

parity

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The Frontline Response to Health and Homelessness



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Parity

Australia's national homelessness publication

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Each issue of Parity has a central focus or theme. However, prospective contributors should not feel restricted by this as Parity seeks to discuss the whole range of issues connected with homelessness and the provision of housing and services to people experiencing homelessness. Where necessary, contributions will be edited. Where possible this will be done in consultation with the contributor. Contributions can be emailed to parity@chp.org.au in Microsoft Word or rtf format. If this option is not possible, contributions can be mailed to CHP at the above address.

The 2020 Parity Publications Schedule

April: Annual Youth Homelessness edition
May: Mental Health, Housing and Homelessness
June: Reforming Private Rental
July: Meeting the Needs of Homeless Veterans
August: Supporting and Sustaining Tenancies in Community Housing
September: Implementing the Royal Commission into Domestic and Family Violence
October: Homelessness Among Older Women
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Foreword

Toby Hall, CEO, St Vincent's Health Australia



This edition of *Parity* brings together a wonderful collection of innovative approaches to addressing the health needs of those who are homeless from across Australia. It highlights the deeply held commitment from many across the health, housing and community sectors to making a difference in the lives of people on the wrong side of Australia's housing crisis.

Many of these examples emphasise the need for flexibility in model design and service delivery. Services must prioritise the needs of the person and put them above any program defined by a funding rulebook. Following this

key principle, and ensuring that what we develop and deliver is guided by the person we are caring for, will produce the most positive outcomes for those who are homeless.

Another common thread you will find throughout this edition is the beautiful message of hope. Many articles highlight the voice of those receiving services and the way they have felt truly cared for, respected, and made to feel like family. Despite our society's increased connection through social media, many people are increasingly feeling isolated and alone. Our response as service providers in reconnecting people with their local community — to improve health and wellbeing — is more important than ever.

St Vincent's Health Australia is pleased to sponsor this edition of *Parity* and would like to take this opportunity to acknowledge all the amazing work done by homeless health services and workers across the health, housing and community sectors. The combination and diversity of responses from hospitals and community-based services contributes to addressing

the complex needs of people who find themselves homeless.

St Vincent's believes affordable and safe housing is fundamental to good health. If we are serious about improving the health of our communities, we need to continue to look for ways to increase housing, particularly for people who are in unsafe or insecure accommodation and those who are homeless.

We hope the stories, not only of survival but of thriving, found in these articles will inspire other service providers to advocate and innovate in ways that better provide access to health services for people who are homeless. We are also optimistic that their creativity, innovation and hope will encourage governments, philanthropists, and investors to consider their roles in ensuring no one exits from hospital, prison, or out of home care into an unsafe environment.

I hope you enjoy the inspiration captured in these pages as much as I have, and that they encourage you in your future efforts to end homelessness.

Cover art: artist, Conrad Clark

I was born in 1941 in Newcastle-on-Tyne and come from a family of musicians. I started life as a painter at a very early age and with the support of a wonderful art teacher I went on to art school in 1960's London. Later, I became disillusioned with painting I turned to furniture making and sculpture. I love inventing and making things in wood, stone and metal and have been constructing and carving large and dramatic works over many years which have powerful humanistic themes. I emigrated to Sydney Australia in 1986.

I was a TAFE teacher in New South Wales and while there collaborated on several projects with landscape architects.

Since relocating to Melbourne, I have been involved in several community arts projects such as stone carvings of native animals for the post-fire Child Care Centre at Kinglake, *Stone carving for Refugees and Asylum Seekers*, funded by the Salvos and more recently Artist in residence at CERES, carving a tree trunk into a giant worm!!!

My current exhibition *Urban Global* is at the St Vincent's Hospital gallery. In this group of paintings, I have reverted to my pre-art school, teenage style,

moving away from the more formalistic tendencies of contemporary art.

This exhibition shows various aspects and images that have both excited and terrified over me the last few years. The portfolio of life that confronts us all every day is both inspiring and despairing. How to process these shocking contrasts? In the last few years I have attempted to compress my emotions and ideas into compact sculptures in timber and other materials, part realism and partly in my own symbolic language. Now I am using my paintings to the same effect. conradclark.com.au — public art, sculpture, interior design

Editorial

Jenny Smith, Chief Executive Officer, Council to Homeless Persons



Chapter 1: At the Frontline

Sam's Journey Through St Vincent's and the Sister Francesca Healy Cottage

Andrew Chan, Manager of the Sister Francesca Healy Cottage

Sam is 50 years old and was brought up in Melbourne's northeastern suburbs to Italian-born parents, who were hard workers but Sam's father used to drink a lot. Unfortunately, Sam — along with his younger siblings — used to bear the brunt of his father's drinking.

'Every night we would all wait for him to go to sleep and then we were OK,' said Sam.

Led by his father's example, Sam began drinking alcohol and then smoking marijuana when he was 14. *'At that age it was fun. But as I got older, life got harder. And the more isolated and depressed I became I turned to drinking to numb myself.'*

In his 20s, Sam's alcohol use was characterised by binge drinking, which often led him into trouble with the law. *'As I got older and drank more, my behaviour became worse. I would be involved with the police and courts and corrections workers. I was living with friends on and off, and then go back home. I would drink, mum and I would argue, and I would be kicked out.'*

Around this time Sam was also in and out of detox and rehab. *'Once I started, I went full bore with my drinking and I just waited for justice or health to step in to save me.'* This pattern continued until Sam reached his 40s, when his mum told him he couldn't stay with her anymore. Sam's mum took out an intervention order which he breached and he was placed in custody. *'Once you go to jail several times you start looking forward to it. If you are on the street it is a much better option. You are part of a community in jail.'*

In his early 40s, Sam achieved some level of stability after he found

long-term accommodation in community housing in St Kilda, and things settled down for a few years:

'I got a traineeship and was working.'

Around the same time, Sam began taking regular medication for his depression but when he drank he would stop taking them. *'In the end it got to a point where I got really bad anxiety. I had a place to stay but I would choose to sleep on the street. I would go home and close the door and my head would be spinning. I couldn't explain it; it was just mental torture. I got angry and I would stay in the park and drank as much as I could as I was more comfortable there.'*

Sam's primary homelessness, drinking and court run-ins continued until his late 40s. *'As long as I got alcohol I would get through. Even if I had cigarettes or food it didn't really matter, I was just functioning on one level with alcohol; I just couldn't get out of it.'*

It was in 2017-18 that his presentations to emergency departments (EDs) escalated, across many Melbourne metropolitan hospitals, including St Vincent's. Sam's ED presentations mounted to more than 30, mostly as a result of being brought in by police or ambulance for alcohol intoxication.

During these ED presentations, Sam would be linked in with drug and alcohol services, offered accommodation, and admitted to various detox facilities, but he would leave and drink again.

It was in 2019, during a presentation to St Vincent's emergency department, that Sam's journey took a positive turn. *'This time I went to DePaul House [a St Vincent's Hospital Melbourne community residential drug*

withdrawal service]. I was just about to leave, but my workers discussed that if I did then I may be put under the Severe Dependence and Treatment Act, as they were so concerned for me. So I stayed and from there I went to the Sister Francesca Healey Cottage.'

St Vincent's Melbourne's Sister Francesca Healey Cottage — known informally as 'The Cottage' — is a six-bed residential facility next to the hospital, specifically designed to address the support gap experienced by homeless people as they leave acute health services and are required to care for themselves.

The role of The Cottage is to:

- optimise the health status of clients through the provision of high quality nursing care in a safe and supportive environment;
- provide complete, continuous, holistic and client-led care;
- reduce incidences of re-admission to emergency or in-patient wards, and decrease the length of stay on in-patient wards; and
- enhance the service system framework for clients and develop appropriate linkages for them with other health and social services.

The Cottage is a unique service. Its philosophy is to provide an atmosphere of calm and security at a time of poor health, and improve medical care.

Sam stayed at The Cottage for three weeks. While there, he was encouraged to reconsider entering rehab again. *'My head was saying, "Don't go to rehab", but I physically took one step after another, and eventually got to the interview.'*



At The Cottage, with the support of nursing staff, Sam also re-started his antidepressants. *'It would give me a bit of breathing space. It was like it allowed me to keep my head above the water.'*

'The way they treated me at St Vincent's and The Cottage made me believe in myself. They showed an interest in me and made me think I can't be that bad.'

Sam was also familiar with The Cottage's staff as he had stayed there before and this also helped: *'I found belief in myself.'*

Sam ended up going to rehab after The Cottage and stayed for the full three months, with continued support from St Vincent's.

'It's different at St Vincent's — it's something about the way they do

things. That consistency when they would come and see me every time, and give me options with my care.'

From rehab he was supported into housing through Ozanam House (a homeless accommodation service run by Vincent Care), where he receives counselling, welfare support, and continues to see his corrections worker. *'It is not a burden anymore to see corrections, it is a pleasure now.'*

Sam is now in transitional housing arranged by Ozanam House and is studying a TAFE course in media studies.

When asked what it was that made his recovery different this time, Sam said: *'I have withdrawn from alcohol hundreds of times — physically it takes only a few days to recover but mentally it takes longer, and I got the break I needed at The Cottage and then going to rehab. After that, I found purpose. I felt part of something that goes beyond the medical stuff.'*

'Gentle persuasion works better than "You should do this", and that's what I got at St Vincent's.'

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Tierney House

Cameron French, Manager Tierney House, Homeless Health Service, St Vincent's Hospital Sydney

Established in 2012 — and for many years the only program of its type in New South Wales (NSW) — St Vincent's Hospital Sydney's Tierney House provides accommodation, health care and other supports to chronically homeless people as they convalesce from illness or receive treatment for ongoing conditions.

Located in Darlinghurst, Sydney — one of the most densely populated areas for homelessness in Australia — Tierney House's location ensures it is accessible by homeless people in the inner city who most need its services.

Tierney House first began when the hospital's Homeless Health Service identified a way to address the challenge of rough sleepers in Sydney's inner city presenting, and re-presenting, to the hospital's Emergency Department (ED) — and often requiring preventable re-admission — while also improving the health outcomes and life expectancy of this vulnerable group.

One of the major challenges facing inner city public hospitals serving large homeless populations is once a homeless person is no longer ill enough to require an acute bed they can be discharged to an environment that is not conducive to their recuperation and subsequently they can end up back in hospital.

Partly funded by NSW Health, but also by private donations, Tierney House provides 12 beds where chronically homeless people can stay for short-to-medium periods while they convalesce or receive the ongoing, integrated care they might need to stabilise a chronic health condition.

The care provided by Tierney House is flexible depending on a person's health needs, and it

also tailors help on a range of other important non-health issues, such as housing, Centrelink, legal, financial or social needs.

Tierney House's care focuses on the high risk period of the first 28 days after a homeless person has been discharged from hospital.

The provision of stable, short-to-medium term accommodation allows support workers and clinicians to monitor their ongoing treatment while providing a central point for the co-ordination and integration of a range of health and non-health services.

The health system can be a scary place for many homeless people. But Tierney House's staff make the experience less frightening by accompanying residents to medical appointments and by acting as 'interpreters' — deciphering the often complex medical advice of specialists.

By making sure a homeless person's health is attended to and maintained — and also by linking them with housing support and other services — Tierney House dramatically reduces ambulance callouts, visits to the hospital's ED, and preventable re-admission.

Residents transfer from Tierney House, not only with their most immediate health needs addressed or resolved, but linked to GPs or drop-in clinics, ensuring on-going assessment and treatment of future health concerns.

A team of academics from the University of Western Sydney, the University of NSW and University of Western Australia independently evaluated Tierney House's effectiveness and found that in addition to its health advantages,

it delivered a net cost-benefit to NSW taxpayers of \$8,276 per person over two years by reducing ED and other hospital presentations and admissions.

In mid-2019, the NSW Government picked up St Vincents' Sydney's recommendation that, based on its effectiveness and cost savings, state governments should roll out the Tierney House model for areas with large homeless populations, both to improve care but also save money in the long-term.

The service was used by the Government as the basis for its \$20 million 'healthy homes' package, designed to assist homeless people find accommodation after they are discharged from Sydney hospitals.

Key to the Tierney House model's success is its established partnerships with NGOs, GPs, housing providers, and other support services in the local community. It's a genuine partnership model.

But while Tierney House's staff are justifiably proud of their achievements, it is the stories of its residents — of feeling like they're in a true home for the first time in years, of re-engagement with family, of being able to contribute to evening meals or potter in the service's garden — that are the most rewarding.

Feedback has been extremely positive as residents experience Tierney House's values — respect, compassion, dignity and hospitality — first-hand; emotions and behaviours rarely encountered sleeping rough on the streets of Sydney.

Residents report relationships of mutual respect with staff rather than the formal 'clinician and patient' structure. This, combined with an



Sister Maurus Tierney serving food and drinks, (which she sourced herself) for up to 100 and 40 women in Potts Point. The image was taken in 1934, (during the Great Depression). She did this for over 30 years.

ability to observe residents in the home environment, permits greater understanding and rapport, and therefore better outcomes.

Positive outcomes with residents, who report these experiences to others in their community, only enhance Tierney House's reputation.

A Case Study

Background

John is a 52-year-old Aboriginal male, originally from Narrabri in NSW, and experiencing primary homelessness within inner city Sydney for some 12 years now.

John has a long list of chronic physical health concerns, in combination with increased ethanol use, depression, and is a heavy smoker (in excess of 25 cigarettes per day).

John was admitted to St Vincent's Hospital and then transferred to the hospital's Sacred Heart Rehabilitation service. His list of health concerns included: chronic foot ulcers, Type 2 Diabetes, hypertension, cardiomyopathy, obesity, alcohol misuse, chronic obstructive pulmonary disease, dental issues, and vision impairment.

Treatment Plan

Foot Ulcer

John was referred to a high risk foot clinic and to the hospital for wound care. He was also commenced on oral antibiotics and encouraged to use crutches, a frame or walking

stick to keep his weight off his feet. While John found compliance with this quite challenging, with on-going support and reassurance, he became quite adept at utilising the crutches. John also started wearing his specialised Darco shoes with inner soles for increased support.

Diabetes

John was educated and supported about his Insulin and oral medication regime. He attended regular appointments with the Diabetes Centre Educator and Dietician as well as receiving education around managing blood pressure. He was also supported in checking his blood sugar level four times daily. John was provided education around his ethanol consumption and advised of local Smart Recovery and Alcoholics Anonymous meetings.

Similarly, John was encouraged to utilise nicotine replacement therapy and taught about the benefits to his health of reducing his cigarette use.

Hypertension

John was commenced on oral medication for hypertension, and once mobile, encouraged to take part in the Healthy Living exercises offered at Tierney House. John was educated on specific exercises he could manage, even while only partially mobile. John was also advised of the health benefits of maintaining a consistently nutritious diet.

In Tierney House

After John found short-term accommodation at St Vincent's Hospital Sydney's Tierney House he

received regular supervision for his medication use along with prompts to maintain regularity; and support and encouragement around his medical appointments. With help from the service's Residential Support Workers, John was able to set realistic achievable goals. A client-centred approach allowed for the creation of a comprehensive care plan which was formulated in conjunction with John. He was also linked with a local General Practitioner for on-going care and was escorted to his first appointment.

John realised the following outcomes during his stay at Tierney House:

- his diabetes was consistently managed and as a result his insulin dose was reduced
- his blood sugar levels were restored to reasonable levels
- he was compliant with all medications and appointments
- the wounds on his feet healed
- he received an eye test and new glasses through the OneSight program run by OPSM
- he developed friendships with other residents and completed an artwork for hanging in Tierney House, such was his fondness for the house and the care he received
- he managed to achieve the majority of Care Plan goals set in conjunction with the Residential Support Worker.

Client Goals for the Future

John was discharged as per plan and returned to family on country, with adequate medications and prescriptions, education about how to better manage his health, and a renewed spirit.

John set himself some goals post Tierney House and these included seeing his grandchildren and opening a savings account for them. He had a desire to learn to drive again and was interested in learning how to read and write. Once back on country he wished to have an apartment and garden of his own. His final goal was to keep shaving his beard as it made him feel younger.

John's parting comment as he was leaving was: *'Our people need people like you: not racist and willing to help give us a go. You're helpful and cheeky and I thank you for that. I owe you all a favour.'*

The Kirketon Road Centre Inner City Outreach Project:

Provision of primary health care services to vulnerable populations experiencing or at risk of homelessness within the Inner City of Sydney

Gary Gahan, Projects Manager, Kirketon Road Centre and Ed Silins, Research Coordinator, Kirketon Road Centre

Who Are We?

The Kirketon Road Centre (KRC) is a recognised leader for the provision of safe, accessible and inclusive primary health care, given freely, respectfully and without judgement. The service has a long-standing and demonstrated experience of providing specialist primary health services to vulnerable populations using a holistic and fully integrated model of health care delivery.

What is the Issue?

Over recent years, communities of rough sleepers have been growing in areas across the inner city of Sydney. In late 2017, KRC conducted an extensive review of its outreach programs to assess the extent to which the program was meeting its aims in terms of the location of outreach settings and the times at which outreach services were provided. This review identified that the outreach program needed the flexibility to rapidly respond to emerging areas of need, such as the dispersal of the settlement of rough sleepers at Martin Place and the subsequent concentration of rough sleepers seeking shelter at Central Station.

What Did We Do?

With funding support provided by the Central and Eastern Sydney Primary Health Network, KRC expanded its after-hours Inner City outreach programs to people experiencing homelessness, many of whom have complex health and social care needs. The aim of this program was to improve the health status of people experiencing homelessness, reduce unplanned admissions to hospital, and to reduce the demands on services such as Emergency Departments.

How Did We do It?

We scaled up our outreach program to deploy a fully operational mobile clinic staffed by a multi-disciplinary team every night at inner-city locations known to be frequented by people experiencing homelessness. Core services provided from the mobile clinic included:

- assessment and management of general health issues
- wound care
- assessment of soft tissue infections
- initiating of mental health and/or drug and alcohol assessments
- blood borne virus screening using Dried Blood Spots
- crisis intervention and psychosocial support
- overdose management and prevention
- facilitated referral.

Did We Have an Impact?

A recent evaluation¹ of the program reported on a range of key performance indicators across the following domains:

- access (for example, occasions of service by priority population)
- effectiveness (for example, clinical interventions, referrals to specialist services)
- appropriateness (for example, program acceptability).

Access

In the context of afterhours outreach, an occasion of

service is any consultation, treatment, examination or other service provided to a client by a health education officer, counsellor, doctor or nurse in the outreach setting.

- 5,491 occasions of service were provided during the funding period, equivalent to about 1,000 occasions of service per quarter
- Approximately one in four (23 per cent) engagements were with Aboriginal and/or Torres Strait Islander people
- The majority (71 per cent) of engagements were with males and 24 per cent were with females.
- About four per cent of engagements over the funding period were with people who identified as non-binary gender

Effectiveness

Over the funding period, one-quarter (24 per cent) of clinical interventions were for sexual and reproductive health issues and a similar proportion (22 per cent) were hepatitis-related. General medical interventions comprised about 20 per cent of all interventions and 18 per cent were related to social issues such as housing support.

During the funding period, 2,117 referrals were provided for outreach clients. From quarter to quarter, there was considerable variation in the number and type of referrals, possibly due to seasonal variation and reduced need/demand for referrals to KRC and other services in warmer months



Client Satisfaction

A total of 48-clients were surveyed over the first three weeks of December 2019 with the results being overwhelmingly positive. Eighty-nine per cent of people rating their experience of using the service as very positive and the remaining 11 per cent rating it as somewhat positive. Everyone surveyed would also recommend the service to other people.

People were also given the opportunity to make any suggestions or comments, feedback included:

- *Keep up the good work!*
- *More naloxone available, if possible.*
- *The staff's attitude and knowledge gets better and better.*
- *Maybe a coffee be great. Otherwise don't change.*
- *It's perfect.*

- *You're better than my doctor's surgery.*

Appropriateness

Appropriateness was assessed as the extent to which the service engaged with specific vulnerable populations (people who are homeless, people who inject drugs, people in sex-work, and at risk youth).

The overwhelming majority of engagements were with homeless people. Over the entire funding period, people who were homeless accounted for 82 per cent of all engagements and people who injected drugs accounted for about half (48 per cent). People in sex work and youth at risk comprised a relatively small proportion of all engagements (five per cent and four per cent respectively).

What Does a Typical Shift Look Like?

Starting their shift at 1.30pm, Clinical Nurse Consultant Brett and Health Education Officer Gary spend

the afternoon working through their regular clinical and health promotion duties. At 6.00pm, they check the outreach backpack before setting off on foot patrol. The backpack contains sterile injecting equipment, condoms/lube, Dried Blood Spot kits for HIV/HCV testing, Nyxoid/Prenoxad kits (medications used to reverse opioid overdose), resuscitation masks, disposable gloves and service referral information.

They head north along the Kings Cross Strip towards the Wayside Chapel, stopping to engage a number of men who require sterile injecting equipment. When they arrive at the Wayside Chapel, Nurse Brett is asked by Wayside staff to assess a woman who appears to be in some discomfort and who doesn't want to see a doctor. Following his assessment, Brett is concerned that she may have a urinary tract infection. In discussions with the woman, they agree that she will return to Wayside

the following day at 11.30 am and Brett will liaise with the KRC nursing team to ensure that a urine sample is obtained prior to commencing the anti-biotic therapy prescribed by the KRC Medical Team. Brett and Gary spend around 30 minutes checking in with a number of homeless clients who are known to KRC, making sure contact phone numbers are up to date, reminding people of upcoming appointments and providing people the opportunity to discuss any health concerns they may have.

They then return to KRC and pick up the Outreach Bus, a fully equipped mobile clinic. Their first stop is Martin Place, a location frequented by high numbers of people accessing homeless support services and food vans. Over the next 90 minutes, Nurse Brett:

- sees two people presenting with injection related wound injuries
- sees a man with high blood pressure and chest pain who needs immediate transfer to Sydney Hospital
- does a hepatitis C Dried Blood Spot test on a man recently released from custody
- conducts a couple of mental health assessments and together with Health Education Officer Gary, engages and supports a number of other people who simply need a bit of time out from the street.

While Brett is providing clinical care on the bus, Gary is providing sterile injecting kits and harm reduction information as required, and checking in with known clients requiring follow up care from Brett, such as blood pressure monitoring and blood glucose monitoring.

When they are finished at Martin place, they pack up and head to Tom Uren Place in Woolloomooloo, an area used by many rough sleepers to bed down for the night. With its proximity to the Mathew Talbot Hostel and the food provided by the Coptic Orthodox Community Outreach Service (their rice pudding is legendary!), there are approximately 100 people in the area hanging

out, chatting and eating, most of whom may be experiencing some degree of homelessness. Brett and Gary mingle with the crowd, introducing themselves and discretely offering assistance and letting people know about the range of services offered by the outreach team and main KRC clinics.

