visas. Twenty-eight per cent of residents are over 60. Twenty per cent require assistance with core activities, and 34 per cent speak a language other than English in the home. With

this in mind, we also know that being forced out of your home when you are older, have a disability, have multiple health conditions and do not speak English can have prolonged and sometimes generational, physical and mental health impacts. For some it means losing access to trusted health providers and care services that are close by and accessible by public transport. It means losing neighbours who might have helped you get your medication, book your appointments and do daily activities. It means being reminded of painful episodes of war and displacement. It means leaving behind a community of people who speak your language, who share your settlement experiences and make you feel that you belong. When health appointments are harder to get to, medication and care are harder to access and loneliness, isolation and trauma concentrate, lives are risked.

We know that for some migrant and refugee mothers, inappropriate relocation away from the towers, far from support networks, schools and services, has already occurred. For example, one migrant mother shared with the ABC that she spent almost 4 hours a day getting her kids to and from school after being temporarily relocated to Werribee from the Flemington flats. She told the ABC, 'I see myself one day maybe collapsing on the road. Physically it is draining my whole body.' MCWH fears that under the proposed demolition plan outcomes like this may be repeated.

Displacement also impacts migrant and refugee families who rely on the networks of care fostered within the towers. One former resident shared with MCWH her experience of growing up in the Flemington flats. She said, 'When my mum ran errands, she would take us to the neighbour's home to babysit us. We would play until Mum got back, and all the other kids would join. You feel safe and secure because everyone looks after each other.' For many mothers, losing access to care networks and moving far from schools, services and employment centres means losing the possibility of ever balancing caring for children with paid work. For women, lack of access to financial independence and secure and suitable housing are well-known factors that increase vulnerability to violence. The possibility of these outcomes should be antithetical to any government efforts to improve access to housing.

In conclusion, MCWH believes that this plan would not have gone ahead if the health and wellbeing impacts of the plan on migrant and refugee women and their communities had been properly considered. Therefore, we firstly strongly recommend the plan to demolish the towers be reconsidered in favour of strategies that minimise the possibility of long-term displacement of residents. Secondly, we urge the committee to recommend that the net stock of public housing in Victoria is increased more generally, not decreased even temporarily. Public housing plays an important protective role for migrant and refugee women against exposure to discrimination and disadvantage in the private housing market, which itself has significant health impacts. Thirdly and finally, for any future plans for the towers we recommend that residents are meaningfully consulted about the impact of any plan on their health and lives, in their language, in person and with plenty of time for engagement. We know that this is possible because at MCWH we have been able to directly engage with hundreds of migrant and refugee women in the towers in their language, even in the challenging circumstances of COVID-19. This is because we employ bilingual health educators who speak the same languages and come from the same communities as women who live in the towers, and we encourage the use of this model in the future. Thank you.

The CHAIR: Thank you very much. I will start off, and then we will just go through the committee. I do not have too many questions other than: you have obviously done a lot of work in supporting those residents that are trying to navigate this process and what it means for them in terms of consultation, and as you say, it is in language. What are you finding is the feedback from them?

Arundhathi LEKSHMI: We have not consulted with residents directly about this particular plan, so we can only speak to their experience during the 2020 lockdowns, when we were engaged specifically to give health education to them. We cannot say exactly how they feel about the plan. Again, that consultation has not actually occurred, but what we can say is we know that they have compounded issues that mean this plan will have very, very significant health impacts. And when I say 28 per cent need help with daily activities and 20 per cent are over 60, it is often the same people. The same people have these vulnerabilities, and they are highly concentrated. I am sure everyone knows that moving house is very stressful, but it could actually have long-term health impacts for them, and it can lead to a reduction of their lifespan.

Delaram ANSARI: Can I just also add that one of our key concerns, as Arundhathi mentioned, is that that consultation that results in the answers you were after has not happened meaningfully, and everyone has not been provided equal opportunity to provide their opinion and voices, even though we know the residents are

very much in favour of actually having their voices heard. I feel like that has not really been provided adequately.