The KRC staff then conduct a foot patrol around the surrounding side streets, checking in with people bedding down for the night. Once everyone is settled, Brett and Gary return the bus to KRC, conduct another foot patrol along the Kings Cross Strip and the Wayside Chapel.

Everything is quiet so they return to KRC, write up their notes, flagging which of the clients seen tonight are due to come in tomorrow for follow up, restock the Needle and Syringe Vending Machine and turn the lights off.

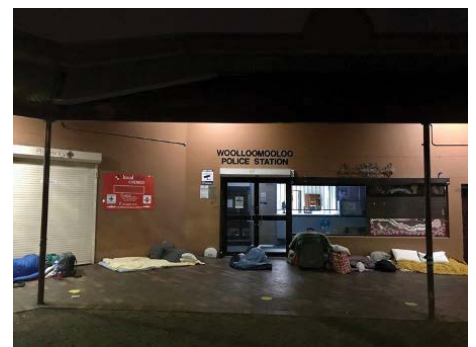
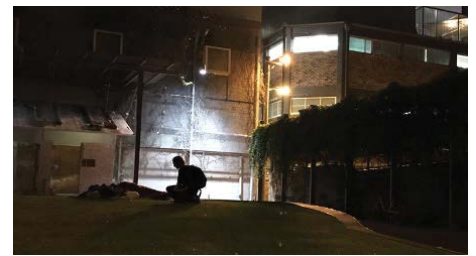
It's 10.00pm. Time to go home.

Conclusion

With funding support provide by the Central and Eastern Sydney Primary Health Network, KRC expanded its after-hours inner-city outreach programs to increase access to clinical services to people experiencing homelessness, many of whom have multiple and complex health/social care needs.

In addition to the high levels of client engagement and primary care provision, the workers at KRC have demonstrated:

- that effective and acceptable outreach health care and services can be provided at times and at locations in or near where people experiencing homelessness live or frequent
- that services are delivered by staff who are culturally aware and skilled in engagement
- that assertive referral processes are in place to promote continuity of care from outreach to in-house clinical services
- that KRC remains linked in with and co-ordinated with other healthcare services across the homelessness and health sectors.



Captions...

Endnote

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Tackling Homelessness and Healthcare on the Frontline:

The Innovative Response of the Homelessness Assertive outreach Response Team and the role of the St Vincent's Hospital Sydney Homeless Health Service

Erin Longbottom, Nurse Unit Manager, St Vincent's Hospital Homeless Health Service

Every week a group of health and social services collaborates to provide an assertive outreach response to people sleeping rough on Sydney's streets and parks. This group of services is known as the Homeless Assertive outreach Response Team (HART) and consists of St Vincent's Hospital's Homeless Health Service (HHS), Department of Communities and Justice (DCJ), City of Sydney (CoS), Missionbeat Outreach, Neami National, Innari Housing, Launchpad Youth Services, Aboriginal Corporation for Homelessness and other specialist homelessness services.

The HART Terms of Reference (TOR) state: *'The purpose of the HART is to share skills, resources and knowledge among specialist services to support people sleeping rough in Inner City Sydney to exit homelessness, access ongoing health care and access long-term housing with support. All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it.'*

Clients are prioritised for HART outreach support and coordinated case management based on the following:

- they are without a clear pathway to housing
- there is no SHS (specialist homeless service) involved
- there are significant concerns for wellbeing, mental health, physical health or vulnerability
- they are rough sleeping within the City of Sydney boundaries.

How Does HART Work?

One morning a week HART services meet in the city, are coordinated

into small groups and allocated an area of the city to patrol by foot or by car. The aim is to meet and engage with people sleeping rough wherever they are, some who are already known to HART, some who are unknown, and some who have been flagged as needing support.

Each small group consists of housing workers, specialist homelessness service personnel, and health workers. Specific service responses are also provided in areas that are known to have a high number of populations at significant risk of vulnerability, such as young people, Aboriginal or Torres Strait Islander people, or people identified as having complex health needs. People sleeping rough are approached by only two group members as more than that can be overwhelming.

There is a shared HART consent form that ensures the group has consent to work with people and exchange information as required. Once a month HART services come together for a meeting to discuss patrols, share service information and to coordinate care for HART clients as required.

HART provides this assertive and collaborative response so that the services can all work together to find solutions for people who may otherwise struggle to access accommodation, healthcare and support.

What is the Role of St Vincent's Sydney's Homeless Health Service (HHS) in HART?

The HHS has been a member of HART since its inception in 2015 and although some staff have changed throughout this time, we have consistently been part of the weekly outreaches and regular meetings.

The role of the HHS within HART is to provide health support and improve access to healthcare including direct health assessments, interventions and referrals, as well as indirect health consultation and advice to the agencies involved.

HHS staff currently attending HART Patrols and their roles are:

- **General Practitioner (GP) Registrar:** who provides comprehensive health assessment, wound care, medications, and referral. Can also provide medical evidence and supporting documentation for housing.
- **Mental Health Clinical Nurse Consultant (CNC):** who provides mental health assessment, care coordination, and referral. Can also provide medical assessments and supporting documentation for housing.
- **Peer Support Worker (PSW):** who partners with a clinician on patrol and supports people sleeping rough with engagement in healthcare utilising their own lived experience.
- **Aboriginal Health Worker (AHW):** who partners with a clinician on patrol and provides cultural support to people sleeping rough who identify as Aboriginal or Torres Strait Islander. The AHW is integral to the engagement of Aboriginal and Torres Strait Islander people with health services.

HHS staff are available for all HART members outside patrols or meetings for referral, consultation and advice. We recognise the relationships between members of HART are integral to achieving

positive health and housing outcomes for people sleeping rough.

Delivering healthcare on the street can be challenging, but as one of our partners commented:

'Many of the rough sleepers tend to shy away from mainstream services which impacts on their quality of life that can lead to serious life-threatening conditions. For the homeless person, engaging with Homeless Health in an outreach capacity removes the apprehension of the clinic environment: the smells, the memories, and the people in white coats using language that they don't understand.

Coming to them in their environment allows the Homeless Health to get a more rounded picture of what is happening for the homeless person.'

— Missionbeat Outreach

Homeless health staff also agree on the benefits of providing outreach based healthcare:

'The HART is actually the heart of the people that do the job. People start addressing their healthcare needs when they see that people actually care about them. The HART closes the gap for Aboriginal people sleeping rough and enables them to start addressing their health, social and wellbeing concerns. They are able to receive treatment, build rapport and trust with staff and clinicians, and then they are more likely to start accessing services in our organisation, including Homeless Health Outreach Clinics or other services at St Vincent's Hospital.'

— Clay, Aboriginal Health Worker, St Vincent's Hospital Homeless Health Service

'I think HART is very beneficial as it addresses some of the gaps evident in providing healthcare to people experiencing homelessness. There is a focus on building rapport and establishing a therapeutic relationship with individuals that potentially find it difficult to trust services based on previous experiences. HART is able to bring services to individuals rather than waiting for them to access services on their own.'

— Jon, Mental Health Clinician, St Vincent's Homeless Health Service

Working in Collaboration

Feedback from our partners in the HART model is also positive.

'Without the assistance of the (St Vincent's) homeless health teams many of our rough sleepers would not be able to complete their HNSW applications so the pathway out of homelessness doesn't happen. The health service is like the blood that pumps through the HART and all of the services are there providing for the people on the streets.'

— Missionbeat Outreach

'Having the Homelessness Health team working closely with our Homelessness Outreach Support Team (HOST) and being involved in assertive outreach patrols as part of a multidisciplinary team is invaluable to provide immediate health care and ongoing support for people sleeping on the street.'

— Department of Communities and Justice

'The addition of St Vincent Homeless Health team to HART is absolutely essential to its success. The consistent involvement of Homeless Health in both outreach and case coordination has been invaluable in achieving the outcomes to date within HART. The importance of having a dedicated Health team that works within the homeless sector, cannot be undersold, they are a critical service.'

— City of Sydney

'Working collaboratively with St Vincent's Homeless Health team has allowed the HART to engage with consumers that would not engage with health services in general. Being able to link consumers into an assertive health team means that they receive adequate mental and physical health support where they are at and on the streets, in particular those consumers who refuse to go to medical services or hospital. Without the continued effort and support of the Homeless Health team we would not be able to achieve overall engagement and support for these consumers.'

— Neami

Our Homeless Health staff also agree on the benefits of having a collaborative response:

'The collaboration between all the services involved in HART is essential. It allows for the support workers and clinicians involved to meet, share ideas, formulate plans and establish relationships. This improves overall communication and understanding between services and ensures that we are all on the same page and have the same goals in mind. The combination of mainstream and non-government services also helps to deliver streamlined support and a wide variety of assistance to individuals experiencing homelessness.'

— Jon, Mental Health Clinician, St Vincent's Homeless Health Service'

'Since I started with HHS I have found the whole process of HART to be invaluable. The post patrol meeting is a chance to not only debrief about who and what we had experienced but to refer clients between agencies with immediacy and with the experience of the client fresh in our mind. It has also been useful to find out how other services are faring, what current pressures each other is experiencing and negotiate different ways we can support each other. It is a reminder that we all work toward one goal, that of facilitating vulnerable people's recovery from homelessness.'

— John, Peer Support Worker, St Vincent's Homeless Health Service

Conclusion

Having the Homeless Health Service (HHS) involved in the HART improves access to healthcare and housing for people sleeping rough and highlights the importance of collaboration and shared goals. Not only does the HHS being a member of HART help the other services involved by improving access to healthcare, it also helps the HHS by improving access to housing and support. The relationship between all HART services is a mutually beneficial collaboration which in turn improves health and housing outcomes for people sleeping rough in the City of Sydney.

Partnerships in Health and Housing: You Guys Change Lives

Amy Cason, Manager, Assertive Outreach Service and Heidi Martin, Registered Nurse, Assertive Outreach Service, St Vincent's Hospital Sydney Homeless Health Service

St Vincent's Hospital Sydney's Homeless Health Service partners with Wesley Mission to form the Wesley Mission Therapeutic Support Team. The partnership was born from the NSW Government's *Going Home, Staying Home* reforms and has been operating since 2015. Wesley Mission funds two senior mental health clinicians employed by the Homeless Health Service and who are embedded within the Therapeutic Support Team (TST), a Sydney-based specialist homeless service that assists people experiencing homelessness or at risk of homelessness. The partnership acknowledges the importance of wrap-around tenancy support and healthcare in supporting people to permanently exit homelessness.

Since its inception, the partnership has supported many clients through their journey out of homelessness. People like Matty, who became homeless in the context of complex health and psychosocial issues and limited

support. Matty referred himself to the TST, to access support from highly skilled case workers with expertise in providing early intervention services, care coordination, outreach support, rapid rehousing and transitional accommodation.

People accessing the TST can present with complex psychosocial and health issues, with needs across physical health, mental health and substance use. Working side-by-side, clients and case workers are able to meet these challenges and work towards psychosocial rehabilitation, housing stability and other goals identified by clients. With TST support, Matty was able to access Wesley Mission transitional housing. Having support and a safe and secure place to stay gave Matty the opportunity to focus on addressing his psychosocial and health needs.

Due to Matty's complex health issues, his TST case workers referred him to us, the TST mental health clinicians. We work alongside the

case workers to provide high quality mental healthcare to clients. Our role is to provide outreach to assist clients to access mainstream and specialist healthcare and support services of their choice, to improve their health and wellbeing. We do this through comprehensive initial assessment, clinical intervention, care planning and referral.

We were recently in contact with Matty and he expressed how important the support of the partnership was in enhancing his health and wellbeing as he transitioned out of homelessness. He provided an insight into his journey and how wrap-around psychosocial and tenancy support and healthcare have helped him. He said, *'I had no doctors and only my specialist at the hospital who I had seen all my life for diabetes. Family wasn't around... problematic relationships, homelessness, it was overwhelming at the time, the thought of going blind was overwhelming and I thought about hurting myself.'*

'I remember your team came and supported me at my appointments. You guys felt like family to me. Mental health is a real issue but support and communication is key, that is what you guys showed me and that is why I am the way I am now.'

Our team works creatively to ensure that the healthcare and support we provide is tailored to each client, and that the goals we work on together are client-driven. Matty recently told us, *'I think some workers are more textbook but your team really work with people in different ways, with the person, not just from a textbook. You get down to the same level as the person.'*



Despite working with people until they are comfortably accessing mainstream services, this is not always enough for some people. For Matty, this was important, *'Just a little bit more time, I can see that some people need more time.'* Sometimes the transition to other services can be challenging, and the TST works hard to ensure people feel supported through the change.

The TST covers a large geographical area because homelessness is not limited to the inner city. We liaise with health services across three NSW Local Health Districts along with multiple support services and councils across local government areas. We work in partnership with clients, local service providers and communities to build and strengthen client support networks and assist clients to permanently exit homelessness.

Our role is not just about the healthcare that we provide directly to our clients. We spend time with our Wesley Mission case worker colleagues to offer consultation and education. We talk about challenging

situations and strategies they might use, services they could refer to, and join them in reflecting on the work we do. We are here to build capacity in the TST but it is definitely a two-way street and our understanding of housing and tenancy systems and support continues to grow. Being able to provide integrated healthcare and psychosocial and tenancy support benefits our clients and staff too.

Our partnership offered Matty healthcare as well as psychosocial and tenancy support that was person-centred, strengths-based and trauma-informed. We use this integrated model of care not only to assist people to permanently exit homelessness but also to provide security, improve health and wellbeing, facilitate access to health and support services, and assist people to reconnect with their community. Our aim is for all of our clients to be empowered to address their needs and have a positive, life-changing experience, like Matty:

'Before, I thought life was over but now I know it's not and I

am looking forward to finding employment. I've even been able to tell my story at a conference.'

'You gave me the push I needed, showed me that people do care.

When I sit here I always think back to all the people who have helped me. You guys change lives and I would tell everyone who may need your service that. My experience and everything I am saying now is because of your team.'

* Thank you to Matty for agreeing to provide feedback for this article.

A POWERFUL ANTHOLOGY OF WRITING FROM PEOPLE WHO HAVE KNOWN HOMELESSNESS.

All profits from the sale of this book will be donated to charities that work with people experiencing homelessness.



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Providing Homeless Health After-hours

Jane Currie, Jasmine Yee, Amy Aitkenhead, Homeless Health Service After Hours Team, St Vincent's Hospital Sydney

Since 2006, St Vincent's Hospital Sydney has provided specific services that target those experiencing homelessness. People who experience homelessness are known to experience poorer health outcomes than the general population. Physical health issues, including musculoskeletal disorders, respiratory tract infections, skin infections and poor oral health are common amongst people experiencing homelessness.¹ There is also disproportionate use of acute health services by this cohort including emergency department presentations (homeless people were three times more likely to re-present to the ED than non-homeless people) and longer length of stay^{2,3} when compared to the general population. Research has also identified that homeless people have lower rates of accessing GPs compared to non-homeless individuals.⁴

A recent evaluation of St Vincent's Hospital Sydney's homeless health services,⁵ identified that the largest proportion of service contacts was for physical health issues (70 per cent) followed by case coordination (15 per cent) and substance use (seven per cent). Feedback from stakeholders identified the need for an extended delivery of clinical services, particularly in the later afternoon to meet the needs of the population.⁶ To meet this need, an after-hours homeless health service, funded by the Primary Health Network, has been in place since May 2019.

The after-hours homeless health service team comprises of a nurse practitioner, a clinical nurse consultant and a peer support worker. As an extension to the existing weekday homeless health service at St Vincent's, the after-hours team practice on Friday evenings and through the weekend

to provide outreach clinics at a number of inner-city shelters and drop-in centres, as well as providing assistance to people at street level and in the hospital's emergency department, as appropriate. The aim of the service is to increase access to care for those experiencing, or at risk of, homelessness.

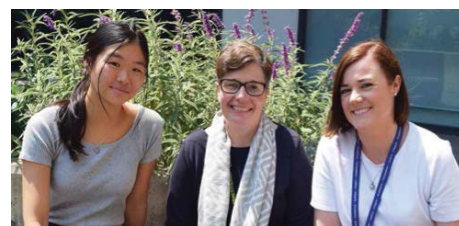
The after-hours team are able to provide clinical assessment and treatment, including prescription of medications, referral for investigations and referral to specialist services. In the last six months the team have provided 59 clinics, and cared for 116 female and 124 male clients. Of these, 52 identified as Aboriginal Torres Strait Islander, and 63 as culturally and linguistically diverse. The after-hours team have made 105 client referrals, most commonly to general practitioners, mental health and drug and alcohol services.

The Peer Support Worker Role

The peer support worker role is critical to the after-hours homeless health service. Making the clinics a safe space for vulnerable people is an integral part of helping them heal, with the ultimate goal of linking them to health services so they can have access to long-term holistic care. The lived experience of the peer support worker helps to provide this safe space for clients.

The uniqueness of the peer-to-peer relationship fosters clients' trust and may enable a deeper and a different connection than the one between a client and a clinician. It may be hard for people who are experiencing homelessness to trust clinicians, so having a peer worker present prompts some commonality between shared experiences and emotions.

Peer workers are able to put themselves in a client's shoes, which often means clients are more inclined to seek guidance, strategies and support services when coming from someone who has '*...been through what I've been through...*' In their role, the peer support worker advocates for people who are marginalised and stigmatised in our society. Becoming homeless is often the result of circumstances that are outside of a client's control, yet there can be shame and guilt attached to homelessness, which creates a barrier between clients and their capacity to access the services they need. It is pivotal that the after-hours team build trusting and reliable therapeutic relationships with their clients, so that they can ably identify their specific needs, and enable them to access the services required.



After-hours Team (l-r): Jasmine Yee, Jane Currie and Amy Aitkenhead.

Endnotes

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Minimising the Harm of Rough Sleeping: Integrating Lived Experience into Addressing the Health, Legal and Social Risks of Primary Homelessness

Spike Chiappalone, Peer Worker and Bridget Kelly, Project Worker, *cohealth*

Written with assistance from Robyn Mullins, AIPCA, LA Trobe University

Despite policies and programs aimed at 'housing first' for people who are homeless, the reality is that there are, and will continue to be, people sleeping rough in the City of Melbourne.

This article discusses:

- The background to the current City of Melbourne protocol for people sleeping rough.
- The initiation of a co-design process to develop a resource to assist them to stay safe on the streets.
- A survey of 81 people with current or recent experience of sleeping rough.
- Workshops to develop an appropriate resource.

Background

Accurately counting the number of people who are sleeping rough is not an easy task, but in 2016 the Australian Bureau of Statistics estimated there were 1,123 Victorians living in 'improvised dwellings, tents, or sleeping out', and in 2018 a StreetCount in Melbourne found 279 people sleeping rough.^{1,2} There can be no doubt that despite policies and programs, there are hundreds of people sleeping rough in Melbourne on any given night.

In 2017, there was a dramatic increase in public awareness and media coverage of homelessness when there was an 'occupation' of Flinders Street by people who were homeless, who indicated they felt safer in groups, needed to be close to a working toilet, had nowhere to store belongings, and had questions

related to where people who are homeless can and cannot be in the City of Melbourne.

This activism made homelessness very visible, and initial proposals to deal with the situation were to introduce by-laws which would effectively make homelessness a criminal offence (see Adams for a full description of the efforts to ensure this did not occur).³ Some consultation occurred with the rough sleeping community and organisations including *cohealth*, and eventually a protocol⁴ for homelessness was adopted by the Council, which included a limit on belongings kept in public, restrictions on the number of people sleeping in 'close proximity' and not 'impacting the enjoyment of other users of the public place'.

cohealth is one of Australia's largest community health services, operating across nine local government areas in Victoria. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities. Community Engagement practice is critical to *cohealth's* focus on collaborative and community led models of health promotion and health literacy as a foundation for individual and community activation, inclusion and resilience.

In 2018, *cohealth* was successful in an application for the Rough Sleeping Harm Minimisation Project through the City of Melbourne's — Pathways Innovation Fund, with the overarching aim of the project to minimise the negative health and legal impacts of sleeping rough in the CBD.

This project arose from the recognition that there was little

up-to-date information available for people who are homeless about where or how to access resources, facilities, and services, and ultimately how to live on the street in a way that can minimise harm and is in accordance with the new protocols. At the moment the key source of information for people who are homeless on how to survive life on the streets is other people who are also sleeping rough.

This co-designed project used the lived experience of people who are homeless to produce a resource that will help minimise the health, legal and social impacts of sleeping rough. The co-design process recognises that people who have experienced an episode of homelessness are experts in their own lives and views them as a resource in solving the issue and not the problem.

Overview of the Process

A key stakeholder committee was established comprising representatives from the Council to Homeless Persons, Justice Connect, Bolton Clarke, trained homelessness advocates with lived experience as well as the two authors.

Project workers consulted with more than 20 agencies who had contact with people who are, or have been, sleeping rough in the City of Melbourne. These agencies ranged widely from service providers to security companies, police and on street compliance officers to find out what impacts of sleeping rough they saw, their experiences of working with people sleeping rough, the current gaps in support and their ideas for solutions.



After this consultancy, a survey was developed, and information collected from 81 people who had previously been or were currently sleeping rough. Following this process, a working group of 11 people was formed with people who were representative of the homeless community and who had an experience of sleeping rough in the city of Melbourne. The group was facilitated by a *cohealth* peer worker with a lived experience of homelessness and a *cohealth* project worker.

Thematic data analysis was conducted through several workshops with peer workers. Based on this collected data, fortnightly workshops were then conducted over a three-month period to further discuss, flesh out, refine ideas and guide production of a resource.

Survey

The project team developed an extensive survey covering a broad range of issues including demographics, safety on the streets, health, living in public places, knowledge of council laws and legal issues. Questions were a mix of closed and open-ended questions, allowing respondents plenty of opportunity to describe their experiences, give suggestions and share their skills and knowledge.

The survey was conducted face-to-face (by the authors) and took between one to two hours to complete. Interviews were also conducted via assertive outreach, at services and drop-in centres. Efforts were made to make sure people completing the surveys were representative of people experiencing homelessness (as identified by

StreetCount) and additional efforts were made to interview members of the Aboriginal and Torres Strait Islander (ATSI) community, women and young people. Respondents were generally very happy to feel their voices were being heard and were engaged by the process. Participants were reimbursed with a payment, a thankyou pack, and additional support was offered if required.

Eighty-one people with an experience of sleeping rough completed the survey. At the conclusion, we asked if they would be interested in participating in a working group to discuss the survey results and help develop a resource to reduce the health, legal and social impacts of sleeping rough. It was made clear that this would involve 12 two-hour sessions in a group setting, and that they would be

paid for their time. Sixty one out of the 81 expressed interest at that point. Interviews were conducted with interested people, to identify those who would be comfortable talking about their experiences, able to deal with potential stress triggered by the discussions and who would commit to the time the project required. The project team put significant thought into the balance of the working group including different experiences and length of the homelessness episode as well as gender, age, ethnicity, LGBTQI and ATSI.