The CHAIR: Okay. Fair enough. That is all I really wanted to know, so I am going to pass it on to Mr Galea.

Michael GALEA: Thank you, Chair. Thank you both very much for joining us. Just at the outset, I am conscious of not asking you to go into things that you are not comfortable with. Did you say that you have not spoken to any of the residents in relation to the plan? Okay, cool. I will refocus then to more general things. To be designing new forms of social housing, what things should Homes Victoria and the committee be very mindful of so that we can best respond to the needs of women, especially women in vulnerable situations – and obviously services are hugely important – so that the actual infrastructure of the buildings is not leading to an unsafe environment for people?

Arundhathi LEKSHMI: That is an excellent question. For us, we think consulting with residents is one of the best ways to find that out. But on top of that, like we said, we need housing to be close to services, close to employment opportunities and close to education, because the combined stress of those things being separated creates a vulnerability for women not only in terms of their safety but in terms of their general wellbeing and the wellbeing of their children, which can have generational impacts. That would be the first thing that we would say: it is important that people are located close to services. We already see in Victoria that more and more migrant and refugee women are forced to the margins and forced to the outer suburbs where they have less and less access to these kinds of services and employment opportunities. That is exacerbating the health inequity that they already face. We know that particularly with family violence services, early intervention services and response services, there are not many in these outer suburbs, and that includes the sexual and reproductive health services that we know are extremely vital for the health and wellbeing of migrant and refugee women.

Delaram ANSARI: Can I also add that whilst we do not have adequate consultations yet with the community, we have evidence about what some of the impacts of relocation and isolation will be from this plan. In 2023 the Victorian government funded MCWH to conduct research on the mental health and wellbeing of migrant and refugee women. That funding was a result of the mental health reform that is currently happening in Victoria. One of the things we found was that migrant and refugee women told us that isolation and a lack of belonging to community, or limits to belonging to community, is one of the main factors for their poor mental health and wellbeing. Now, whilst the consultation has not happened, we know that one of the impacts of this relocation is isolation from their networks and their communities. We are deeply concerned that whilst we are in the middle of a crisis with our mental health in this nation and this state, this is only going to contribute to poorer mental health for migrant and refugee women.

The CHAIR: Okay. I am sorry, Mr Galea, your time is up, I am afraid. I am going to hand it over to Ms Gray-Barberio.

Anasina GRAY-BARBERIO: Thank you, Chair. I just want to repeat what you started with: 55 per cent of public housing residents are women. The Multicultural Centre for Women's Health's service is to provide health supports to migrant and refugee women. We have also had a lot of witnesses appear before the committee who are from migrant and refugee backgrounds – some that have rights here but also a lot that are on humanitarian visas and partner visas. I just want to ask you – your submission notes that migrant and refugee women experience discrimination in the private market. Do you see this also happening in community housing?

Arundhathi LEKSHMI: Yes, to keep it short. We know that there is some evidence already that community housing residents and applicants have said they have had experiences of discrimination. I think particularly aged residents have said that. We do not have a lot of research into this area, which is an issue in and of itself, but just comparing the structures of community housing and public housing, public housing has many benefits because it is managed and owned by the government, which gives public housing providers the sort of flexibility to be adaptable to communities that might not fit existing public housing stock. Particularly, I think a lot of people have given evidence already about people with disabilities having the right to have modifications to homes under public housing and how they might not have that right in community housing. But for migrant and refugee families, they may have intergenerational families and may have more children

than one or two. Generally what we find is that community housing is more suitable for much smaller families. In public housing they have more ability to ask for those modifications. I know that homes already in the towers have had two units combined for larger families, and they just will not have access to that in the community housing sector. That is not to mention all of the openings to discrimination.