Workshops

Twelve people were selected to take part in the working group, which met weekly from September to December 2019. The working group worked diligently and actively on understanding and discussing the findings from the survey, refining the ideas proposed in the survey and designing a resource that would achieve the aim of the project. They received payment and support to attend each workshop.

The project team recruited a design company with a shared commitment to the co-design process to assist in the later stage of design process.

General format of the Working Groups:

- **Acknowledgement of Country** — shared by members
- **Reminder about group agreement** — created by group in initial meetings.
- **Updates** — opportunities for involvement, current campaigns and happenings in homelessness
- **Survey findings** — discussion and reflection, using graphs, quotes and thematically analysed data.
- **Activities** — small group work and large group work, for example, matching aims to proposed ideas, matching findings from survey to ideas, idea prioritisation matrix, narrative activities and story boarding.

The working group is now, in 2020, an Editorial Committee meeting fortnightly to produce

a regular peer-to-peer bulletin style publication, available in print and online. The Editorial Committee also discuss, design and review other aspects of the resource such as the community event details, distribution methods and promotion.

Outcomes

The outcome of this project is a monthly peer-produced bulletin style publication called *What you... NEED TO KNOW to survive the streets* which will be available in print, read out at a monthly community event and online.

Examples of what will be covered are:

- Essential Needs: that is, safety, health, food, storage
- Getting Help at Services such as Centrelink, identification, housing, how to use services
- Accessing Justice and Knowing Your Rights i.e. local laws, legal help
- Map with services and amenities mapped and public space information (for example, free events and library information)

Points of difference of this resource:

- Written by peers for peers
- Informed by findings from the survey
- It is not 'just info' — Every section has insights, experiences, skills and strategies from peers
- All aspects of the content are co-designed
- It is regular — so can include any updates on services, changes to times/events, laws
- It is low-fi, focused on quality content and simple low-cost production to ensure sustainability
- It is compact, easy to carry around for those sleeping rough
- It is available in 3 ways to cater for various needs — in print, at a community event where it will be read out and online

as a simple webpage with its own URL but connected to the *cohealth* website.

The first edition will be launched in early April and the pilot phase (estimated to be three editions) will be evaluated throughout this period.

As well as their contribution to the development of the resource, there were also benefits to the people on the working group.

- Capacity building: skills in advocacy, design, public speaking
- Meaningful connections and relationships
- Positive experiences with services
- Building confidence
- Increase wellbeing
- Work skills and pathways to peer roles/homeless advocacy work
- Routine, purpose

At every point, it was made clear to participants that this was a co-design project which involved partnership with the people who are most affected by decisions and services, from the initial point of systemic problem identification through to design, development, delivery and evaluation. The resulting resource is the culmination of a process that was a systematic, supported process that was embedded into the work of *cohealth*, and resulted in an outcome that was tailored to meet the expressed needs of those with lived experience of rough sleeping.

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A Day in the Life of an Assertive Outreach Team Clinician

Amy Cason, Manager and Heidi Martin, Registered Nurse, Assertive Outreach Service
St Vincent's Hospital Sydney Homeless Health Service

Our Assertive Outreach Team (AOT) provides intensive healthcare, support and care coordination for people experiencing primary homelessness in inner city Sydney. We have a multi-disciplinary team including physical health nurses (like me), drug and alcohol clinicians, mental health clinicians and psychiatrists. We are part of the Homeless Health Service at St Vincent's Hospital in Darlinghurst.

Our aim is to provide healthcare and link our clients with mainstream and specialist health services. We also work closely with local

support services and government agencies to assist our clients to access psychosocial support, accommodation and finances. We work alongside our clients to support them to permanently exit homelessness, connect with community and enjoy life. Every day is different. I'm going to tell you about a typical day so that you get a sense of what we do and how we do it.

The day might start at 8am with a phone call from the triage nurse in the emergency department (ED) informing me that Melissa, a client

of our service, is sleeping on the floor of the waiting room. Last night she didn't present with any urgent medical needs so wasn't assessed as high priority for medical care. This is the second time this week that Melissa had spent the night waiting and sleeping in the waiting room, as she has nowhere safe to stay. Her alcohol use, acquired brain injury and ensuing chaotic interactions with others, mean that her needs are classed as 'too high' for most local accommodation services. She's been temporarily banned from her preferred service



due to fighting. Melissa is a domestic violence survivor and she doesn't feel safe sleeping rough, especially since her ex-partner has recently been released from prison. She is seeking medical detoxification from alcohol.

Melissa's care coordinator, who is one of our AOT drug and alcohol clinicians, and myself (physical health nurse) speak with staff in the ED. We advocate for a review by the Drug and Alcohol Team, and because Melissa has not been managing her Type 1 diabetes, we also request a medical review by an ED doctor. We then contact the Drug and Alcohol Team and advocate for Melissa to be offered an admission to the hospital detoxification unit, as our many attempts for outpatient treatment had not been effective and we are concerned for her health and wellbeing.

Fortunately, there was a bed available and the team accepted Melissa for admission to the detox unit. Melissa is relieved and grateful for this opportunity. We reinforced her decision to ask for help and gave plenty of encouragement about completing the medical detoxification treatment plan. This is a huge step for Melissa. She knows we're here for her and that we'll drop in and see her every day. Navigating the health, housing and disability systems can be challenging at the best of times, so it's important that we're here to share the load.

While Melissa was receiving the medical care that she needed, the rest of the Assertive Outreach

Team were in our morning handover meeting, planning the day's activities and discussing any concerns for clients. We spend a lot of time on street-based outreach. We work in pairs using a multi-disciplinary approach, so clients and staff benefit from different expertise. Team members can support each other through challenging or distressing situations. Working in pairs is much safer for our team and our clients. Given we often work in public space and do not always have control over the immediate environment and who is present, it helps to have two staff present in case any safety issues arise.

Later in the morning, one of our AOT mental health clinicians and I go out on outreach to locate a new client Bobby, who needs assertive treatment for his complex health needs. The description and location provided to us in the referral are vague and so we drive around Sydney's Domain in the hope of finding our new gentleman, who is described as white, most likely shirtless, and with an untreated mental illness.

Because he doesn't have an address, Bobby has missed out on treatment that could improve his health. He doesn't believe doctors when they say he has schizophrenia and he's got a long history of trauma, some of which has been experienced in hospital. It's understandable that he might want nothing to do with our team.

As luck would have it, we find Bobby in the Domain. He talks with us briefly about Centrelink benefits and housing. He is even willing to sign a consent form so that we can follow up about his access to finances and accommodation. Bobby tells us that he is a Kamilaroi man from Moree, and he agrees when we offer to introduce him to our Homeless Health Aboriginal Health Worker for cultural support. The engagement was brief but it is an important first step of a slow rapport building process.

Gaining trust is often very difficult as many of our clients have significant trauma histories and have often been let down by many people, services and systems throughout their lives. As with most of our new clients, we need to prove to Bobby that we are safe people who are worthy of his trust. We have to make sure that when we commit to something, we deliver and show that we are here to help, especially in the tough times.

The main goal for our Assertive Outreach Team is for our clients to comfortably access the healthcare that they need, through the services of their choice. We work closely with local services to support our clients to access safe, stable accommodation — this is a basic human right. This also means that a good portion of our day is spent advocating for our clients, liaising with stakeholders to

coordinate care, and writing reports to facilitate access to treatment, accommodation, support or finances.

Later I receive a phone call from Khaled, a client that I have worked with for over a year. He moved into his new home last month. He tells me that he just got home from an appointment with his new case manager at his local mental health service. Khaled talks about his new home and how his support worker was with him for his housing inspection yesterday. He says he is grateful for the support we provide and said that he was especially happy that he had a roof over his head during the recent storms. We talked about all the changes he has made over the past year and his dreams for the future.

Next week I'll visit Khaled for our final appointment together. Our team is careful and responsive when transferring healthcare to new services and exiting clients from our service, as we work intensively and build strong connections. It took a long time for Khaled to trust us, and we've walked alongside him while he confronted many challenges. He's taught our team a few lessons and has helped us to change our practice for the better. Saying goodbye is bittersweet but opens the door for us to meet new clients.

Background

The Assertive Outreach Team (AOT) uses a trauma-informed, strengths-based, culturally sensitive approach, and addresses the health needs of service user with a tri-morbidity framework (physical health, mental health and drug and alcohol use).

From mid-2017 to mid-2019, the AOT supported 122 clients, conducted 437 assessments, facilitated 214 case conferences, and coordinated 394 referrals to health services and made 453 referrals to support services and government agencies. More than half (64 per cent) of the clients seen by AOT in this period experienced health needs across all three domains of drug and alcohol, physical health and mental health, and 29 per cent presented with issues from two domains. These statistics emphasise the importance of using a holistic approach to meeting the health needs of this population.

A Nurses Perspective: Integrating Primary Health at the Salvation Army's 614 Precinct

Paisley Suggett (RN), Kirsty Owen (RN), Bernadette Smith (RN), Ana Jerak (Project Coordinator)
Health Independence Program Complex Care Services, St Vincent's Hospital Melbourne

The primary health service at the Salvation Army's 614 Hub in Melbourne's central business district (CBD) was created in January 2018 as a joint initiative between the Salvation Army and St Vincent's Hospital Melbourne (SVHM). The program is a three-year pilot funded by St Vincent's Health Australia's Inclusive Health Program.¹

The 614 Hub is a unique space where people experiencing homelessness and social exclusion can access help in a range of ways: from a hot meal or a coffee through to material aid such as clothing, along with mental health, alcohol and other drug (AOD) support.

The service began when the Salvation Army identified that the acute and chronic health needs of their patrons were not being addressed. At times, they would call for an ambulance and send patrons to SVHM's Emergency Department (ED), but it was felt that many presentations could be avoided by offering an on-site health support service. As both SVHM and the Salvation Army have a strong partnership, and work closely with people who are homeless or at risk, the relationship between the two services has developed into an innovative health outreach pilot program.

The program provides three primary health/mental health clinicians for four days a week. As nurses we work closely with the Salvation Army staff to identify those in need and reach out to those who appear particularly vulnerable in their health care.

Perhaps the most unique aspect of the program is that we do not work from a traditional health clinic, but rather from within the 614 Hub's Magpie Nest Café.

The Magpie Nest operates like any other café, where clients can walk in off the street, receive a hot meal, coffee, and table service — and at all times being treated with dignity and respect. Operating a health service in this environment does present challenges, but it has also allowed us to develop meaningful relationships with our clients. Our clients are unique, and they face many complex challenges in their day-to-day lives.

For a range of reasons, many homeless and vulnerable people have a mistrust of health workers and traditional health settings. As nurses, we have encountered this same wariness among the 614 Hub's clients. However, as the program has developed over time, we have built rapport and trust, and café patrons now reach out to us for support. We also have an onsite clinic room for one-on-one confidential assessment and treatment we can use if required.

On Any Given Day

A typical day begins with our 8am arrival. We certainly do not look like on duty nurses — we dress casually, in jeans and runners, but wear our SVHM identification. The lack of uniform helps minimise any fears or uncertainties surrounding the traditional hospital or medical environment.

We check in with the Salvation Army staff who flag anyone they are concerned about and update us on any significant events from overnight (the Café is a 24-hour service with up to 150 people sleeping every evening). As we have now been in this role for almost three years, we know many of the regular visitors and are often stopped for a chat when we walk through the café. It's also not uncommon for regular patrons to identify others in the café who

they feel would benefit from our attention and to discuss their needs.

Many of our regular clients will keep us up to date on their own health and ask our advice, including on how to navigate the health system. At times, we encounter clients who are unwilling to engage with us and do not want our assistance. Our hope is that our regular presence and our openness to chat — without initially focusing on their health — will allow us to build these relationships over time so that they will eventually engage in conversation when ready.

For nurses, not only is the café a non-traditional healthcare setting, but this is also a non-traditional nursing role. We often feel like we are nurses combined with social workers, AOD, mental health workers, personal assistants, personal stylists and legal aid. There is no such thing as a 'normal' day for us here. Our daily interactions with clients can vary from removing stitches, dressing extensive wounds, and helping with pain management, to discussing safe injecting practices, referring clients to housing support, and finding a shelter to care for a dog while a pregnant woman goes in to labour. As nurses, we are unable to provide scripts to our clients, but we have a close relationship with *cohealth's* Greencross Street Doctor bus program, which visits the 614 precinct fortnightly. We also refer clients to local GP practices based on the urgency of their need. Through the local pharmacy, we can arrange for over the counter products including Hydralyte for rehydration, Gastro-stop and cough lozenges.

There's no doubt the environment in which we work can be very challenging, particularly due to the presence of substance use and

people with significant mental health issues. We are very fortunate that we work closely with one another and are supported in our practice by 614's management and the wider Salvation Army and SVHM teams. Additionally, we have been overwhelmed at the amount of support there is in Melbourne for homeless and socially isolated people and have developed strong working relationships with a range of other homeless and housing services.

Last year, in conjunction with *cohealth*, we administered more than 50 flu shots to café patrons who may otherwise not have had access to this prevention measure. We have learned over time that for many clients we work with, health is not always their priority and we have to respect and work with this.

One particular client we have worked with closely over several months is an older gentleman who was sleeping at the 614 Hub after losing his housing. Initially we linked the client with *cohealth*'s podiatry service, which worked with him to manage his poor foot health. Over time, our relationship with him developed and we were able to assist him in accessing mental health services and social support. Next, after a short stay at SVHM's The Cottage² service, our team were able to get the client into housing through Ozanam House. We are very

proud to see how he has flourished since being there, with obvious improvements in his physical and mental health. We continue to visit this client every couple of months and enjoy our catch-ups with him over a coffee in his new home.

Another client who holds a special place for us is a young woman with a complex social history and an extensive history of illicit drug use. When we met her in the café, she casually mentioned a breast lump and a one-year history of unusual discharge. She acknowledged that while she knew it needed investigating, it was simply not a priority for her, as finding somewhere to sleep, eat and maintaining a relationship with her children, took precedence.

We facilitated through her General Practitioner (GP) referrals a breast ultrasound and MRI scan at SVHM. Her scan and results were reported back to her through the outpatient Breast Clinic, where she was informed her lump was benign. This was an enormous relief to her and sparked an interest in trying to make some positive changes in her life. She has since moved on, but we are grateful we were able to engage as we did and that she knows where to find us in the future.

Perhaps one of the most notable characteristics of our work is the

shift in the power dynamic from the health care professional to the client. Traditionally, we have always seen clients in 'our' space, typically a hospital or clinical setting. Our pilot sees these roles reversed, with us going to our clients in 'their' space. Over time, we have learned that the rules governing patients in a hospital setting do not apply and we must adjust our expectations accordingly. As we have developed rapport and built trust, we have also seen a growth in respect — among our clients for the roles we play, and among ourselves for our clients and the journeys they have had and are still on. We are in a privileged position where we get to hear our client's stories and gain an insight into the events and actions that have affected their lives.

At times, we have clients who we refer to SVHM's ED or who self-present. When this happens, we will visit them — either in the ED or, if they're admitted, on the ward. This helps our clients feel supported and ensures a familiar 'outside' face is regularly checking in on them. It's very important that not only do our clients feel supported in hospital, but also that they feel supported as active participants in their healthcare; that they receive targeted and individualised education and resources to maximise the chances of compliance and success.

The role of the primary health nurse in a setting populated by homeless and marginalised people is an unusual one, but it is also filled with surprises and unexpected humour. It can be challenging and at times sad, but being part of such a unique team that makes a difference is ultimately rewarding and fulfilling.

Endnotes

1. The Inclusive Health Program funds projects that address the impacts of poverty, marginalisation and vulnerability on health and access to healthcare. Priority groups for the program include: people experiencing mental illness, alcohol and other drug addiction, homelessness, Aboriginal and Torres Strait Islander people and those in prison. The program funds initiatives including service innovation, research and advocacy.
2. A six bed home-like service located adjacent to the SVHM hospital which provides medical, nursing, and restorative care to people who are experiencing homelessness, or at risk of homelessness.



Peer Worker on the Coalface of Homelessness Health

John, Peer Support Worker St Vincent's Hospital Homeless Health Service

Until I was in my early 30s, I had been a successful acute care nurse. I had all the trappings of doing well: car, house, family, health. Then, following a very traumatic event at work, I fell into a spiral of addiction. Within two years I had lost everything and became homeless. I share this because it's important to remember that homelessness can affect anyone, at any time.

When I started in homeless health, my only past experience of what peer-to-peer work entailed was going through rehab and various 12 step programs. This involved being with people who are in the same boat as you, going through recovery together.

I did feel conflicted, knowing what I knew about healthcare from my time as a nurse, and the experience I had of peer work (working in a deep and personal way with others by sharing your own experiences). I had a certain amount of uncertainty on whether I could, or even should, marry the two together.

At this stage, no one on the St Vincent's Sydney Homeless Outreach teams knew what peer work should look like in this setting, and the job description did not have much information other than 'lived experience of homelessness required'. In one way it was an exciting chance to paint a picture for future peer workers, but in another way it scared me! How do I start this? Have I been through the 'right' kind of homeless? Do I have the right to be here when some of my peers had been through worse experiences than I had? I got a clue early on from a much loved peer of mine when he introduced me to some of the local homeless community as 'one of us'. And I thought 'Well that's a start...I'll just be one of us!'

Initially I was nervous about how I would be received, but my saviour was Tierney House — St Vincent Hospital Sydney's homeless health residential service. I went there a lot because I needed to connect with the people that I would be working with and, weirdly enough, prove to myself that I was essentially the same as everyone else that experienced, or was experiencing, homelessness. I used to go there every day to speak to people, listen to their stories and in doing so I became more and more comfortable in that space.

I learned to be vulnerable with people I didn't know. I had to open up sensitive parts of my life and say *'this is my story, I got through it and I'm alright now...I'm recovering.'*

This gave me the strength to stand in my own truth and realise that I'm still recovering despite having a home, job, and money in the bank. Once I realised this and was comfortable with my own story, I felt empowered enough to take this role and make it my own. I started to become an expert through my own experience.

I think it inspires hope that recovery from homelessness is possible when I'm able to sit down with a peer and genuinely say *'I know what you're talking about because I've been there, I understand'*. By role modelling my recovery to others, I want them to think 'If this bloke has done it then so can I'. I want to show my peers that

making a positive choice around their health can make massive changes to their overall circumstances.

I have been a peer worker with St Vincent's Sydney's Homeless Health Service now for almost a year. In that time, I have learned that I can be 100 per cent present with people and let them know that I unequivocally accept them in that moment as they are. When I say to a peer *'I accept you, where you are and who you are because I've been there too'* this takes away some of the shame and stigma that people feel about their situation. A lot of people don't understand how difficult and shameful it can be to say *'can I have somewhere to live/something to eat/some fresh clothes please?'*

Peer work within the Homeless Health Service builds a bridge between the health worker, the health system, the person experiencing homelessness and, eventually, the community. An important way I have found to achieve this is performing at least one outreach daily. This outreach can be with any member of our team, clinicians, aboriginal health workers and/or other peer workers.

This experience has led to me going from calling people 'clients' to 'peers' because I realise in many ways I'm still in the same boat as them... I'm still in recovery from homelessness. They are just as much a part of my recovery as I am of theirs. Realising this keeps me centred and self-aware.

By creating the Homeless Health Service peer support worker role, St Vincent's Hospital Sydney is showing the homeless community that we are embracing the 'nothing about us without us' approach and every day is an honour to represent my peers in our service.



Young People's Health at the Frontline

Christine Parrott, RN MPH, Clinical Nurse Consultant, Youth Health, Young People's Health Service, Department of Adolescent Medicine

Primary healthcare 'provides entry into the health service system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere by others'.¹ The Young People's Health Service (YPHS) is a primary health service for homeless and/or marginalised young people accessing services in the city of Melbourne. Co-located with Frontyard Youth Services, a youth homelessness program of Melbourne City Mission, YPHS has access to homeless young people and aims to meet the primary health needs of those at risk.

'Despite self-identified claims of good health, young Australians are frequently exposed to negative individual and societal pressures that can directly impact on their health and well-being'.²

Those accessing Frontyard are not necessarily health-seeking but are at particular risk of poor health and their health outcomes are consistently reduced, due to the predominance of negative social, economic and cultural determinants in their life.^{3,4} This is the period when risk taking behaviours typically emerge — behaviours such as unprotected sex, binge drinking and alcohol and other drug (AOD) use — and it is these coupled with lifestyle and exposures that can put them at risk of poor health. Targeting interventions early in these stages can significantly impact on future health, and attempts to prevent future diseases.^{5,6,7,8}

To optimise access, YPHS is co-located in the central business district (CBD) with Frontyard Youth Services, enhancing interagency collaboration and multi-modal care.

Young people attend Frontyard primarily for assistance with finding accommodation — often a crisis driven interaction. Through the use of a comprehensive intake tool, developed collaboratively with co-located services, the young persons' needs are identified and opportunistic referrals are offered to see 'the health service'. Clients may not have intentionally prioritised their physical health but are encouraged by youth workers to see YPHS, particularly if they have not seen a health service in the last 12 months.

YPHS has evolved over time to meet the needs of homeless young people but ultimately is striving to reduce gaps in service provision, to improve accessibility by removing barriers (drop in service, no cost) and approaching health in a youth-focussed manner. A strong feature of YPHS is the nurse-led model. Advanced practice nurses (APNs) who are specialised and skilled in adolescent health are employed in the service and have the capacity to assess and conduct clinics independently. YPHS exists under the Department of Adolescent Medicine, The Royal Children's Hospital (RCH). RCH provides clinical governance as well as two Adolescent Fellows who work in the clinic twice per week.

Participation in a health consult is completely voluntary. The clinician completes a psychosocial health assessment (a HEADSS tool) which examines health in the context of social and environment determinants and allows the clinician to broach otherwise uncomfortable topics that are important to not overlook, for example, sexual health. Psychosocial assessment tools are recommended for best practice when working with young people. It allows for the development of rapport in a safe

space, as well as assessing risk and protective factors. Opportunistic conversation, education and harm minimisation are also a positive by-product of the assessment that may not always be possible in mainstream health service.⁹

While clinical services at YPHS are broad, what is most commonly offered, based on need, are sexual health screens, contraception, blood borne virus screens and immunisations.

Three common interventions are described below:

Sexual Health

Adolescent disclosure with a physician regarding sexual health occurs in only eight per cent of visits, so if a clinician does not ask about sexual health directly, it is unlikely that the young person will bring this up themselves.¹⁰ Utilising the HEADSS allows those conversations to happen. Young homeless people are at particular risk of STIs due to lack of accessible screening and treatment services, insufficient sex education, affordability of and capacity to negotiate contraception, transactional sex, and sexual assault.¹¹

Chlamydia is the most common STI in Australia with those under 29 years accounting for more than 80 per cent of infections. Chlamydia trachomatis is a bacteria that, if left untreated, can potentially lead to pre-term labour, ectopic pregnancy and infertility. Young people often have limited knowledge of STIs, particularly the asymptomatic presentation of many infections.^{12,13} Despite the transient nature of clients, YPHS has been successful in treating a majority of cases of diagnosed Chlamydia, preventing further spread of infection and long-term complications.

YPHS treats those with infections and also facilitates the treatment of partners using Patient Delivered Partner Therapy which further decreases risk of reinfection.

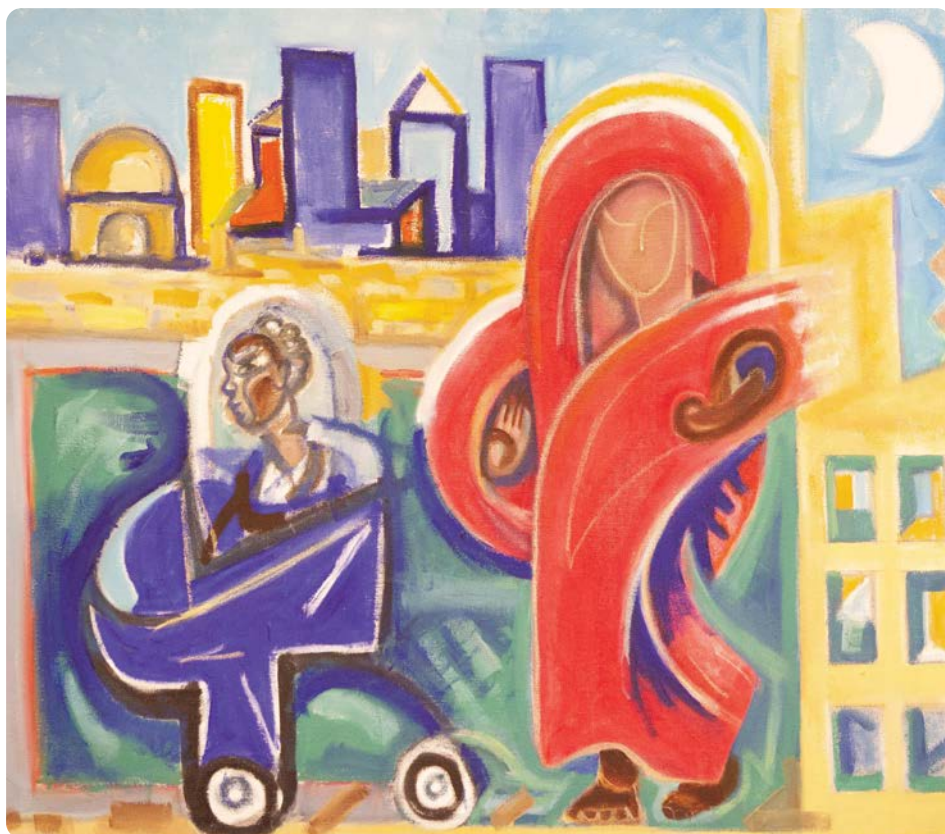
Contraception

Providing access to contraception increases a young persons' choice about their future. Long acting reversible contraception (LARC) is recommended, where an implanted device can provide contraception for three to five years, both for the coverage duration and the rates of preventing pregnancy.¹⁴ However, many young people have not previously pursued LARC because they are not able to prioritise this in their finances (accommodation and food are generally prioritised), they do not have a General Practitioner (GP) they are comfortable with or they are afraid of being judged.

YPHS APNs are trained in and opportunistically offer and insert Implanons. This has been well received by young people with feedback indicating a long acting contraceptive is easier than remembering to take the pill every day, especially when your accommodation changes so frequently. Procedures at a familiar location with culturally sensitive care can have a positive effect on young people's outlook for accessing future healthcare.

Immunisation

Australia has an excellent school-based vaccination program. However, for young people not accessing school, who have moved schools frequently or who have guardians/parents who don't consent for vaccination, school-based programs are insufficient. Anecdotally, young people don't know what vaccines they have received or if they are 'up to date'. YPHS routinely reviews their vaccination record and conducts catch up immunisations. While the impact of vaccination is generally not experienced in the short term, there are enormous benefits to the young persons' long-term health and the health of those around them. YPHS data demonstrates that over approximately 11 months in 2019, 183 young people were offered reviews of their vaccine history. Staggeringly, 98 per cent were not



up to date with their vaccinations. During that time 56 per cent initiated catch up plans. Reception by young people has been encouraging; anecdotally we frequently administer multiple catch up vaccines per person.

YPHS in the Future

As advances have been made in other fields, YPHS has sought to provide those — for example, early detection of Blood Borne Viruses and linking young people in with treatment for Hepatitis C. The YPHS model of a drop in clinic and clinical refuge outreach (not detailed here) has successfully worked to provide preventative, primary healthcare for homeless young people. The model of co-location and nurse-led health services is a key to reaching those who are hardest to reach.

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Towards Home+: A Collaborative Approach to Homelessness Support

Pete Warden and Di Nally, Neami National Regional Managers

People sleeping rough or on the streets are some of the most vulnerable in our society. The 2016 census estimated 8,200¹ people sleeping rough across Australia. In the state of Victoria, some 1,100² people are estimated to be sleeping rough on any given night. In 2018, the Victorian State Government released *Victoria's Homelessness and Rough Sleeping Action Plan*. The plan is an important step in tackling many of the underlying causes of homelessness.

In response, Neami National worked with key partners to develop and implement the Towards Home+ program, which supports people who have experienced chronic homelessness. Funded by the Department of Health and Human Services (DHHS), Neami National's Towards Home+ services are now established in Dandenong, Frankston and Geelong.

People supported by the program may have a range of serious needs and may have experienced persistent failures in the systems which support them. The program supports people to obtain and maintain housing, improve physical and mental health and develop connections within their local community.

Multi-disciplinary Support Addressing Complex Needs

The causes of recurring and ongoing homelessness are complex and multi-faceted. People may be facing a range of issues including family violence, mental health struggles or addiction. Towards Home+ delivers its support within a shared care framework. Through partnership and collaboration, Towards Home+ can meet a range of support needs

within the one team. The key agencies involved include:

- Neami National: mental health supports
- Launch Housing: housing support
- Uniting Care Regen: alcohol and other drug treatment and education
- Bolton Clarke: health and nursing services
- Melbourne City Mission: support for young people
- Wathaurong Aboriginal Co-operative: social and emotional wellbeing in Geelong.

'Working within a multidisciplinary team allows me to work much more closely with staff of differing backgrounds and roles, allowing me to develop new insights into shared care roles.'

— Janine, Intensive Housing Case Manager.

Strong partnership means comprehensive wrap around care for people experiencing homelessness. It ensures a multi-disciplinary approach that forms strong connections to community and other services. These additional supports can be crucial in enabling people to maintain housing over the longer-term. The multi-disciplinary team also includes staff with a lived experience of homelessness, helping to ensure that the program remains truly person-centred.

'Having staff with lived-experience brings a foundation of valuable knowledge to our practice that flows through the staff group to consumers. It helps ensure we stay

recovery focused and humanistic and improves workplace culture. For the consumers that are fortunate enough to work with staff with lived experience directly, they have the opportunity to feel understood and supported on a deeper level. Having lived experience can aid in developing trust in the initial stages of engagement and can serve as a platform for regaining consumers' hope for their recovery by witnessing another persons' positive recovery journey.'
— Courtney, Youth Case Manager.

End-to-end Support

Towards Home+ is made up of three key components:

- Assertive Outreach
- Housing Support
- Modular units.

The Assertive Outreach team engages people who are sleeping rough. It focuses on brief interventions and short-term support. Assertive outreach staff can support people to access stable accommodation, access emergency accommodation and connect to health and support services. By working as part of a multi-disciplinary team, assertive outreach workers can offer responsive support to a range of needs.

'Being able to deliver complete, wrap-around support by having a 'one-stop-shop' is really beneficial.'
— Kurt, Assertive Outreach Worker

The Housing Support team support people to maintain their housing. They provide long-term support in a manner that is intensive, flexible and consumer centred. People receiving support from the Housing Support team can expect assistance to establish and maintain tenancies, develop daily living skills



and participate in social activities. Staff work with people to identify goals, strengths and to develop a person-centred, coordinated plan. They can also provide case management and care coordination to facilitate multi-agency 'wrap-around' support. This often means referral and connection to other agencies, as well as helping to strengthen a person's informal supports.

The Modular Units are the third component of the service. The modular units provide accommodation for up to two years for people with histories of recurring and persistent homelessness. Residents

have access to responsive, individually targeted, 'wrap around' support. The program aims to improve residents' wellbeing, social connectedness, and address any mental health and physical health needs. Staff engage consumers using a trauma-informed and strengths-based approach and provide practical support to help them gain and maintain independent living skills and access permanent housing.

Improved outcomes

The program has achieved some incredible outcomes to date. Consumers are reporting amazing outcomes. In its first twelve months of service, Towards Home+ has provided

support to over 230 individuals. Over 100 individuals have been housed and many others have been supported to maintain their existing tenancies, breaking the cycle of recurring homelessness. Towards Home+ shows what can be achieved when individuals and organisations work together to make change in our communities.

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An Unlikely Alliance

Mary Gibson, Manager Clients Specialist Centre, NSW Trustee and Guardian

Flexibility in approach, professional cooperation and a willingness to tackle complex ethical issues is essential in providing services to vulnerable rough sleepers. An unlikely alliance between an area Health Service Homelessness Unit and a government-appointed financial manager has developed new pathways to achieve some remarkable client outcomes for homeless people with extremely complex needs.

At 8:30am on a Monday morning, in a street front office in Sydney's Surry Hills, 50 to 80 men and women are gathered in a reception area waiting to see officers from the New South Wales (NSW) Trustee and Guardian, the agency which has been appointed by a court or tribunal to manage their finances. Behind a glassed area, a cashier is handing out funds to clients. These clients require a cash-handling facility to access funds for their daily needs because bank accounts are inappropriate: sometimes because of organisational incapacity, sometimes because of behavioural issues, or sometimes exploitation prohibits a person's access to their own funds.

The NSW Trustee and Guardian Client Specialist Centre (CSC) provides a service to some 400 clients. The people using the service vary in age, but the common denominators are chronic mental illness, a history of substance misuse and vulnerability to homelessness. More than 100 of the office's clients at any given time are homeless — people who are rough sleepers, couch surfers, in crisis accommodation, incarcerated or in hospital.

Also in reception are two men – a psychiatrist, Dr Mike Scott, and clinical nurse, Tim Neate, from St Vincent's Hospital Sydney's Homeless Health

Outreach (HHO). For 90 minutes every week, Mike and Tim operate a clinic from the office. They greet and catch-up with clients, arrange referrals, assess and respond to welfare and chronic and acute health issues, write reports, and provide advice. For some clients, the interactions with Mike and Tim are the only health service they will accept or receive for prolonged periods.

Other clients at the Surry Hill's office advised that Franco, a rough sleeper who was notoriously difficult to engage, had a serious burn injury. Franco had been prompted 'by devils' to set fire to his jumper, which adhered to his arm and caused a large third degree burn. For three days, in significant pain, Franco eluded services until the HHO team was able to meet with him and arrange non-voluntary transport to hospital, where he remained while the burn was treated and his mental health stabilised. His hospitalisation also allowed for long-overdue engagement with services and a post-discharge accommodation plan.

Homelessness: The Contact and Engagement Challenge

Eight years ago, staff from St Vincent's Hospital approached the NSW Trustee and Guardian about setting up a clinic. It had become apparent that the Client Specialist Centre was a meeting place for extremely vulnerable people who often had no other contact with services. Rough sleepers and itinerant men and women who faced risks in their chaotic lifestyles attended the office to collect cash but otherwise 'fell through the cracks' of service provision. They were often unwilling or unable to seek assistance, had

little insight into their illnesses, and avoided engagement because of paranoia or fear of hospitalisation. Many clients had intermittent hospitalisation or incarceration after a medical or legal crisis and then disappeared back into the streets. Familiarisation, monitoring and planning — essential for meaningful change — was not possible.

It is not obvious how address-dependent many services are. When a person becomes homeless, access to many services is lost. Community mental health services generally see homeless people as 'out of area', and Centrelink ceases payments if clients do not respond to letters and if compliance requirements are not met. Social and community housing providers expect regular responses to written updates seeking confirmation that a person wants to stay on the housing waiting list.

Minh Tran has cognitive impairment and advanced disease related to alcoholism. He presented at the CSC/HHO clinic with injuries related to being bitten by rodents while sleeping rough. Clinic staff arranged a referral to St Vincent's Hospital drug and alcohol specialists who met Mr Tran at the office, built trust with him and worked towards a detox admission. Mr Tran is now in supported accommodation.

Familiarity and the Building of Trust

It is well established that the most important factor in good health care is familiarity. Efficient responses can be managed if a client is well known — their health history, their baseline, their unique identifiers of their mental health, and knowing what



Germaine had been diagnosed with breast cancer during a previous hospital admission. She was homeless, had no access to services, and was frightened by, and resistant to, any treatment options. An indomitable Homeless Health Outreach Case Manager liaised with the clinic and hospital staff to arrange engagement and eventually was able to arrange a mastectomy and follow-up care.

Client-centred and Outcomes Focussed

The 'Monday Homeless Clinic' has expanded to include service providers and stakeholders from other agencies who can take the opportunity to connect and engage with clients and conduct client meetings. These engagements would not be possible if everyone involved had to convene to meet with homeless clients, who often lead chaotic lives.

The collaboration between St Vincent's HHO and CSC now has a history of positive outcomes. Many vulnerable people have accessed preventive and reactive medical care; young women have been referred to services to escape domestic violence and have access to accommodation; requirements for Centrelink entitlements have been met; referrals have been made to podiatry and dental clinics; legal advocacy has been supported and NDIS applications made, and housing applications have been facilitated and tenancies secured.

Providers trying to reduce risk for homeless clients with complex needs face significant challenges. There are no 'quick wins' and sometimes there are no 'wins' at all. Collaborations like that between St Vincent's Sydney and the NSW Trustee and Guardian require a strong client-centred and outcomes-focussed approach to overcome the myriad practical and theoretical obstacles.

But with perseverance and patience, service providers can together develop pathways to alleviate distress, reduce suffering and ultimately improve the quality of life for homeless people whose outlook may otherwise be dire.

exacerbates symptoms and who the key stakeholders are, all inform the provision of effective health care.

The clinic at Surry Hills allows for the gradual accumulation of information about a client and their circumstances. Just as importantly, the weekly interactions foster trust between clients and staff, enabling an openness to share their circumstances and express their needs. In this more casual and trusting environment, clients have proven to be more willing to consider therapeutic options.

Overcoming Organisational Caution and Demarcation of Roles

Staff from the NSW Trustee and Guardian and from St Vincent's Hospital Sydney's Homeless Health Outreach have been on a sustained learning curve, negotiating

professional cooperation between a mandated, non-voluntary service and a health outreach service. In a resource-poor environment like homelessness support, role allocation needs to be elastic and strict adherence to 'that's not my job' hinders progress.

Ongoing discussion at all levels has helped develop sustainable strategies in relation to ethical and practical issues. Just some examples of the areas where a balance needed to be found have been: the sharing of financial and health information while respecting confidentiality, and the provision of incentive payments to promote medication compliance.

The willingness of both organisations to put the client's welfare at the centre of any decisions about policy has allowed effective cooperation.

Partners in Community: A Health-Justice approach

Mary-Anne Rushford, Bolton Clarke Homeless Persons Program, Charlotte Jones,
Mental Health Legal Centre, Nadu Dove, Dove Ideal Project Solutions

The foundations of positive health and well-being are safe and secure housing, financial security and social inclusion. People experiencing homelessness are amongst our society's most vulnerable and health compromised community members.¹ Routes into homelessness and experiences of homelessness are often accompanied by multiple and complex legal and non-legal needs.

Unresolved legal matters become increasingly complex to manage, both for the individual and for the justice system. The financial costs are increased as legal matters escalate. The health impacts of increasing stress and anxiety are clear.

Since 2015, the Mental Health Legal Centre (MHLC) and Bolton Clarke Homeless Person Program (HPP) have

worked collaboratively to deliver a unique Health-Justice Partnership (HJP) called Partners in Community. Community health nurses (CHN) and lawyers work together to address the legal and non-legal issues impacting on clients' health and well-being.

It all started in November 2014, when the Manager of the MHLC spoke about the work of MHLC at a



team meeting of nurses that work with Bolton Clarke HPP. The nurses listened to the presentation with interest, however immediately post-meeting many nurses wanted to use this opportunity to ask a lawyer about the individual issues their clients were experiencing. As the queue of nurses formed, so did the idea that there should be a coordinated service response.

A HJP approach was developed in direct response to this identified unmet needs and service gap for people experiencing homelessness. The idea was then, importantly, co-designed with CHNs, lawyers and clients to develop a service model for Partners in Community that is highly accessible, effective and has embedded continuous feedback processes to ensure effectiveness at the point of impact.

The international development of HJPs are in response to the substantial evidence which shows that legal problems compound and exacerbate health issues, that people experiencing disadvantage are more vulnerable to compromised health and unresolved legal matters and that people are more likely to talk to their health workers about the stress and anxiety caused by legal matters than to seek out advice from a lawyer. There are a range of individual and systemic barriers to accessing legal assistance and Health-Justice Partnerships seek to reduce barriers to accessing legal services, resolve legal matters and improve health and well-being.

The co-design of Partners in Community has been a key to its success for its clients. Access into the legal service is easy and eligibility requirements are minimal or non-existent. Flexibility of HJP support is critical — the HJP lawyers and CHNs will work completely separately with all information held entirely confidentially in accordance with each profession's protocols or will work together from first legal appointment through to court date, or anywhere in between, as suits the individual client's preferences.

Bolton Clarke HPP CHNs can make referrals at any time, for any client, through email or through the dedicated Partners in Community

HJP phone number. The HJP lawyer then provides an outreach service, meeting clients wherever suits them best often at services they already access as well as providing monthly legal clinics in Frankston and Glenroy.

The services work very closely together. Monthly Steering Committee meetings are held, which include the independent evaluator, for real-time reporting and feedback processes which make sure the project adapts responsively. The HJP legal team learn about working with people with complex needs experiencing homelessness from experienced outreach CHNs. The CHNs participate in legal education sessions around areas of law that impact on their clients. Discussions between CHNs and lawyers highlight the key issues that are being presented, which means appropriate collaborative client-led responses can be developed.

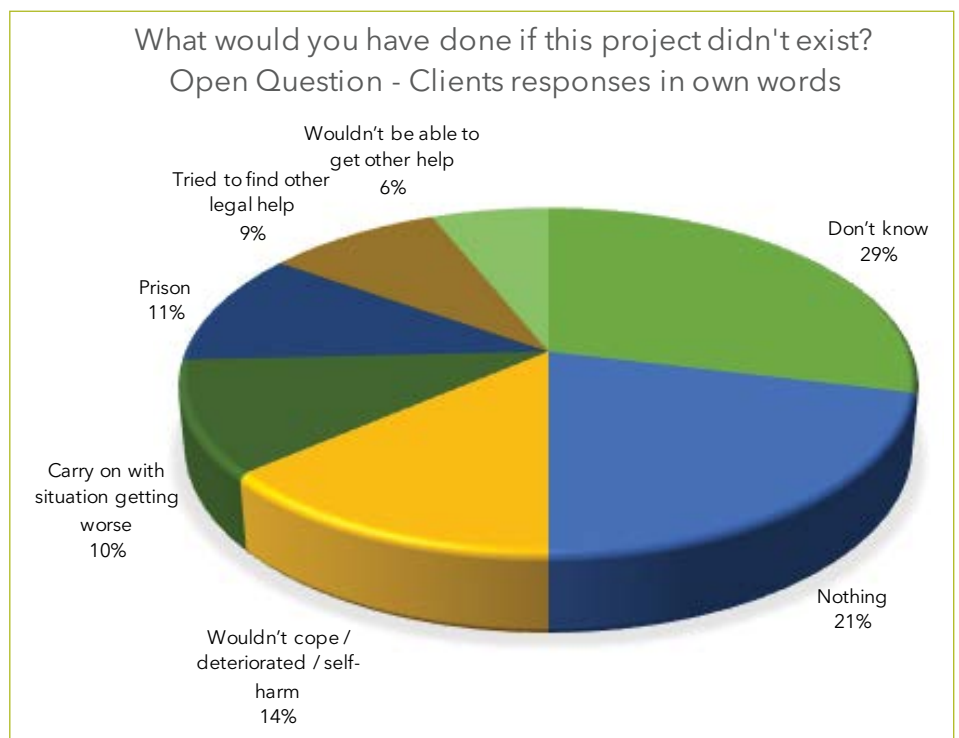
From November 2015 to November 2019 Partners in Community HJP provided legal assistance services to 339 people with 448 legal matters, which included over 300 legal cases. In more than 80 per cent of legal matters the client had one or more risk indicators related to their mental health. The multiplicity of legal matters related to areas of law such as Infringements, Debts, Tenancy, Wills, Guardianship,

Superannuation and Family Law have allowed the partnership to identify systemic issues and advocate for system improvements.

Partners in Community legal outcomes have made a tangible and significant difference to the lives of people experiencing homelessness, from stabilising tenancies and reducing risks of return to street homelessness to increasing access to entitlements and enabling clients to resolve legal matters which have had a dramatic impact on their circumstances.

Client voice guides the service developments. Clients are asked to provide feedback about their experience of the HJP project, gathered through surveys that were co-designed with the initial cohort of clients. The client-led co-design consultations provided insights about how to measure quality and effectiveness from the perspectives of people experiencing co-occurring homelessness and legal issues.

People accessing Partners in Community consistently report that alongside very high levels of satisfaction with processes and outcomes, accessing the lawyer has made a positive difference to their health and well-being. The majority indicated that without the service they would not have addressed their legal issues or known what to do about their legal situation.



As well as exceptionally high rates of service satisfaction including, critically, feeling 'heard' by the lawyer, clients self-report that the using the HJP has had tangible positive impacts on their health and well-being, in their own words: less stress, less anxiety, able to focus on health and well-being, more money to buy food and medications, improved ability to focus on/ think about other things, less worried, improved mental health, stopped me hurting myself, peace of mind, improved sleep, more empowered to ask for help, feel more positive.

Respect is an obvious key to success, respect for human rights, respect for people's dignity, and mutual respect between the health and justice partners. There is a clear and obvious values match between the two key service agencies, both with a genuine social justice lens, a commitment to working from a person-centred foundation and a willingness and determination to walk alongside clients towards improved outcomes.

HPP CHNs have been impressed by the results of the HJP to date, appreciating the significant benefits of being able to identify legal needs and provide a coordinated easy access specialist legal response for their clients. The CHNs passionately nominated the HJP lawyer for recognition as Law Institute of Victoria Community Lawyer of the Year.