Also, a lot of people have said how this plan and the move towards community housing sort of signals a move towards privatisation-like approaches. We know that in privatisation-like approaches, people who are already disadvantaged tend to become more disadvantaged by these issues. For example, community housing providers rely on the income of residents. We know that migrant and refugee women, even if they have access to the same sort of benefits, tend to have a lower income because of discrimination in the housing market. But also, for example, for older migrant and refugee women there is a five- to 10-year waiting period before they get access to the pension, so for many of them, they may not have any access to social security; they may only have rental assistance. I think we have already heard from people in this very inquiry that rental assistance itself, just on its own, is not even enough for some of these community housing providers to continue to provide services. It is not specifically direct racial discrimination, but it has a discriminatory impact by the way that the community housing is structured.

Anasina GRAY-BARBERIO: Great. Thank you. I have run out of time.

The CHAIR: I will hand over to Mr Batchelor.

Ryan BATCHELOR: Thanks, Chair, and thanks, both of you, for coming in. You said at the start you have not spoken to anyone about the tower redevelopment plans, but more broadly in the engagement you have done previously with public housing residents who might be living in any of the towers, what are some of the issues with the state of the current buildings that have been raised with you? We have certainly had evidence from people who, whatever their views on the redevelopments might be, have expressed some concerns about conditions in the current set-up. I was wondering if you had any evidence of that that you could give to the committee.

Arundhathi LEKSHMI: Our major engagement with residents in the community housing towers was during COVID-19, so we mostly heard from them that the greatest impact was not being informed while they were living within the towers, so it was not conditions necessarily about the structure but the way they were being treated by Homes Victoria and the health department. I think that issue is replicated in this plan. There is a lack of information. There is a climate of fear that is emerging that has really detrimental mental and physical health impacts. I do not think that can be understated. So given that that was the major way that we engaged with community housing residents, I think for some of them it was the mental health impacts of the isolation within the towers, and we assume that this might be replicated in this climate of fear. It was so significant.

Ryan BATCHELOR: You said the mental health. You are talking about the mental health impacts –

Arundhathi LEKSHMI: Of the lockdowns.

Ryan BATCHELOR: The lockdowns, right. Sorry.

Arundhathi LEKSHMI: Of the lockdowns – that kind of isolation and fear is incredibly profound. Some people were on the phone with residents for 30 minutes to an hour to 2 hours just because residents were so afraid during this period.

Ryan BATCHELOR: And do you have evidence that that is happening now?

Arundhathi LEKSHMI: No, we do not. We do not have any direct engagement with public housing residents at the moment, and we have not been engaged for any consultation with them.

Delaram ANSARI: One of the key concerns that we have is that there is evidence that some of these towers probably need some upgrades and there are issues within them – and that is something we have heard just through news outlets and hearing other witnesses in the previous days that provided evidence – but for us, one thing that is not clear is any evidence or evaluation that these towers are beyond the point that they are livable. We just have not seen any evidence to suggest that retrofitting does not work, and we heard from experts in the previous session that they also would like to have some evaluation or robust evidence to suggest whether

retrofitting works or not. I think that is very troubling for us – that we are resorting to displacement and demolition without that clear evidence. For our community we find that deeply concerning, particularly because they have the history of displacement and trauma – of displacement and being refugees – so that is an extra trauma that is not being considered.

Ryan BATCHELOR: My time is up.

The CHAIR: I will now hand over to Ms Payne.

Rachel PAYNE: Thank you, Chair, and thank you to you both for your submission and presenting before us today. Most of the questions that I had for you you have essentially answered in your opening statements or in responding to questions that have already been heard. But I would like to go back to your submission: you highlight the unique impact displacement would have on migrant and refugee women and, in particular, accessing support services. I just want to know if we could delve a little bit more into those concerns around women's health and safety.

Delaram ANSARI: Yes, absolutely. One of the key concerns we have and that we have already touched on is the fact that for migrant and refugee women, they already have limited or lower access to services that are timely, culturally responsive and in language, particularly when we discuss services like family violence or safety services. So when they are pushed to the margins and they are in locations that already do not have those services, that makes this accessibility and availability even harder for them.