Established in 1978, Bolton Clarke (formerly RDNS) HPP is a rights and equity-based model of health care, which is underpinned by the belief that people who experience homelessness have the right to holistic health care that is accessible and relevant; of a high standard; equivalent to that received by the general community; and self-determined.² The care is self-directed by the client.

HPP CHNs assertively outreach to people on the streets, in parks, at food programs, in low cost hotels, boarding houses or other sites such as caravan parks.³ This allows for a flexible response to work with clients who often have complex health needs but who are not engaged with any other services. Often HPP CHNs are the first point of contact for clients, which often leads to one or more of the following: a needs assessment; clinical response; health education;



ongoing monitoring; personal support; advocacy; and referral to required services. The relationship that the community health nurse develops with clients is central to the service they provide. This relationship, based on trust, enables the nurse to support clients to identify the issues they wish to address, and assist them to engage with and access the required services.⁴ The HPP's model of practice successfully engages homeless people by actively participating in their healthcare.

The Mental Health Legal Centre was established in 1987 and has developed and maintained a reputation as a trusted and independent legal service, recognised by both mental health services consumers and cross-sector practitioners as flexible and committed to improving social and legal justice outcomes for people experiencing mental health challenges. The MHLC is committed to ensuring that people living with a mental illness have access to appropriate and specialist legal services, representation and information, to encourage opportunities for this vulnerable cohort to effectively participate within equitable and inclusive Victorian communities.

The MHLC has extensive expertise in disseminating important complex information that has significant

impact on people with co-occurring mental health and legal challenges, to increase their capacity to understand and exercise their legal rights. The MHLC have a diverse and talented multidisciplinary team and deliver a variety of consumer-centred projects which are able to evidence effectiveness of service, and importantly, flexibility of modalities which include outreach, in-reach, co-locations, in person, by phone, and in partnership with others.

The MHLC utilises consumer and stakeholder co-design practices to develop and embed their outcomes framework, evaluation mechanisms and tools and utilise strong continuous improvement processes through service delivery, service adaptations and developments and new initiative design. The key themes of the MHLC's outcomes framework are access to justice, empowered communities, holistic responses to need, fairer laws and system and effective services.

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Happy Feet: A Not-for-Profit Collaboration Towards Happier Feet

Leanna Helquist, *cohealth*, Rajna Ogrin, Bolton Clarke Research Institute,
Mary-Anne Rushford, Bolton Clarke Homeless Persons Program, Rebecca Mannix, *cohealth*
and Anthony Lewis, Footscape

Happy Feet is a collaboration between three not-for-profit organisations. We are working to describe the foot health needs of people experiencing homelessness with the aim to improve access to foot care for all people experiencing homelessness in metropolitan Melbourne.

Foot problems are frequent in people experiencing homelessness.^{1,2,3} These problems can include skin, nail and biomechanical issues as well as chronic disease.⁴ Foot and leg pain is also common.⁵ In addition, not many people go to a Podiatrist. One study showed that only 16 per cent of people experiencing homelessness who attend a General Practitioner (GP) had accessed podiatry services.⁶ Of even more concern is that three quarters of these were single episodes of care,⁷ given the frequency of foot problems commonly identified in this group this means that foot problems are largely going untreated.

Further, the only reason the podiatrist was seen was because the podiatrist was available on the day at the drop-in centre the individuals attended.⁸ This suggests that access to podiatry care is opportunistic, and many people experiencing homelessness may require alternative access to care.

A 2015 audit of podiatry clients at Central City Community Health Centre (CCCHS) indicated that basic foot care is an ongoing need for people experiencing homelessness. Common presentations are for footwear, current or developing wounds, chronic disease and fungal infections. Although a number of people identifying as requiring podiatric care, many do not access this care. There are a number of services providing foot health services in Melbourne, and to date these had not been delivered in a coordinated way, further compounding disadvantage.

Recently, Igniting Change, a charity, provided funding to supplement any support needed by people experiencing homelessness to improve their foot health. This ignited the project Happy Feet. Happy Feet is a collaboration between Bolton Clarke, *cohealth* and Footscape to provide coordinated foot care to people experiencing homelessness, see Figure 1 for the program. So far, the project and collaboration has provided vouchers for people to obtain new shoes, increased access to footwear, socks and foot first aid kits and importantly improved access to podiatry services.

To measure the success of this collaboration, a study is underway to evaluate referral pathways between nursing and podiatry, the frequency and outcomes of this care including the provision of footwear, socks and foot health first aid kits donated from Footscape. The project has

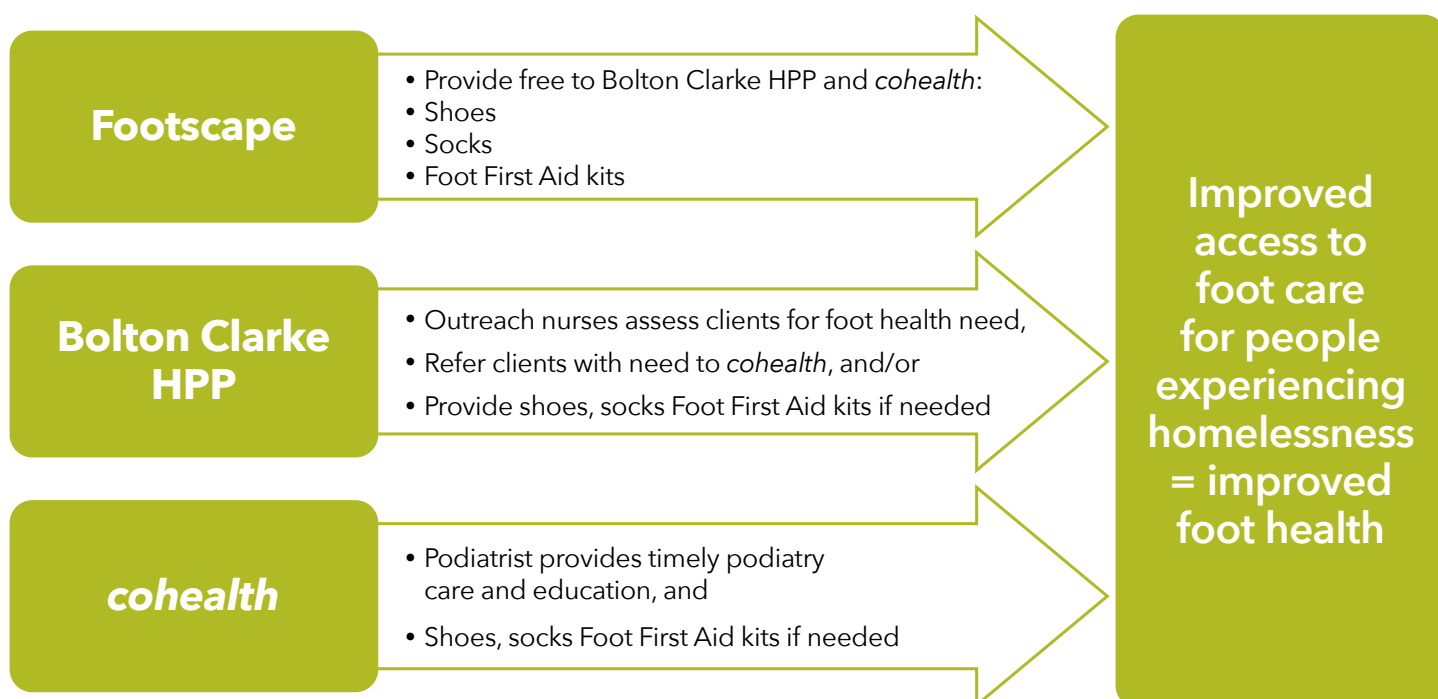


Figure 1. Collaboration between organisations to support improved foot health in people experiencing homelessness.



been underway since June 2019, and so far, 39 individuals have been identified by the nurses as potentially needing podiatry input. Not all have accessed podiatry care, while those that have obtained shoes, socks, foot health first aid kits and treatment for wounds, fungal infections and education on foot care, including education of individuals with chronic disease at risk of more serious foot complications. We anticipate collecting data on around 50 people to obtain sufficient information to begin to better understand the needs of this group. This will support planning and then advocating for services that better meet the needs of people experiencing homelessness, so that foot health services are accessible to those who need them. We will keep you posted with the outcomes of this project.

cohealth is one of Victoria's largest community health services with a mission to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities.

cohealth prioritises people and communities who experience social disadvantage and provides a range of health and other supports to people experiencing homelessness. *cohealth*, in partnership with City of Melbourne, has been providing podiatry services to people who are homeless or at risk of becoming homeless since 2012, primarily at Central City Community Health Centre, CCCHS.

Bolton Clarke is a not for profit health provider of independent living services through at-home care, retirement living and residential aged care. Bolton Clarke Homeless Persons Program is an integrated nursing service that provides wrap around nursing care addressing the complex health and social support needs of people experiencing homelessness.

Footscape is a charitable organisation that recognises disadvantaged communities are predisposed to debilitating foot pathology. Working in partnership, Footscape assists to provide material aid and evidence-based care across Victoria.

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Inclusive Health Partnerships: 14 Years of Local Evidence

Kim Rayner, Clinical Lead — Innovation, Micah Projects and Karyn Walsh, CEO, Micah Projects

This paper will provide a summary of services established by Micah Projects and its partners to shift the local healthcare landscape and address unmet health needs among Brisbane's homeless and vulnerably housed population. It will also highlight evidence what has been generated at the local level to contribute to the national and state policy agenda.

Since 2006, Micah Projects has integrated healthcare within its homeless, housing and social support programs through a Housing First and Social Model of Healthcare framework. This work began in 2006 when Mater Health located a clinical nurse within the homeless service to address unmet physical and mental health needs observed among people accessing the service. Subsequent work led to the introduction of the Vulnerability Index Survey into Australia in 2010 by Micah Projects, and for the first-time key information and data was collected, identifying the alarming morbidity and mortality risk among people experiencing homelessness in Brisbane.¹ Consequently, additional partnerships were formed across local hospitals, Primary Healthcare Networks (formerly Medicare Locals), government and General Practitioners (GPs) to address these gaps. Since this early beginning, several services have been implemented and funding has been continually secured to advance the population groups access to healthcare and housing, two key determinants of health.

Street to Home Integrated Health Services: After Hours

Prior to the commencement of the Homeless to Home After-Hours Health Service in early 2012 there was limited after-hours healthcare for homeless and vulnerably housed populations in Brisbane. The only option available

for outreach workers when presented with an unwell person was to access the nearest emergency department. Outside of the high cost, there was often little or no resolution of the main reasons behind the presentation and/or ill health. This service continues to operate seven nights a week through PHN funding. Clinical nurses work alongside Street to Home workers in a multi-disciplinary team. This assertive health outreach response provides direct nursing care and treatment in a variety of street, public space and temporary accommodation locations across Brisbane, performing follow up consultations while working jointly with the Street to Home workers to address housing and crisis support needs.

*'The intent of the model is to ensure housing support, rapid rehousing and to provide cost effective healthcare services at all stages of the housing process to reduce the personal, and social costs and impacts of homelessness to the individual and to the community.'*²

Key findings from an economic evaluation of the service³ identified that on every measure evaluated the service had an impact:

Expensive hospital usage declined substantially among participants, with a 37 per cent reduction in inpatient admissions and a 24 per cent reduction in Emergency Departments (ED) presentations.

hospital inpatient costs dropped dramatically.

Health related quality of life indicators improved among participants, yielding a monetised value of \$6.16 million when a quality of life adjusted year is employed.

Spending \$503,000 per annum on the service and proactively addressing the health and housing needs of Brisbane's Homeless people (n=1369) saved the Queensland Public Health system between \$6.45 - \$6.9 million.⁴ The annual net social benefit of the service was between \$12.61 and \$13 million.

Extending Care: Street to Home Daytime Response

In 2014, daytime community nursing, funded through the Primary Healthcare Networks, has allowed for improved follow up and case management of people engaged at night. This service is critical to the coordination of care between the night and day teams and for oversighting the care of highly vulnerable individuals. Mobile health outreach capacity was further extended through Brisbane City Council funding in 2017 allowing for the leasing and fit out of mobile health vans and increased nursing capacity across additional Brisbane locations.

Brisbane Common Ground Integrated Nursing Service

In 2012, Brisbane Common Ground, a supportive housing model for 146 tenants opened in Brisbane and not long after integrated nursing services were introduced through a partnership between Micah projects, Mater Health Services and St Vincent's Private Hospital Brisbane. This program delivers direct nursing care, health promotion and care coordination seven days a week to tenants of the building. The nursing care is delivered alongside supportive housing workers. A housing first approach is central to the model, which supports people to maintain their tenancies through integrated health and psychosocial support mechanisms. An evaluation conducted in 2016,⁵ demonstrated the impact

of this integrated multi-disciplinary model. Key impacts included:

- people sustaining their tenancies — preventing a return to homelessness
- tenants using less crisis health and criminal justice services
- people were able to overcome barriers to healthcare
- improved health and wellbeing indicators of tenants.

*'Tenants experiences illustrated how the model enabled them to overcome barriers to start taking control of their primary healthcare and lifestyle needs.'*⁶

Pathways: Hospital Admission and Discharge Pilot

December 2014 marked the commencement of the Pathways Hospital Admission and Discharge pilot funded through Queensland Health and delivered in partnership with St Vincent's Private Hospital, Princess Alexandra Hospital and the Royal Brisbane and Women's Hospital. This program targeted at risk individuals who were homeless or vulnerably housed with multiple and complex health and social needs, providing timely engagement prior to discharge from hospital and then subsequent community follow up. The vulnerability index profile⁷ showed that the majority of participants had been homeless for 2.25 years; rates of chronic disease were high, 87 per cent had a mental health condition, 46 per cent were on a disability support pension and 32 per cent had been in prison in the past.

Pathways nurses, employed by St Vincent's Private Hospital were integrated with Micah Projects, Home for Good-Coordinated Access and Referral Team allowing for a stronger model of direct service delivery, especially with regards to the provision of housing, crisis assistance and case management. The multidisciplinary outreach team, proactively worked with the person to address their complex housing, health and social support needs through assertive advocacy and care coordination to overcome existing barriers while

also providing direct nursing care and mental health interventions.

'They made me feel that I had been given back my dignity, and my self-worth as an individual. Think Pathways made a difference to my life.'
— participant feedback

Economic and program evaluation undertaken^{8,9} demonstrated significant participant and system outcomes and return on investment:

The service prevented unnecessarily hospital admissions and presentations to emergency departments, achieving a 76 per cent reduction in ED presentations; 83 per cent reduction in ambulance use and a 76 per cent reduction in inpatient admissions, while participants were in the program.

- improved a person's ability to manage their health and avoid hospital admissions
- improved housing access and stability, addressing homelessness
- increased access and sustained engagement with GP's, community and social support systems

An indicative cost benefit analysis study of the Pathways pilot identified that when the resource intensity of inpatient use is modelled, Pathways returns as much as \$7.25 per \$1 spent.⁷

Community Response to ED-Frequent Presenters Program

In July 2015, Micah Projects and Footprints Inc commenced discussions with the Royal Brisbane and Women's Hospital Emergency Department to create a collaborative response to people who present five or more times in a month to the emergency department.

Many of these people were known to Micah and had a history of significant disadvantage, few or no supports, homelessness, chronic disease(s), disability, mental illness, drug and/or alcohol addiction. This program is now called Working Together to Connect Care. Service delivery in the community commenced in April 2016, with funding from Brisbane North PHN. A small, targeted community

based assertive nursing and social support team was implemented, tasked with responding to referrals for at risk individuals identified within the emergency department.

While funding remains inadequate to scale up the service, significant participant and service system outcomes have been achieved. The current high threshold eligibility criteria has also resulted in many people missing out on the benefits of this service.

Outcomes achieved^{9,10} include:

- Strong integrated links and critical information exchange between NGO's and hospitals within the Metro North Brisbane region
- 64 to 67 per cent reduction in ED presentations for Micah Projects participants
- 57 per cent reduction in hospital admissions
- decreased interactions with police and the justice system
- improve housing stability and access
- increased linkage and sustained engagement with GP's and community services
- noted improvement in self-management and understanding of health issues.

'I'm really glad you didn't give up on me and although it was difficult to work with me at times I felt that people listened to me, responded well to my crises and this really helped me eventually to be able to find my feet.'
— participant feedback

Inclusive Health and Wellbeing Hub

The Inclusive Health and Wellbeing Hub opened in 2017 through a partnership with Tzu Chi to address gaps in conventional mainstream models of primary healthcare and increase access to GPs, medical, dental, social care, women's health and wellness programs. In doing so, this service aims to address health and social inequality. The Hub interfaces with Micah Projects support teams

to ensure high quality, flexible, targeted and accessible care with full consideration of the persons lived experience, current needs and the impact of the social determinants of health on a person's life.

The Hub is a central integration point for hospitals and community organisations with an additional Homefront outreach team based out of the clinic and funded through Qld Health to respond to hospital referrals from the Princess Alexandra Hospital, ensuring continuity of care. The service continues to work closely with the Mater Hospital and a range of social services especially those supporting people who are homeless, have a disability, women and children escaping domestic violence and refugees. The wellness program has provided the opportunity for people to access services like acupuncture and myotherapy with positive benefits. Next steps include the implementation of mental health initiatives that provide greater identification of needs and follow up care; Increased access to addiction medicine and treatment.

Conclusion

The services discussed share common elements that include high-quality person-centered care that is compassionate, and solution focused. Clinical integration of physical health conditions, mental illness and addiction along with housing and social support needs is critical to achieving high impact outcomes. Continuity of care regardless of housing status or complexity of needs and assertive engagement all contributed to improving people's health, ending homelessness and increased health system efficiency and sustainability. What we have learnt overall is that it is critical to ensure coordination between hospital and community services and the best outcomes we can achieve are those which give better access to healthcare in the community and are delivered in collaboration with social services. This also achieves the economic benefits sought by government, however we need to be able to provide services at the scale required to meet demand, and not just as pilot programs. The challenge that now remains is the absence of a national policy and funding framework that builds on the evidence, such as that presented in this paper and from

others nationally and internationally in order to achieve sustainable programs of care that have lasting impact on a person's life and our society. The Australian Alliance to End Homelessness is a national group that is now seeking a health-informed end to homelessness in Australia

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20 Years of ALERT

Samantha Corrie, Senior Project Officer, Inclusive Health Program, St Vincent's Health Australia

Introduction

The Assessment Liaison and Early Referral Team (commonly known as ALERT) at St Vincent's Hospital Melbourne (SVHM), is an Emergency Department-based, multi-disciplinary care coordination service that provides care to clients with complex needs, especially those presenting with homelessness.

'Care coordination' in ED is the provision of person-centred care that supports clients to access an integrated system of services within and across hospital and community sectors.

In 2020, ALERT celebrates its 20th birthday. We spoke with Rebecca Power (who managed ALERT in its early years) and Andrew Chan (the current program manager) to explore why this program has endured, and how it continues to work with some of Melbourne's most vulnerable.

Q: Thinking back to the early days, what hurdles did you overcome when setting up the service?

Rebecca:

I think that there are always hurdles in setting up something new. In the beginning the Emergency Department (ED) did not want to have a bar of any type of care coordination in ED. The staff in ED were saying things like: 'I don't know what these people want? We can all do this. This is our role too.' But we had some very skilled clinicians who got a few quick runs on the board and actually showed their worth. Probably within six to 12 months of commencement, we had an ED that was saying 'we could not work without this service.' If you can manage to get over the hurdles,

the people who were doubters turn into your best advocates.

We were going through annual funding at the time, so that was another challenge. Everyone was on fixed term contracts, and a few times the funding was challenged. People would ask, 'Should we be spending money on doing this?' But we (ALERT) wouldn't need to say anything because the Emergency Department would say, 'Hey, we actually need this. These people make a difference.'

From a workforce perspective, another hurdle was getting the right people into the care coordination role. It was an interesting time because we were entering that space of intra-disciplinary work — everyone had a discipline background (for example, occupational therapy, physiotherapy, social work, nursing) but had to develop a baseline (of care coordination skills) and then understand where to refer on to. Other hospitals tried different models (Melbourne Health brought allied health staff from the wards into the ED) but we went for a very different care coordination model — I think it worked.

Andrew:

ALERT is a permanently-funded model now sitting within the Victorian Government's Health Independence Program. Embedding the model of ALERT in ED early on in those days has really helped the model now. ALERT is very much seen as a team that is vital to the ED. In saying that, the ALERT model could not and cannot work without the commitment and care that ED Doctors and nurses have for the vulnerable client groups who present to ED. ALERT can't do what we do without the support of ED.

The 'can do' attitude and flexibility of our role in ED is still evident within staff practice. When a situation presents itself in ED that doesn't fit the box, people often say: 'Get ALERT'.

ALERT has also expanded in its service now to fit the needs of our vulnerable client group with Aboriginal-identified positions, closer integration with the Francesca Healy Cottage, and primary health nursing into the Salvation Army's Magpie Nest café on Bourke St. With the current ALERT service, I hope we are positioning the team and the ED to meeting the needs of our client group who are experiencing homelessness for the next 20 years.

Q: What was the client group like early on and what are they like now?

Rebecca:

There were probably about 20 clients who would rotate in and out of frequent presentation — the top 10 per cent of frequent presenters, and we all knew them. I can still remember some of them. We worked with them on a long-term basis.

I think that we gained a really good understanding of that top 10 per cent of frequent presenters. There's a bit of stereotyping of that group but they were actually really fun to work with and fascinating people.

And then we had a mix of other people. There were clients with whom we could do short-term care coordination, that was quick and fast, and you could actually make a difference with one or two interventions. And there were the clients who were going through a crisis, and who we cared for a little while longer, before we got them back out [into the community] again.

We also developed a better understanding of how we can come from a patient-centred perspective as opposed to a medical model, which hospitals, especially in Australia, are want to do.

Andrew:

Frequent presenters to our ED are still a focus, although I do see that the client group has changed over the past 20 years. We are seeing fewer clients with chronic homelessness that consistently come to ED over many years. Back in the early years of ALERT, it was very much that profile of the middle aged male who is homeless with chronic alcohol use. We are now seeing more presentations relating to family violence, poly-substance use with significant behavioural issues, and significantly unaddressed mental health issues, all compounded by homelessness. Housing stock has reduced, particularly those small independently run rooming houses, as has crisis housing for those that are at the pointy end of health and psycho-social complexity. Over the years we have developed an integrated and collaborative way in which we provide support and management of those who frequently present to the ED through our 'ED clinical review meetings'. Each meeting has focus on a particular client around 'what is working' and 'what's not working' for that client in ED. This meeting is shared and has contribution from all in ED: doctors, nurses, mental health, ALERT, and various community housing and health stakeholders.

Q: What was the team like 20 years ago, and what is it like now?

Rebecca:

It was a very, very close, dynamic and fascinating team full of diversity. They were a handful to oversee, but a delightful handful because their strengths were just so broad. If you took a strengths-based approach, then you actually got so much out of them that made a real difference to clients and that's what we were there for.

I think you have to employ for cultures and behaviours more than you employ for skills and knowledge, in some ways. I think we needed to be really clear about what this

'thing' was that we were looking for (in our staff). Flexibility of thought is important; being able to be very flexible, and open, and values-based. Those behaviours were very 'can do' were really important too.

Andrew:

ALERT is a big team with a big presence in ED. There are 16 (equivalent) EFT of multi-disciplinary staff — social workers, occupational therapist,

physiotherapists, nurses, and dieticians. All of them come from a discipline background but they all still provide care coordination. The important thing in the team is all of them have that same philosophy and culture around wanting to work with a vulnerable client group. It is very much as Rebecca has described it: we recruit new staff to ALERT more on their social justice and focus on care for the poor and vulnerable than their care coordination experience.



The experience and interests of the current staff are diverse as well as progressive, including: Aboriginal health, family violence, homelessness, sexual health, and modern slavery. We are currently in the process of recruiting our first peer support worker role in homelessness which exciting.

Q: What are you most proud of from those early days in the ALERT?

Rebecca:

The thing that I am most proud of, and which held me in good stead for my future (career), is being able to make a demonstrable difference to people, families and communities. You could actually touch and feel that in ALERT. ALERT had a really direct connection to making things better for people.

We had the ability to be quite flexible in what we were able to do. It wasn't 'here's this standard package, you either take it or leave it.'" And being able to have that really strong advocacy role and follow people through their ED experience, through inpatients, and back out into the community.

I am a nerd, so I love data and impact and evaluation, and we did that — a lot of it. It was actually good to be part of a program that was held to account because it made us be reflective of everything we did. It wasn't just set up and going to be there forever. We actually had to make an argument about why, and that's something that I think made the team quite agile, and held the team to account.

Q: What makes you proud now?

Andrew:

ALERT has quite a big presence in our ED, and that's a big thing for us because at St V's, we see ourselves as the 'centre of excellence for care to the poor and vulnerable'. I think this is reflected in how the community sees us as well.

I am very proud of the level of advocacy, commitment, client-centred care and skill in

the staff I work with in ED. They are amazing people who strive to do the best for our clients with their heart, their head, and their hands — and who doesn't want to be around people like that day in and day out?

It is important to note that ALERT couldn't do what we do without the support of the entire Emergency Department. The doctors and nurses have the same philosophy in relation to our client group — a real commitment to social justice. And that's a big part of the reason ALERT works. This ethos also extends to all levels of the organisation, all the way up.

Q: Any final thoughts?

Rebecca:

I remember it as a fantastic time. That buzz of being part of something really new and exciting. And something that has been sustainable, and continues to make a difference, which is unusual these days. It had a great team, that had impact, that had purpose, and

that's what I loved being part of — it was an absolute pleasure.

We are about to embark on the next big phase as a health sector in Victoria, focusing on really delivering care outside of hospital walls. I think it would be a shame to embark on that without really understanding the benefits of programs like HARP, and particularly like ALERT, and trying to get learnings from that model. I really hope that we are able to take what we learned from that and deliver that, rather than add another model. Victoria has a big challenge to deliver future healthcare — we haven't got there yet — and we are under a huge amount of pressure to do so. I think that these next five years will be when the rubber hits the road, and how that works is going to be really interesting, but I hope that programs like ALERT will be used to inform some of that future care.

Andrew:

It is difficult work working in this space, from all aspects, especially emotionally, with the complex situations that we see people with in ED. But we keep a focus on fun in the team and there are many times where we take to opportunity to laugh and find joy in the day-to-day things we do.

Those are really nice words from Rebecca about her time with ALERT, and I would also emphasise the focus of St Vincent's in providing 'care beyond the hospital walls'. There are currently some great initiatives in place that St Vincent's are pursuing in the homelessness area, and there is more to come. It is an exciting time to be part of this work and having the privilege to lead a team that to this day continues to demonstrate that St Vincent's cares: always has and always will.

With thanks to:

Rebecca Power, Director — Centres of Clinical Excellence, Safer Care Victoria

Andrew Chan, Health Independence Program: Psychosocial Stream Manager (ALERT), SVHM



Chapter 2: Research and Advocacy

Data Linkage Highlights Shortcomings for Integrated Health and Housing Responses

Rebecca Howard and Andrew Hannaford, Health Independence Programs, St Vincent's Hospital Melbourne, George Hatvani, Andrew Hollows and Shaun Feeley, Launch Housing

This article reports on a recent study by Launch Housing and St Vincent's Hospital Melbourne (SVHM) to quantify consumers experiencing homelessness who are moving between our specialist housing, homelessness, and acute health services.

As a major teaching hospital on the northern fringe of Melbourne's CBD, SVHM provides a range of programs to support the health needs of homeless people including Australia's first medical respite centre, the Sister Francesca Healy Cottage ('The Cottage'). Launch Housing is an independent Melbourne-based community organisation working with people at risk of, or experiencing, homelessness. One of Launch's major homeless services in Melbourne's inner north shares geographical proximity with SVHM, yet opportunities to collaborate in service delivery models are often overlooked due to disparate data collection frameworks and fragmented information sharing.

Background

Inner Melbourne has experienced a dramatic increase in visible rough sleeping over recent years¹ with significant repercussions for inner-city hospitals and homelessness services. Homelessness is not only a serious housing issue; it is also a severe health inequity.² Disproportionately high rates of mental illness, trauma, victimization, cognitive impairment, substance use, chronic disease, musculoskeletal disorders, skin and foot problems, poor nutrition, poor oral health, Hepatitis C, cirrhosis and tuberculosis are found.

These acute and chronic health issues are compounded by other social determinants of health such as low educational attainment,

unemployment, poverty, and isolation. For this cohort, moving frequently between rough sleeping, crisis accommodations and other forms of temporary lodging, access to primary care and appointment-based health systems are notoriously challenging and difficult to prioritise over daily basic survival needs.

Consequently, people experiencing homelessness are over-represented in hospital emergency departments (ED), often with a more serious and protracted illness that may have been avoided through earlier primary care interventions. Furthermore, it has long been recognised that people experiencing rough sleeping, especially those with chronic needs, cycle through acute mental health care and exit to homelessness, only to return repeatedly to hospital-based care, and the prison system.³ Along the way, their health deteriorates which also has the effect of creating a significant financial cost to the community.

The most alarming example of the health inequities for people experiencing homelessness is the disparity in mortality rates with the general population. Research in Australia⁴ suggests that the mortality risk exceeds that of non-homeless people by up to six times. An analysis of the Launch Housing's client death register⁵ over the 12 months to June 2019 underscores this. It showed that the median life expectancy of the 47 known deaths of current or former clients was 42 years of age, with 84 per cent of this cohort reporting a diagnosed or self-disclosed mental illness.

Across the health and homelessness sectors, there is increasing recognition of the need for integrated health and homelessness service responses⁶ to

overcome these shocking disparities. However, variability in data collection methods, reporting frameworks, and funding sources results in poor visibility of the people who are concurrently accessing health and homelessness services. This has significant implications for the design of partnership service models, continuity of care, efficiency of service delivery, pricing frameworks and ultimately, consumer outcomes.

Current State: Data Collection

In 2017, SVHM's evaluation of its homelessness services⁷ identified key shortcomings in data collection and sharing both within and outside the hospital. For example, different definitions and standards for recording homelessness are used across multiple hospital data sets that report to the state government, such as the Victorian Admitted Episodes Dataset (VAED), the Victorian Emergency Minimum Dataset (VEMD), and the Victorian Integrated Non-Admitted Health (VINAH) dataset — the latter which is used for hospitals' community-based outreach services.

All of these datasets have variable definitions and none comprehensively collect the range of homelessness categories under the Australian Bureau of Statistics' 2011 definition,⁸ or match those collected by Specialist Homelessness Services. The absence of consistent definitions leads to workarounds, such as the use of proxy measures like a postcode of '1000' or an address of 'no fixed place of abode' to quantify consumers who are rough sleeping.

Furthermore, after admitted patients are discharged from hospital, medical records are manually 'coded' to Diagnosis Related Groups (DRG), which are then used to inform

hospital funding. An ICD-10 code of 'Z59' is defined as 'homelessness', however, it is thought to be broadly under-reported¹⁰ and only collects those with overt homelessness, such as rough sleeping.

Collectively these limitations result in considerable underestimation of people moving between various forms of homelessness and accessing health services. This underestimation was quantified by a 2017 study at another metropolitan Melbourne hospital where VEMD data was found to identify 0.8 per cent of Emergency Department presenters as homeless, whereas manual screening identified 7.9 per cent as homeless.¹¹ The consequences of undercounting are significant, from unmet client needs through to funding decisions based on data that does not reflect the scale or nature of the problem, nor the impact upon hospitals. For example, this data is critical in deciding potential resourcing under the Pricing Framework for Australian Public Hospital Services.¹²

In contrast, Launch Housing clients' housing and/or homelessness status is predominantly collected using the Specialist Homelessness Services Data Collection¹³ and reported monthly to the Australian Institute of Health and Welfare. Data collected under housing status (dwelling type, tenure type, and occupancy type) allows for the housing and homelessness status of the person to be ascertained. Furthermore, these can be mapped to the Australian Bureau of Statistics' operational categories of homelessness if required. In addition, Launch records intake information from clients presenting at their three access points, allowing capture of housing status for initial assessment drop-in clients.

The problematic nature of data collection, and the likely over-representation but under-identification of people experiencing homelessness, emerged as a key feature of our recent study, which sought to quantify and map the nature, frequency and service usage profile of clients who have retrospectively accessed both SVHM and Launch Housing.

Method

The study was approved by SVHM's Human Research Ethics Committee (Ref: LLR 066/19).

Due to the challenges in identifying homelessness at SVHM, a cohort of persons from a previous study¹⁴ (n=359) was utilised, who in 2015 accessed at least one of SVHM's specialist homelessness services (The Cottage, Clarendon Homeless Outreach Program, Prague House, or the Assessment, Liaison and Early Referral Team). This group was compared with Launch Housing's top 100 Frequent Service Users (FSUs) from 2013-17. The two cohorts were matched using a Statistical Linkage Key (SLK), which enables confidentiality of clients while still allowing each organisation to establish if the person was one of their clients.

Results

In comparing the two datasets, we found a very large overlap of consumers accessing both services. Of the 359 SVHM homeless cohort, 48 per cent were found in the data set of all Launch Housing Entry Point, support and housing services across inner Melbourne. Of Launch's top 100 FSUs, 59 per cent had at least one SVHM ED presentation during the 2013-17 period.

The demographic profile of the two overlapping groups was different (Table 1) with the SVHM cohort

being on average slightly older and with higher representation of males and those from Aboriginal and/or Torres Strait Islander background.

An area they had in common was a similar history of incarceration, with 15 per cent for both cohorts, a likely underestimate in Launch's data due to under-reporting. The Launch Housing FSU cohort were significant users of SVHM's Emergency Department with a mean of 9.1 ED presentations per client compared to the overall mean of 1.8 ED presentations per client during the 2013-2017 period.

Ambulance usage was also substantially higher for this group with a mean of 4.6 ambulance arrivals per person compared to the overall mean of 1.6 ambulance arrivals per person in this period. The data showed overlap with mental health services, with 14 per cent having an acute mental health unit admission; this is a key area of under-reporting as this group is known to have very high co-occurring mental health co-morbidity.

Both matched cohorts received a significantly higher number of support hours from Launch Housing than the organisational average of around 14 hours. When Launch Housing service utilisation data was analysed, it showed an average of 91 contacts (37 hours) per client for the SVHM homeless cohort compared to 29 contacts (14 hours) per client for Launch

Table 1: Demographic findings

	<i>SVHM Cohort</i>	<i>Launch Housing Cohort</i>
Mean age	50	36
Male	73	64
Female	27	36
Aboriginal/Torres Strait Islander	14	10

Table 2: Matched client with Launch Housing support periods / tenancy agreements during the same period.

<i>Launch Housing Program Area</i>	<i>LH FSU</i>	<i>SVHM</i>
Entry Points	89	96
Permanent Housing	18	39
Crisis Accommodation	15	30
Transitional Housing	15	21
Real Estate	5	4
Youth Transitions	N/A	0.6

Housing overall across a diverse range of program types. The Launch Housing FSU group average was 58 hours of support (53 contacts), and the SVHM group had an average of 37 hours (91 contacts). Both had also received support from multiple areas of Launch Housing over the same period (Table 2), but most of the support was clustered around the crisis response at 'point of entry' services, with the SVHM group in receipt of significantly more long-term and crisis accommodation support.

Policy Implications

This study by Launch Housing and St Vincent's Hospital Melbourne quantifies a significant overlap and repetitive instances of consumers cycling between acute hospital and specialist homelessness services. Despite health and homelessness being critically entwined, our data collection systems and sharing processes are insufficient and siloed, resulting in the invisibility of clients that the service systems are working separately to support.

Our first practice priority is to improve this situation by working more closely together for this extremely vulnerable cohort. The most immediate policy implication of this study is the need for better identification of people experiencing homelessness in all aspects of the hospital system including ED. Our study supports the recent report¹⁵ by the Alfred Hospital concerning the substantial under-recognition of homelessness in presenting patients, in particular people who are in crisis housing, couch surfing or tenuously housed.

At an individual level, failure to identify these people contributes to inequity of access to specialist services and poorer health outcomes. At a service system level, it underestimates the true cost to public hospitals in managing their care. As our data shows, many patients who are presently homeless have multiple and often protracted hospital stays.

Enhanced and harmonised data collection – ideally led at a national level by the Australian Institute of Health and Welfare — and improved data sharing practices can support the development of integrated health and housing responses that foster continuity of care, and the evaluation

of the effectiveness of novel models of care, including longitudinal housing stability over time.

For example, a key bridge between health and housing services is the provision of step-down medical respite services, such as The Cottage at SVHM, which provides recuperative nursing care in a home-like environment to people exiting hospital who are homeless or tenuously housed.¹⁶ An evaluation of The Cottage¹⁷ has demonstrated a reduction in unplanned hospital admissions while a systematic review of American research¹⁸ showed that medical respite programs reduce future hospital admissions, inpatient days, and result in improved housing outcomes.

Furthermore, the current Royal Commission into Victoria's Mental Health System has repeatedly highlighted the co-occurrence of mental health and homelessness, and the urgent need for targeted responses. Continued data silos make understanding and cooperation between multiple service systems and the achievement of this goal extremely difficult.

The ultimate conclusion of this study by Launch Housing and St Vincent's Hospital Melbourne is that the high degree of overlap demonstrates the need for integrated responses to health and housing. Fundamental to the identification of individuals and the provision of integrated care, are enhanced data collection and sharing systems. The key healthcare intervention for someone experiencing homelessness is access to affordable, stable accommodation and community support to maintain their housing while managing underlying health issues.¹⁹ Put simply, housing is good healthcare.

Endnotes

1. Australian Bureau of Statistics (ABS) 2016, *City of Melbourne Street Count 2017*; Furthermore, Launch Housing estimates that the level of service demand for crisis accommodation in Inner Melbourne (the local government areas of Melbourne; Maribyrnong; Port Phillip; Stonington and Yarra) is approximately 1,960 to 2,155 over a full year. This is a conservative estimate.
2. FEANTSA 2016, *'Policy Statement: Average Age at Death of People Who Are Homeless'*, September
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adults under a system of universal health insurance', *American Journal of Public Health*, vol. 103, no. S2, pp. S294–S301; Bevitt A, Chigavazira A, Herault N, Johnson G, Moschion J, Scutella R, Tseng YP, Wooden M and Kalb G 2015, *Journeys Home Research Report No. 6*, University of Melbourne, Parkville.

4. See: Arnautovska U, Sveticic J and De Leo D 2014, What differentiates homeless persons who died by suicide from other suicides in Australia? A comparative analysis using a unique mortality register, *Social Psychiatry and Psychiatric Epidemiology*, no. 49, p. 583–589
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6. For example, Parsell C, ten Have C, Denton M and Walter Z 2018, 'Self-management of health care: multimethod study of using integrated health care and supportive housing to address systematic barriers for people experiencing homelessness', *Australian Health Review*, vol. 42, no. 3, pp. 303–308.
7. Wood L, Vallesi S, Martin K, Lester L, Zaretsky 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. [SVHM HREC-A 086/16]
8. Australian Bureau of Statistics 2012b, 'Information Paper: A Statistical Definition of Homelessness', Cat. No. 4922.0, Canberra.
9. Z59 is an International Classification of Disease (ICD-10) code, which is one of three sets of standards which form the basis of the Australian Refined Diagnosis Related Group (AR-DRG)
10. https://www.ihpa.gov.au/sites/default/files/pricing_framework_for_australian_public_hospital_services_2019-20_-_consultation_-_submission_-_catholic_health_australia.pdf?acsf_files_redirect
11. Lee SJ, Thomas P, Newnham H, Freidin J, Smith C, Lowthian J, Borghmans F, Gocentas RA, De Silva D and Stafrace S 2019, 'Homeless status documentation at a metropolitan hospital emergency department', *Emergency Medicine Australasia*, vol. 31, no. 4, pp. 639–645.
12. Independent Hospital Pricing Authority, *Pricing Framework for Australian Public Hospital Services 2018–19 – November 2017*, p. 27
13. Australian Institute of Health and Welfare 2019, 'Specialist Homelessness Services Collection Manual' Cat. no. HOU 313, AIHW, Canberra.
14. Wood 2017 op cit.
15. Lee 2019 op cit.
16. Wood L 2018, Hospital discharges to 'no fixed address' — here's a much better way, *The Conversation*. <https://theconversation.com/amp/hospital-discharges-to-no-fixed-address-heres-a-much-better-way-106602>
17. Wood 2017, op cit.
18. Doran KM, Ragins KT, Gross CP, Zerger S 2013, Medical respite programs for homeless patients: a systematic review, *Journal of Health Care Poor Underserved*, vol. 24, no.2, pp. 499–524.
19. See: Wood L, Wood NJ, Vallesi S, Stafford A, Davies A and Cumming C 2019, 'Hospital collaboration with a Housing First program to improve health outcomes for people experiencing homelessness', *Housing, Care and Support*, vol. 22, no. 1, pp 27–39.

Leaving No-one Behind

Australian Alliance to End Homelessness*

Despite having a universal health system, not all Australians enjoy health equity. Physical and mental health outcomes in this country follow a social gradient, which means the higher up the social scale a person is, the better their health outcomes and overall life expectancy. A study by the Australian Institute of Health and Wellbeing¹ between 2009 and 2011 found that people in the lowest socio-economic areas died three years younger on average than people in the highest socio-economic areas.

Research has shown that the people who have experienced long term rough sleeping have an average life expectancy of just 47 years compared to 77 years amongst other Australians. We need to close this 30-year life expectancy gap for people who sleep rough.²

Understanding the causes of the disparity in health outcomes requires a holistic analysis of what contributes to good health. It is impossible to stay healthy if you don't have a roof over your head or enough money to afford food and medication. Other considerations such as education, health literacy, employment opportunities and cultural or language barriers known as social determinants of health must also be considered in any policy or program response.

Without addressing these social determinants, we can never achieve equitable health outcomes for all Australians. Not only should health equity be an aspiration for a country that cherishes the fair go but the pursuit of health equity is an economic necessity for the whole community.

The most vulnerable and disadvantaged groups in our community are more likely to have complex, compounding health needs but they face the biggest barriers to accessing treatment. The result is avoidable presentations to hospital, which are significantly more expensive and a drain on resources. People are dying on our streets or in social isolation in housing without adequate care, monitoring or review. No study to date in Australia has examined the cause and frequency of deaths associated with homelessness and vulnerability in housing across Australia.

For example, people experiencing homelessness have some of the highest levels of mental health, drug and alcohol and chronic physical health problems of any cohort in society. National and international research corroborates the profile of disproportionately high baseline rates of chronic health conditions, psychiatric and substance related morbidities.³ Targeted interviews with over 8,000 people sleeping rough or otherwise homeless in Australia confirmed high rates of chronic conditions, mental illness and alcohol and other drug use and found substantially higher rates of cancer, heart disease, HIV/ Aids, Hepatitis C and diabetes.⁴

The appropriate setting for managing this complex morbidity is in the community and primary care. Unfortunately, for a variety of reasons, particularly the need to prioritise basic survival, people experiencing homelessness tend not to seek medical care in this setting. Instead, they delay treatment until their condition

deteriorates and they present to the tertiary sector with acute exacerbations of illness.

The relationship between healthcare and homelessness has created a reciprocating



and multiplying cycle. Poor health conditions contribute to homelessness and homelessness further exacerbates ill health. Poor mental and physical health is both a cause and consequence of homelessness.

While there needs to be greater investment in housing and social support services, it is important that our health system is complemented by targeted health services for people experiencing homelessness to ensure that all Australians can live fulfilling and healthy lives.

On 15 November 2018, a national health, homelessness and vulnerably housed roundtable

was convened by the Australian Alliance to End Homelessness (AAEH) to share intelligence to improve health outcomes for vulnerably housed populations.⁵ Participants called for the development of a national policy on health equity housing and homelessness to ensure that no one is left behind by providing access to timely and appropriate services that can meet the multiple psycho-social and health needs of vulnerable groups.

The Problem

- Social determinants of health such as socio-economic position, social exclusion, social capital, employment,

housing and lifestyle can either strengthen or undermine individual health and are primarily responsible for health inequities and avoidable differences in health status.⁶

- People who are socioeconomically disadvantaged have, on average, a greater disease burden and require greater investment and sustained effort to reduce risk, health complications, multi-morbidities and disabilities associated with their conditions.⁷
- People who have or are experiencing homelessness are more likely to have poor physical and mental health compared to the general population and are far more vulnerable to problematic drug and alcohol use.⁸
- People experiencing homelessness carry a heavy burden of trauma and disease and are dying at unacceptably high levels because their healthcare is not being addressed adequately.⁹

78 per cent of people experiencing homelessness report having a physical health condition compared to 37 per cent for the population and 44 per cent of people experiencing homelessness have a mental health diagnosis, in comparison with 23 per cent of the population.