One of our concerns right now is that that lack of access for migrant and refugee women will lead to them not being able to access the services they need in a timely manner. The other addition to that is that, again, mentioning that isolation has that mental health impact, but it also is a tool that perpetrators often use. Isolating them from their networks and their community can have an impact on their experiences of violence or prolong the impact of violence. On the other side of things, unstable housing can lead to financial hardship, and we know within that, that exacerbates or contributes to experiences of violence. It is not the cause of violence, but it exacerbates violence, and that is one of the number one factors for homelessness for women. That is how we see this vicious cycle of violence play out when there are not adequate consultations and social planning.

Rachel PAYNE: Thank you. Thank you for today. Thanks, Chair.

The CHAIR: Thank you very much. Mr Puglielli.

Aiv PUGLIELLI: Thank you, Chair. Just to follow on from my colleagues' questioning earlier, if we are seeing migrant and refugee women in the community experience discrimination not only in the private market but in the community housing sector, what happens to them if public housing, in the government's current approach, is effectively replaced by community housing – where do they live?

Arundhathi LEKSHMI: That is an excellent question. Well, assuming they can even get access to community housing is still tenuous. The pathways to accessing community housing are sometimes not particularly open for migrant and refugee women. Application processes are often in English or they are through particular social work pathways that new arrivals especially may not even know exist. What we do know is that many migrant and refugee women who are forced into the private market experience lower quality housing, often housing that is not legal – they cannot go to VCAT, they do not have the kind of rights that come with a legal rental – and they are often provided with housing that, because of that, has health defects like mould or unstable foundations basically. One academic, Anna Ziersch, has quite a bit of evidence on the impact of unsafe housing and specifically substandard housing on refugee families, particularly in the private market. The impact of it is not just the structural housing, but the impact of discrimination, of being continually knocked back from being offered essentially a safe place to stay, is particularly intense for refugee families. Like my colleague said, they have already experienced significant displacement from where they have come from, and experiencing this sort of continual rejection has a very significant mental health impact.

Aiv PUGLIELLI: Thank you. We heard earlier today in testimony that the department's relocation policies are only available in English – that it was what we heard this morning. Do you believe that women from CALD backgrounds have been afforded appropriate access to information to then in turn make informed decisions around relocation? Have we effectively, through this testimony, seen that they have been put at a disadvantage

through lack of provision of information compared to other residents who, for example, speak English as a first language?

Arundhathi LEKSHMI: It would be interesting to look at evidence about who was left in the towers and what is the demographic make-up of who has stayed. I know that evidence was given earlier about how people who took earlier deals were given more favourable conditions to live in, and for migrant and refugee women, if they have not been offered opportunities to consult in language, especially if English is not their first language and they struggle with English, this can certainly have discriminatory effects. Maybe they even want to be relocated, but they have not been given the opportunity to engage in that proactively. We take a sort of maximalist approach to consultation. We think it is possible. Australian society is multicultural and diverse, and many people in the community have the skills to do consultation in language with residents and to engage with residents in language, so regardless of what the plans are, we would 100 per cent recommend that.

Delaram ANSARI: Can I just add to that point that with consultations it is important they be done in a way that that power imbalance is not there or at least is minimised. We have heard from people who have only been consulted through someone who holds relatively significant power, and within that it is very difficult to provide a response that is consensual and non-coercive. So it is really important for us to make sure that consultation is in language, is accessible, is equitable but is also balanced. That is really important for true, meaningful consultation.

Aiv PUGLIELLI: Well said. Thank you. That is my time.

The CHAIR: That brings this session to a close. I want to thank you both for appearing today. I appreciate it. You will get a copy of the transcript if you need to make any minor changes. Thank you from us, and enjoy the rest of your day.

Witnesses withdrew.