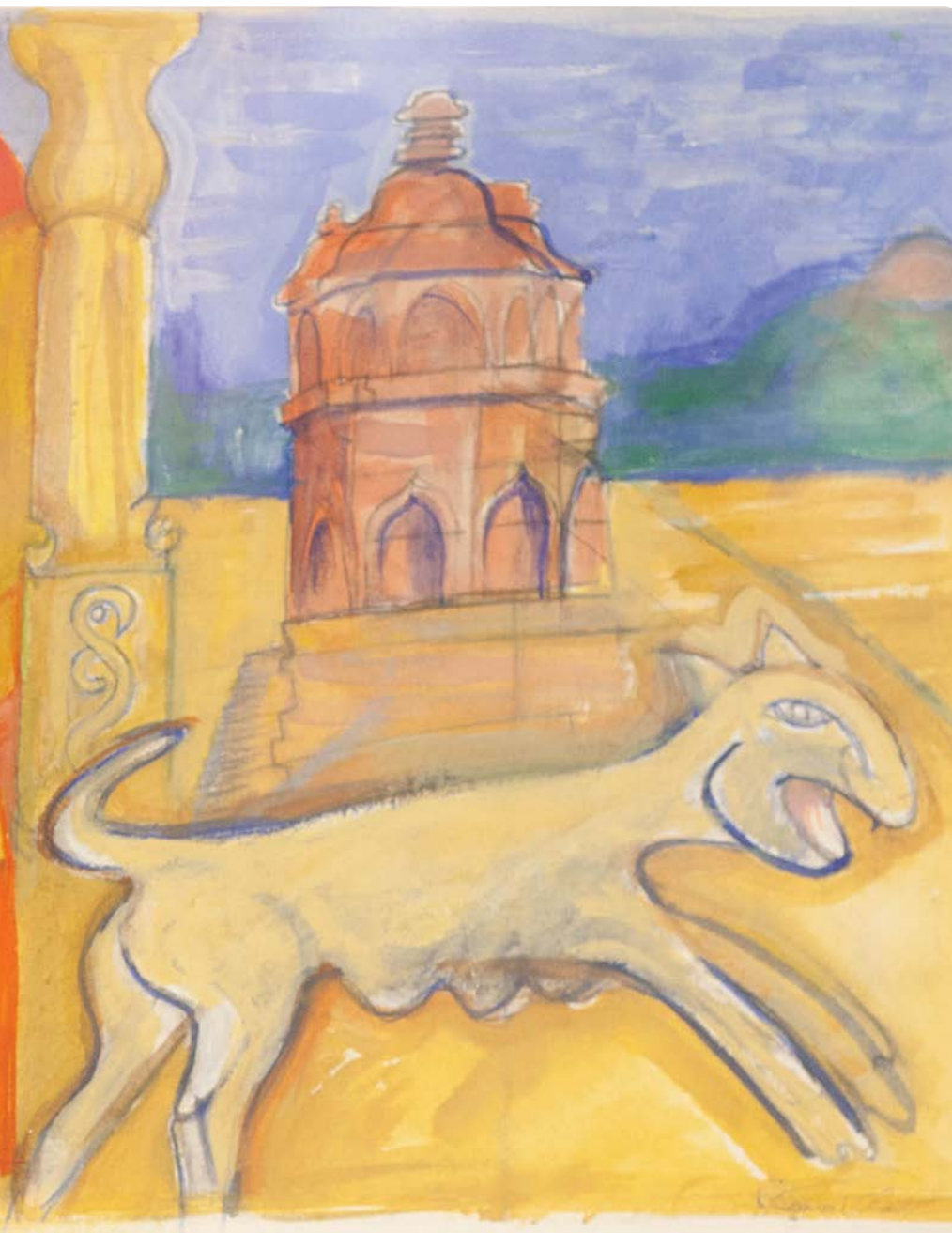
— Health Needs Audit, 2016 — Homeless Link.

Studies have shown the need to better link homelessness and suicide prevention services for high-risk individuals.

The Cost of Treatment

Health crises frequently precipitate presentations at primary or tertiary health services.¹⁰

The pattern of only seeking help when health has deteriorated to crisis level results in a high rate



of presentation to emergency departments and a high rate of usage of non-elective, acute hospital healthcare.¹¹

Homelessness significantly impacts on ambulance use; the number of presentations to emergency departments, the number of hospital admissions and the length of stay.¹²

The total cost to provide services to 635 patients experiencing homelessness over a three-year period was estimated by the Royal Perth Hospital Homeless team to be over \$19 million.

— Royal Perth Hospital Homeless Team:
A Report on the First 18 Months of Operation 2018

In relation to mental health, the West Australian Auditor General conducted an assessment of the State Managed Adult Mental Health Services in 2019¹³ and found that the main customers were 10 per cent or 21,000 people who, over the five years reviewed, consumed 90 per cent of the hospital care provided and around half of the community treatment services and ED mental health care. People experiencing homelessness make up a significant portion of this small group of people who are consuming a disproportionate amount of the care.

'International evidence indicates that homelessness is associated with delayed accessing of health services, hence greater need for acute care, longer hospital admissions, and by extension, greater treatment costs'

— Gaze, A., Vallesi, S., Cumming, C., and Wood, L. (2018).

The Solutions

A National Policy on Health Equity, Housing and Homelessness

Both the Federal and State Governments have invested heavily in transforming health

care systems. However, research confirms that traditional health sector service models do not provide optimum health and psycho-social outcomes for people experiencing homelessness.

Many barriers impact on equitable health access and quality of life outcomes for people experiencing homelessness. For example, having no fixed address, unreliable telecommunications and focussing on day-to-day survival significantly inhibits compliance with appointment-based health services.

The aim of a national policy on health equity, housing and homelessness is to improve health outcomes, enrich quality of life, and simultaneously drive down the rising costs of healthcare.

Using innovative approaches to removing barriers to service

Many innovative models have been trialled in Australia and Internationally that have been shown to reduce the barriers to healthcare for people experiencing homelessness and improve outcomes at a reduced cost.

Flexible service delivery and street outreach allows primary health care to be delivered in spaces where people experiencing homelessness feel welcome, increasing engagement and improving outcomes. Models for healthcare include fixed site, drop-in centres, accommodation services and street outreach.

Medicare billing requirements prohibit practitioners from billing for street outreach services. Enabling practitioners to bill for these services would significantly reduce the barriers for people sleeping rough in accessing primary health care. In fact, it would remove an inequity that prevents people from accessing health care because they have no fixed address.

Trust is a major issue for people experiencing homelessness. The current the practice of

offering service providers with 12 months' funding at a time undermines the capacity of those organisations to build and maintain this trust and reliability. Securing existing funding through Primary Healthcare Networks for five-year periods would give service providers greater operational and strategic efficiency, benefiting clients and generating a greater return for government.

Primary health services for people experiencing homelessness should not just address physical health issues but must also address mental health and alcohol and drug issues. A current pilot of embedding a specialist health team within a homelessness service in Perth is showing a promising reduction in unnecessary tertiary health care utilisation.

As many people experiencing homelessness only access the tertiary health system, primary care in-reach is vital to get them better engaged with primary health care. The Homeless Healthcare Team at the Royal Perth Hospital and the Inclusive Health Partnerships project in Brisbane are examples of in-reach services.

Emerging practice in Australia has seen service providers innovate by integrating health practitioners into housing and community teams. Examples include RUAH Community Services and Homeless Healthcare in Perth, Micah Project's Inclusive Health Partnerships in Brisbane and St Vincent's step-down respite centres in Melbourne and Sydney.

An investment of \$503,000 in the Micah Projects After Hours Street to Home Nurses program saved the Queensland public health system between \$6.45 - 6.9m per annum by proactively addressing the health and housing needs of people experiencing homelessness in Brisbane, as evidenced by a study of 139 individuals.

(Connelly, L, 2014)

Additionally, the return on investment to delivering targeted models of care to people experiencing homelessness and other vulnerable populations was as high as \$7.25 for every \$1.00 spent in an economic cost benefit study conducted on a community-based hospital discharge pilot project in Brisbane.

(Connelly, L; Maguire, A, 2017)

An international example is the Canadian Pathways to Housing model, which takes a person-driven Housing First approach, providing immediate access to an apartment without requiring initial participation in treatment. However, it is coupled with Assertive Community Treatment, which is an integrated health approach where people are proactively provided with access to a team of nurses, mental health specialists and substance abuse specialists 365 days a year.

A National Health, Housing and Homelessness Network

There are many services and individual practitioners who seek to better connect the health systems with housing and homelessness systems. We need to give these leaders a greater voice in the policy deliberations nationally. The Canadian Alliance has successfully established a Canadian Network for the Health and Housing of the Homeless (CNH3). The AAHEH believes that a similar network is required in Australia to bring these leaders together and to support their efforts to integrate these service systems. In particular, the network would:

1. Promote collaboration amongst the healthcare, homeless and housing sectors to drive innovative responses to the health and housing needs of the homeless.
2. Provide a national forum for the sharing of experiences and models of care and support amongst health and housing providers and organizations.

3. Support and develop strategic national initiatives to address the health and housing needs of people experiencing homelessness in Australia.
4. Collaborate with local and national partners to advocate to end homelessness in Australia.

Recommendations

1. A Policy

The Federal Government should create a taskforce on health equity, housing and homelessness to develop a national policy response in collaboration with State Governments, Primary Healthcare Networks and the community sector. Included in this policy should be a nationally consistent commitment of no exits into homelessness for people with mental illness who are discharged from institutional care — including hospitals and prisons.

2. A Network

The Federal Government should support the AAHEH to establish a Health, Housing and Homelessness network with a broad range of health and community organisations, professionals and people with a lived experience.

3. A Pilot Project

The Federal Government should fund an Assertive Intervention pilot in every state and territory, featuring flexible medical and outreach service delivery — including primary healthcare and psychiatric response, 365 days a year. The pilot would cost \$2.5 million per city, plus evaluation costs.

4. Funding Certainty

Existing funding arrangements between Primary Healthcare Networks (PHN) and health, homelessness and vulnerably housed services should be secured with a baseline commitment for a five-year period. This will give services the certainty they need to operate with the greatest effectiveness.

5. Funding Equity

The Federal Government should widen policy provisions to allow medical practitioners to bulk bill patients who have no fixed address and

enable bulk billing for street-based and outreach consultations.

6. A Meeting

Recognising the urgency of this task, the Federal Government should call a special COAG meeting of health and housing ministers to consider, support and drive the implementation of these recommendations.

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'If you have mental health, alcohol and drug use issues you often fall through the cracks of the health system':

Tackling This Challenge Through a Novel Dual Diagnosis Outreach Service for People Experiencing Homelessness

Lisa Wood, School of Population and Global Health, The University of Western Australia (UWA), James Hickey, Dual Diagnosis Medical Practitioner, Homeless Healthcare General Practice, Melanie Werner, Mental Health Nurse, Homeless Healthcare General Practice, Andrew Davies, Medical Director, Homeless Healthcare General Practice, Amanda Stafford, Clinical Lead, Royal Perth Hospital Homeless Team

Background

The co-existence of mental health, alcohol, and drug issues among people experiencing homelessness is pervasive,¹ often as a result of trauma and adverse childhood experiences, compounded by the experiences of homelessness.^{2,3} In a recent Canadian study of people sleeping rough, more than half had co-existing mental health and alcohol and drug (AOD) issues, and often reported difficulties accessing the health services they needed.⁴ In Australia, data collected from 8618 people experiencing homelessness between 2010 and 2017^{5*} indicates that 74 per cent reported having a mental health issue, 72.3 per cent an AOD issue, and 57.5 per cent had both.⁷

Clinically, the term dual diagnosis is used to describe people with co-occurring mental health and substance use issues⁸ and the two are often entwined (see Box 1). In people with dual diagnoses, support is more effective when mental health and AOD issues are addressed together and in conjunction with underlying determinants of health.⁹ Yet the health

system response remains largely 'siloe'd' — addressing both issues simultaneously are rare, and people with dual diagnoses are commonly 'bounced' back and forth between mental health and AOD services without the coordinated approach needed to improve patient outcomes.

Or, as is the case for many people experiencing homelessness, their mental health and/or AOD issues may not even have been diagnosed. Consequently, mental health and AOD use issues among people experiencing homelessness are big drivers of Emergency Department presentations and unplanned inpatient admissions across Australia.^{10,11,12,13,14}

In response to these dual diagnosis challenges and health sector gaps, in February 2019 the Homeless Healthcare GP practice (HHC) commenced a pilot outreach service, the Homeless Outreach Dual Diagnosis Service (HODDS) targeting people experiencing homelessness in Perth who have comorbid mental health and AOD issues. The pilot is funded by a WA Department of Health Research Translation Projects Grant, and is being evaluated by the Home2Health Team at UWA[^].

Given the co-existence of mental health and AOD issues among people experiencing homelessness is widespread across Australia, learnings from the first year of the HODDS pilot in Western Australia (WA) may help to bolster advocacy to close the chasms in healthcare that people can experience when homelessness, mental illness and drug and alcohol use co-occur.

The HODDS Model of Care

HODDS comprises of a Mental Health and AOD trained doctor and nurse embedded within the General Practitioner (GP) practice,¹⁵ seeing most patients in drop-in clinics and outreach settings. In its first year HODDS has supported 182 patients, and the response from patients themselves, and from homelessness and health services in Perth, testifies to the gap that is being addressed. The key elements of the outreach service model are depicted in Figure 1.

While dual diagnosis is the primary focus, for people sleeping rough, this is invariably accompanied by poor physical health, trauma and a raft of social determinants, including a lack of stable housing, poverty, food insecurity and limited social support. The integration of HODDS within a primary care setting brings enormous benefits in terms of well integrated holistic patient care. Collaboration with the homelessness services in Perth (including clinics conducted at the main homelessness drop-in centres) and with the Royal Perth Hospital Homeless Team is critical,¹⁶ helping to facilitate continuity of care between the hospital, GP and community settings for patients who present to hospital.

As a pilot, the referral process to HODDS has evolved over time. Patients referred to HODDS are first assessed medically by a HHC GP prior to assessment by HODDS clinicians. Following initial assessment patients are provided different levels of support depending on their complexity. For example:

- *higher complexity patients:* GP manages their dual diagnosis care with regular appointments,

'Dual diagnosis in people who are homeless is often rooted in childhood trauma; alcohol and drugs are frequently used to regulate mood and emotions associated with trauma and the severe adversity of homelessness. Practical issues can also perpetuate AOD use – for example women who use meth to keep awake on the streets at night when it is most dangerous.'

— Entwined mental health and AOD issues,
Clinical Lead,
RPH Homeless Team

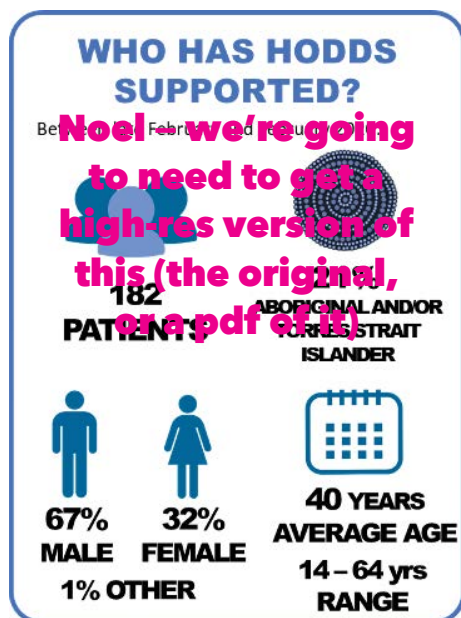


Figure 2 – HODDS Patient Demographics

while the mental health nurse provides ongoing support.

- *lower complexity patients:* HODDS provides advice to support GP management.
- Ongoing collaboration between HODDS and the HHC GP ensures holistic care.

Where are People Seen?

Overcoming barriers to healthcare access(17) by taking services to where people are is a core ethos of the HHC General Practice and the HODDS team sees people in a range of settings:

- weekly clinics at drop-in centres for people who are sleeping rough
- ‘home’ visits to clients living in transitional accommodation or housed through 50 Lives
- Royal Perth Hospital inreach to establish rapport before discharge
- within mental health inpatient or drug and alcohol units
- Outreach contact with people sleeping rough in a range of places, including shopping malls, parks, inner-city streets or caves at local beaches where people often sleep

People Supported by HODDS in its First Year

In its first 12 months, the team has supported 182 people, the demographic profile of whom seen is shown in Figure 2. Many have a complex history of mental health and AOD conditions, most of the people seen have multiple mental health diagnoses, and two-three AOD co-existing issues is not uncommon.

The most common diagnosed conditions for this cohort of 182 patients are shown in Figure 3. The prevalence of these various mental health and AOD conditions are not surprisingly, substantially higher than the general population. Nearly 1 in 5 (18 per cent) for example have a diagnosis of PTSD, 3 times higher than the prevalence of PTSD in the Australian population.(18) Further, in the clinical view of the HODDS team, PTSD tends to be under-recognised in the homeless population in Australia, and in the mainstream mental health system, is at times misdiagnosed as an underlying personality disorders or described as ‘anti-social behaviour’.

Outcomes to Date

In the 12-month period the HODDS team provided 791 episodes of care, complemented by more than 1300

episodes of care from GPs within the HHC practice. By having HODDS mental health practitioners working in close collaboration with the GPs, they can more effectively deal with the comorbidities that so many people experiencing homelessness face.

One aim of HODDS is also to reduce ED presentations and unplanned hospital inpatient admissions, and in the coming year the UWA evaluation will be looking at patterns of hospital use pre and post intervention for patients seen by HODDS. The case study below is one example where significant changes in hospital use have already been observed.

Conclusion

With nearly 60 per cent of people homeless in Australia having co-occurring mental health, alcohol and/or drug issues, and underlying trauma pervasive, there is an enormous unmet need for targeted dual diagnosis care. There is also a dearth of mobile psychiatry and addiction services in Australia and the HODDS pilot is demonstrating the enormous benefit of combining these in an outreach model that can work across community, primary care and the hospital setting. HODDS is filling

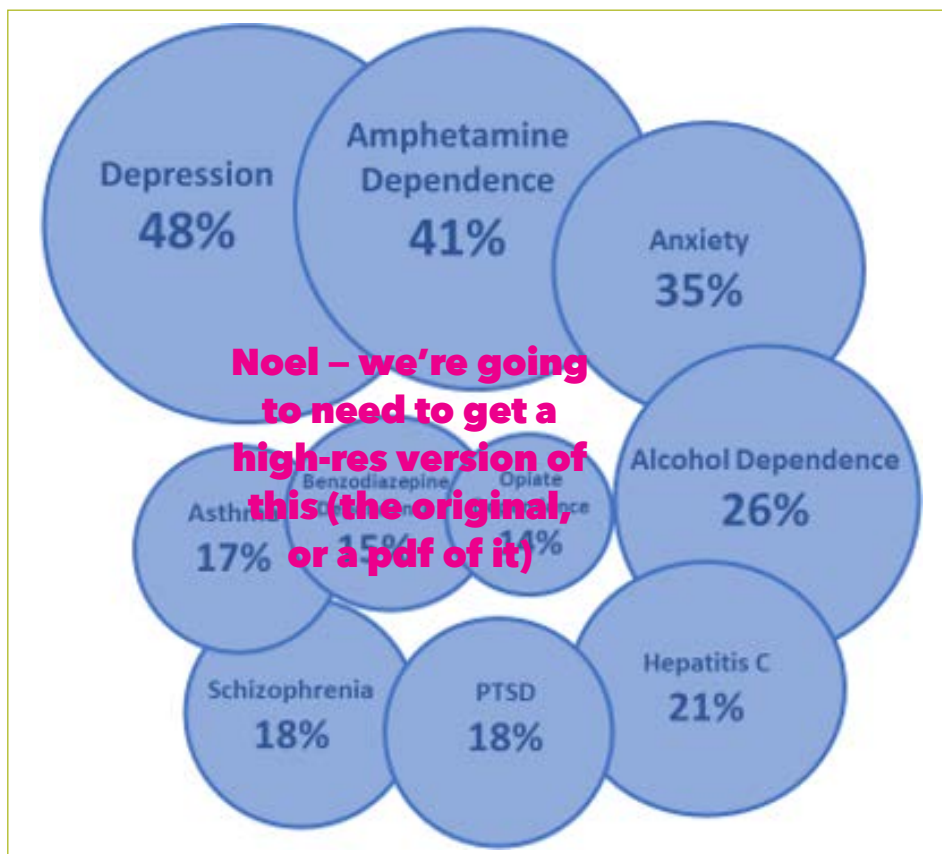


Figure 3: Most common mental health and AOD diagnoses

Background

Ben is a man in his thirties who sustained severe brain damage after being hit by a motorbike as a pedestrian 15 years ago. He spent an extended period in hospital rehabilitation, and as a result of his injuries, lost his job, and his long-term relationship ended. Since the accident, he has struggled with emotional regulation, executive function and impulsivity, consistent with personality changes observable in people with frontal lobe damage. This has led to difficulties in maintaining stable accommodation, resulting in long-term homelessness. Ben has multiple medical problems, including insulin dependent diabetes, suicidal ideation and occasional drug use. Between May 2018 and September 2019, Ben had 42 ED presentations and 12 days of inpatient admission resulting in a cost of \$70,104 to the health system.(19)

HODDS Support

Ben was first seen by HODDS at a drop in centre in mid-2019. He was agitated and HODDS has spent a lot of time building trust and rapport. In addition to psychotherapeutic support, HODDS has advocated to the Public Trustee on his behalf, facilitated an application for a healthcare card, and supported him to procure stable long term accommodation. Ben was connected to 50 Lives (the WA Housing First program) in August 2019, and received public housing in October.

Current Situation

Now that he is housed, HODDS has been visiting him in his home and supporting him to build a social support structure, and find meaningful activity, while also working within an acceptance and commitment approach to managing his emotions and understanding his reactions. Since being housed and with continuing HODDS support, he has had no further presentations or admissions to hospitals in WA. He is keen to look for employment, is managing his bills, and growing vegetables in his courtyard, all things that would have seemed inconceivable six months ago. The combination of attending to his mental health and housing crises concurrently has been instrumental in stabilising his wellbeing. In the past, the lack of attention to one element has undermined actions to help the other.

a vital gap in services for homeless patients whose combined mental health and substance use problems see them rejected by mainstream specialist services as too complex or not within their narrow scope. For some patients, it is the first time they have received regular, dependable mental health care that is responsive to the complexity of dual diagnosis and the tangled web of social determinants of health that accompany homelessness.

* Registry week data is collected by homelessness services in a growing number of locations across Australia⁵ using the VI-SPDAT internationally developed survey⁶ that is done with individuals and families experiencing homelessness to determine a level of risk and vulnerability that can be then used to prioritise assistance. The VI-SPDAT includes questions about health conditions.

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Clinician Capacity and Consumer Experiences: Learnings from the Development and Implementation of a Targeted Homelessness Health Training Program

Stephanie Macfarlane, Homelessness Health Program Manager, Priority Populations, Population and Community HealthSouth Eastern Sydney Local Health District

Background

On Census night 2016, approximately 20 per cent of people experiencing homelessness in New South Wales (NSW) were residing in the geographical area of South Eastern Sydney Local Health District (SESLHD) which comprises the inner city, eastern and southern suburbs of Sydney and extends to the Royal National Park.¹ This is a significant portion of New South Wales' homeless population and highlights the potential role that SESLHD acute and community health services have in improving health outcomes for people experiencing homelessness.

The relationship between health and homelessness is well-documented, however addressing the health needs of people experiencing homelessness is complex and often requires a coordinated and multi-service level response.² This can be particularly challenging for clinicians in busy mainstream public health services, many of who report that they lack the time and skills to adequately respond to the complex needs of patients experiencing homelessness.³

The role of the SESLHD Homelessness Health Program is to coordinate and support initiatives that improve access to

health care and health outcomes for people experiencing, or at risk of homelessness. This is achieved through the development, implementation and evaluation of district-wide strategies; working in partnership with health services, other government and non-government agencies; and, the delivery of targeted workforce capacity building and training programs.

The Role of Homelessness Training in the SESLHD Health Context

People experiencing homelessness have particularly complex health needs that can be difficult to address in mainstream primary health care settings. Evidence suggests that this results in increased presentations to

Emergency Departments, chronic poor health and a shorter life expectancy.⁴ A survey administered by the SESLHD Homelessness Health Program noted that clinicians across a variety of acute and community health services felt ill-equipped to identify and respond to homelessness and the corresponding health and psycho-social issues. Further, a review of state-wide education and training programs, identified an absence of face-to-face training for clinicians to enhance their knowledge and skills in delivering care to people experiencing homelessness.⁵

To better support clinicians and enhance SESLHD's capacity to respond to homelessness, the Homelessness Health Program



Artwork by James Keefe, for the SESLHD Homelessness Health Program

developed an innovative, flexible training program. We believe that this the training is the first of its kind in New South Wales. The program was designed to be delivered by experienced clinicians for a variety of professional backgrounds in a half day workshop format. To maximise the reach of the training program, a smaller one-hour in-service education session was also developed with the intention of reaching staff who may not otherwise get the opportunity to attend longer training, for reasons such as rostering and/or the demand of busy settings such as emergency departments.

The workshop was designed to be flexible and engaging, using a mix of presentation styles as well as small group work.

Most importantly, the workshop was developed to incorporate the voice of people with lived experience. Initially, this was intended to be a guest speaker role, however it was identified early in the development of the program that the training would be enhanced by a co-facilitator model to incorporate this perspective throughout the training. The consumer co-facilitator is paid for their role in line with the SESLHD consumer participation guidelines.

12 months in: reflecting on participant and consumer experiences

The SESLHD Homelessness Health Training Program has engaged over 200 SESLHD staff and clinicians through a combination of five workshops and over 20 in-services over a 12-month period. Evaluation based on pre and post training surveys has indicated that participants have experienced an increase in:

1. knowledge and skills related to identifying homelessness
2. level of engagement with people experiencing homelessness
3. skills in assessing potential health issues
4. confidence in making referrals to local health

and homelessness services. The feedback from the workshops has also highlighted the value of incorporating lived experience throughout the session.

Comments from participants have included:

'Great hearing a real life story from someone who has experienced homelessness'

'The real life guest speaker provides insight and practical understanding [of homelessness]'

'Listening to the consumers lived experience was inspirational!!!!'

'The consumer was a fabulous resource and really personified homelessness as a lived experience.'

Although it is evident that consumer lived experience is vital in providing an opportunity for participants to gain unique and personal insights into homelessness, it is imperative that we acknowledge and mitigate the potentially negative impacts to the consumer in providing their lived experience.

The SESLHD Homelessness Health Training Program has established a number of processes that aim to ensure safety and support for consumers sharing their lived experience. A co-facilitator with a clinical background will always brief the consumer co-facilitator prior to the session beginning. This briefing session allows the clinical and consumer co-facilitators to establish boundaries around story-sharing for the day and agree on a subtle signal for the consumer to give if they begin to experience distress in relation to contributing their lived experience. Additionally, clinical co-facilitators are also responsible for providing a trauma informed environment for story-telling and for moderating participant questions if required. Consumer co-facilitators are also encouraged to identify and have access to external supports should they require assistance after the workshop.

Where to Next?

Currently the SESLHD Homelessness Health Program employs only one consumer co-facilitator for all workshops. Given the value of diverse lived experiences, and the potential impact that repeated story telling can have on consumers, we aim to expand our co-facilitator workforce over the coming year. We aim to achieve this through increased partnership with local services with strong consumer participation.

This will assist in creating a peer support network for our consumer co-facilitators demonstrates the value of consumer participation in the homelessness health field more broadly.

Additionally, the SESLHD Homelessness Health Program aims to undertake a more detailed evaluation of the workshop this year. This will include analysis of survey data exploring changes in relation to clinician knowledge, behaviour and confidence in responding to people experiencing homelessness in health settings supplemented by qualitative data from focus groups.

It is hoped that the evaluation will inform future refinement of homelessness health training in building the capacity of the health system to respond to homelessness across a broad spectrum of clinical areas. There is scope to expand, extend and replicate the training across other Local Health Districts in order to improve the NSW Health response to homelessness in public community and acute health services generally.

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Chapter 3: Issues and Cohorts

Homeless Respite Facility Part of a Vision to Improve Health Outcomes for Vulnerable Patients

Jack Snelling, Health and Wellbeing Project Manager and
Linda Jordan, Communication Project Officer, Baptist Care SA

On any given night, 116,000 men, women and children are homeless in Australia. We know they are among the most vulnerable group of people in our nation; experiencing both social and economic disadvantages. They are also vastly over-represented in morbidity and mortality statistics.

People who are homeless remain at increased risk of psychiatric illness, musculoskeletal disorders, substance abuse, chronic and infectious diseases, skin and foot problems and poor oral health.¹ Despite the complexity of their health conditions, for a number of reasons, this group are often reluctant to engage with primary health services² — placing them at further risk as untreated medical conditions worsen. These persons also often remain in a hospital bed longer than clinically necessary as they cannot be discharged to a usual place of residence to receive care in the community.

Upon receipt of a generous bequest from Mr Frederick Fricker, in January 2020, Baptist Care SA partnered with the Central Adelaide Local Health Network (CALHN) to launch the Homeless Respite Facility pilot. The pilot aims to improve access to care and health outcomes for people experiencing homelessness and/or transient lifestyles. Clients are supported with time limited accommodation by Baptist Care SA, and receive wrap around health services by CALHN, non-government organisations and General Practices located in the surrounding area.

The facility offers safe, supportive accommodation and 24/7 social support services for up to ten people at any given time. Once settled

into their room, the facility team leader, Rochelle, listens to each individual's story and begins to tailor a support plan to meet their specific social needs. Clients receive both health care and case management to connect them with services (including long term accommodation) to address the social determinants of their ill-health.

A strength of the model is the facility's co-location with a range of other longstanding Baptist Care SA services for people experiencing homelessness; including a meals service, advocacy, emergency financial relief, Community Food Hub, laundry services, free legal and dental services, and well-being programs — all of which help to reduce risk factors.

'We've been busy. In our first month we hit 142 bed nights and 200 meals (provided through our WestCare Centre),' says Rochelle.

'It's such a vulnerable time between leaving hospital and the next stage of where to go next. But if we're able to capture people at that vulnerable point and provide wrap around 24-7 support, these great transition pathways can be created and we're working with both internal and external providers to achieve this.



Rochelle, Team Leader at Baptist Care SA's Homeless Respite Facility, helps clients feel at home and connects them into the assistance they need as they recuperate

We have had one gentleman leave us and move straight into a furnished Housing SA unit, others have gone from long term homelessness to boarding houses. Clients that weren't making their dialysis appointments are now attending via our community shuttle.

We're so fortunate to have so much available here on site. We were able to connect one lady to the NDIS by referring her to our NDIS team here. The art studio has provided canvas and paints and we have several clients creating wonderful art.

The feedback from clients and the hospital has been really positive.'

The pilot is the first in a series of steps the organisation is taking towards the vision of a more comprehensive Health and Wellbeing Centre, designed to meet the specific needs of homeless people. The Centre will draw together key allied health, mental health, AOD and other professionals into a multidisciplinary health service, complemented by the many well-being services already available at one site.

As work begins towards this vision with the pilot project, there remains a steadfast commitment to offering practical support and reason for hope. Only then will we begin to see some of the appalling statistics around homelessness begin to decline.

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A Visual Investigation and Exploration into the Physical and Psychological Effects of Trauma Through a Lived Experience of Domestic Violence

Trish Verdouw, Training Coordinator Safe Choices, CatholicCare Tasmania and Visual Artist

'All human beings are born free and equal in dignity and rights'¹

While domestic and family violence is a pervasive and complex problem that affects millions of people across the world it is particularly topical within Australia at the current time.²

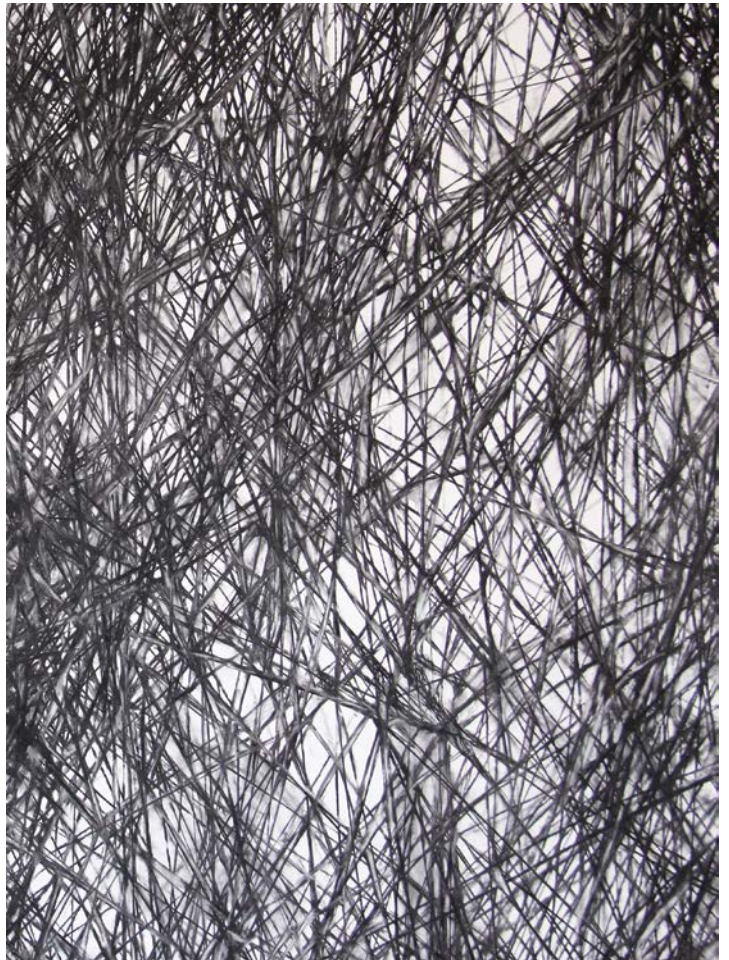
The prevalence of domestic and family violence against women within Australia are revealed in the statistics from ANROWS 2016 Personal Safety Survey confirming that *'one in four women have experienced violence by an intimate partner'*, *'one in five women have experienced sexual violence'* and *'one in six women have experienced an episode of stalking*

since the age of 15'.³ Violence against women is extremely ubiquitous and it is not partial to one particular group within society but it is across the societal landscape. Domestic and family violence doesn't always mean physical or sexual assault, it is also the unseen psychological and emotional abuse that causes trauma, anxiety and fear leaving deep and lasting scars. Physical and emotional abuse in most cases is 'behind closed doors'; it is unseen, not spoken.

It is the emotional and psychological effects that trauma can have on human bodies that the two artworks *Replay*, *Rewind*, *Replay III* and *Rewired* explores. The repetition

of the trauma is captured with the repeated process of drawing, erasing, redrawing and erasing until both trace and mark create a receding and layered web of lines.

Domestic and family violence together with mental health can be key factors for someone to become homeless as homelessness is not discriminative; it can happen to anyone. So, when Domestic and Family Violence interconnects with a vulnerable and disenfranchised group of women, frontline workers who support these women focus on a holistic, collaborative and interagency approach.⁴ It is this interagency relationship between



Replay, Rewind, Replay, 200cm x135cm, charcoal on paper.



Beth (detail), 94cm x 125cm, liquid graphite, acrylic, relief print, ink on paper.

family violence, housing, health, legal and justice services that positions the client in the centre of their own narrative.

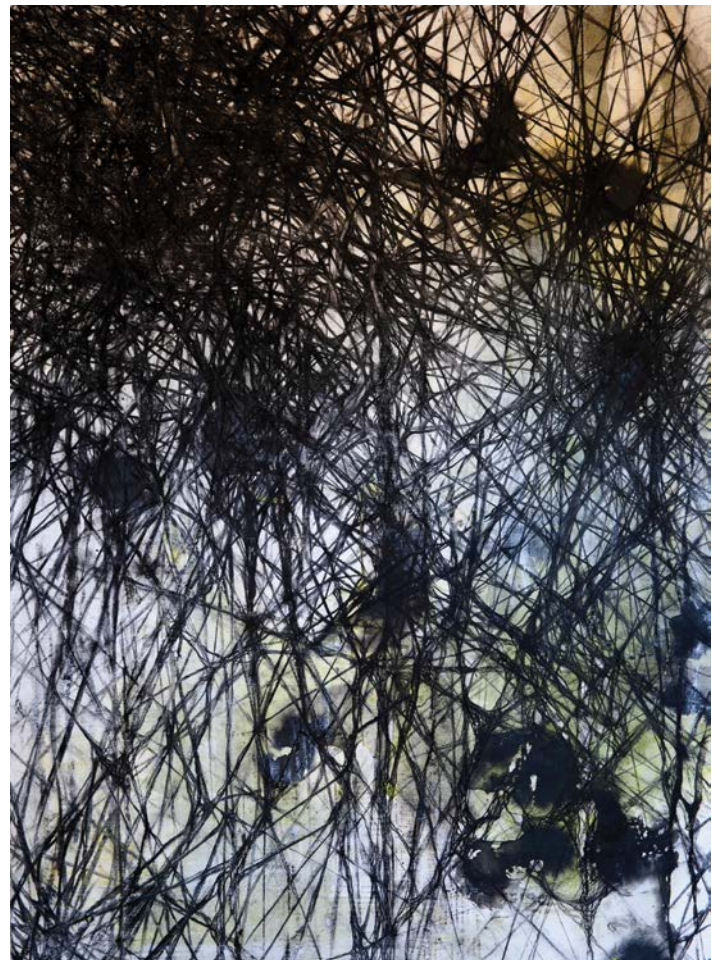
Research shows that when clients have support from a collaborative and interagency approach multiple agencies who specifically focus on improving outcomes for clients with high and complex needs have the tendency to secure and maintain more permanent accommodation. This is highlighted in the works of *Beth* and *Ruby III* whose lives changed forever due to the lived experience of abuse and homelessness leaving them and their children traumatised. The artworks are based on two case studies portraying the physical and emotional journey that they encountered. Both women had been through horrific physical and emotional abuse and with the support and encouragement from frontline workers they were able to move forward with their lives. After the initial decision of leaving the family home Ruby and Beth were linked in with health and legal agencies enabling them to secure stable accommodation and begin to get their lives back on track.

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Ruby II, 94cm x 125cm, liquid graphite, acrylic, relief print, conte, ink on paper. Commissioned by Cassie O'Connor, MP, Greens Leader Tasmania.



Rewired, 96cm x 128cm, charcoal, ink, wax, acrylic on paper.

Immunisations and Preventative Healthcare: Let's Improve Access for Our Community

Belinda Tominc, Clinical Nurse Consultant, Young People's Health Service

The Young People's Health Service (YPHS) is a program of the Department of Adolescent Medicine at the Royal Children's Hospital, Melbourne. YPHS is a nurse-led primary health service co-located with Frontyard Youth Services that offers free and culturally sensitive health care for young people who are homeless or at risk of homelessness.

YPHS received a grant from the Victorian State Government's Immunisation Department to map vaccination rates amongst Melbourne's young homeless population, and to improve uptake of this vital preventative health measure.

Why are Immunisations Important?

Our bodies have amazing ways to protect us from all sorts of diseases. Our skin cells press tightly against each other and resist bugs from entering our body. Little hairs in our lungs, throat, and nose gently push mucus up and out of our respiratory tract. Our tear ducts weep particles out and our eyelashes swat to create a barrier between the world and our eyes.

When a bug or 'pathogen' does enter our body, our cells recognise that it is not a part of us and send a signal to our immune system to come and check it out. Thrillingly, our immune system attempts to seek and destroy the intruder (the 'antigen'), as well as create a memory of the antigen (the 'antibody').¹

Infections happen if an intruder gets through our defence systems. Maybe from a needle with unseen Hepatitis B virus particles piercing our skin and causing dysregulated

inflammation of our liver, or a bacterium like Meningococcal C overwhelming the body's defence and spreading to our brain.

Immunisations are a safe and effective way to stimulate our body's immune system to create a protection against infections such as viruses and bacteria. They give our body the heads-up about what an antigen looks like, so that we can produce antibodies and our defence system can respond quickly to the virus or bacterium if it encounters it in the future.²

Immunisations protect not only the individual but the whole community. COVID-19, a novel coronavirus that emerged in December 2019 is a timely reminder of the implications of globalisation of disease spread. Researchers around the world are enthusiastically working on an immunisation to contain the outbreak.

Following a decline in immunisation uptake, Australia's neighbour, Samoa, has experienced a measles outbreak that lead to 5,707 cases and 83 deaths between September 2019 and January 2020. A mass vaccination campaign was required, and Samoa is moving towards a recovery phase with 95 per cent of citizens now immunised and protected.³

Immunisations and Homelessness

Immunisations are a cornerstone of modern public health care. In order to prevent outbreaks and avoidable deaths, Australia must ensure immunisations are reaching all people equitably.

Young people who see the nurses at YPHS are typically experiencing homelessness compounded with other social determinants of health, such as early school leaving,

experiences of domestic violence, family breakdown, alcohol and other drug misuse, and/or mental health issues. Health care and immunisations are of low priority and frequently crisis-driven.

Immunisations in Australia are usually administered through council sessions, general practice clinics, or school-based immunisation programs. Young people experiencing homelessness are likely to miss out on this preventative health measure. In a survey of five flexible learning sites in metropolitan Melbourne, YPHS found that only one school was regularly being attended to by a local council for routine adolescent immunisations.

Through a mix of co-located services and outreach, YPHS found that immunisation coverage in the young homeless community is significantly below national coverage levels, with less than nine per cent of young people who are homeless or at risk of homelessness and assessed by YPHS being up to date with all scheduled immunisations. As a comparison, an average of 75 per cent of all Victorian secondary school students participated in their school immunisation clinics in 2018.⁴

Which Immunisations are Young People Missing?

YPHS found 46 to 75 per cent of 12- to 24-year-olds who are homeless or at risk of homelessness were missing vaccines scheduled to be given in high school, such as the Human Papillomavirus vaccine and the Meningococcal vaccine. Up to 25 per cent were not up-to-date with childhood vaccine such as the measles vaccine. Table 1 details the immunisations administered by the YPHS nurses and the age it is usually given to people living in Australia.^{5,6}

Table 1. A list of available catch-up vaccines and when they are scheduled to be given on the National Immunisation Program.

<i>Catch-up immunisations given at YPHS</i>	<i>Disease effects</i>	<i>Australian National Immunisation Program</i>
Hepatitis B	Virus that is spread by blood transfer (e.g. by sharing needles, sex, mother to baby). Can cause chronic liver inflammation and cancer.	Given to babies at birth, 2 months, 4 months and 6 months old.
Diphtheria	Bacteria that is spread through respiratory droplets. Causes throat inflammation, 1 in 7 people infected die.	Given to babies at birth, 2 months, 4 months and 6 months old.
Tetanus	A toxin of bacteria in soil that can cause painful muscle contractions and death.	Given to babies at birth, 2 months, 4 months and 6 months old.
Pertussis (Whooping cough)	Bacteria spread by respiratory droplets (coughing). Causes a prolonged cough that can lead to pneumonia or brain damage especially in babies.	Given to babies at birth, 2 months, 4 months and 6 months old.
Polio	Virus that spreads by faecal to oral route. Can lead to paralysis.	Given to babies at birth, 2 months, 4 months and 6 months old.
Pneumococcal	A group of bacteria spread by respiratory droplets. Can lead to pneumonia, meningitis, blood stream infections.	Given to babies at birth, 2 months, 4 months and 12 months old.
Measles	Virus that spreads in the air. Can cause pneumonia and brain swelling.	Given at 12 months and 18 months old.
Mumps	Virus spread by respiratory droplets. Can cause swollen neck glands, brain swelling, inflammation of the testes, deafness.	Given at 12 months and 18 months old.
Rubella	Virus spread by respiratory droplets. Can causes rashes and fever, reduction in platelets. Causes severe abnormalities in babies of pregnant women.	Given at 12 months and 18 months old.
Influenza	Virus spread by respiratory droplets. Can cause fever, pneumonia.	Given each year to those medically at risk.
Varicella (Chicken pox)	Virus that spreads in the air. Can cause an itchy rash and serious complications including brain swelling.	Given at 18 months old.
Meningococcal ACWY	Bacteria that spreads through respiratory droplets (e.g. kissing, sharing cigarettes and bongs). Can cause blood stream and brain infections that usually lead to death or permanent damage.	Given at 12 months old.
Human Papillomavirus	Virus usually spread by sexual contact. Strains can cause genital warts, cancers (cervical, anal, oral).	Given at 12 to 13 years old in high school.

Improving Access to Immunisation

What is YPHS doing to improve access to immunisations for young people who are homeless or at risk of homelessness?

Government-funded vaccines are available in Victoria for people who have experienced socioeconomic disadvantage that has compromised their equitable access to vaccines.⁷

With the assistance of a grant from the Victorian State Government Immunisation Department, YPHS began implementing a catch-up vaccination project in February 2019 to improve access to government-funded

immunisations for vulnerable young people. The nurses at YPHS gain consent from young people they see at Frontyard to check their online immunisation history and let them know if they have missed any immunisations. They then offer the immunisations onsite to start the catch-up plan.

YPHS also endeavoured to reach young people who are staying at youth-specific refuges throughout Melbourne, and young people who are attending flexible learning centres, by offering outreach immunisation clinics at these sites. YPHS provided support for staff at the Youth Support and Advocacy Service (YSAS) to assist in

enhancing immunisation catch-up in young people staying in secure welfare and those attending drug and alcohol services.

The co-location of services and interagency collaboration has contributed to enhanced immunisation coverage in this group of vulnerable young people. In the first 11 months of the pilot role, YPHS has seen the percentage of young people fully protected from vaccine-preventable diseases rise from 8.8 per cent to 30.2 per cent.

By offering immunisation administration within existing services, young people can receive their immunisations opportunistically, in



a way that is acceptable to them. Over 73 per cent of young people who are offered immunisations are willing to commence their immunisation catch-up plan, a suggestion that young people who are experiencing homelessness are keen to take on preventative health measures when able.

Looking Forward

Young people who are experiencing homeless or other forms of marginalisation are missing out on immunisations that are given through the mainstream health and education system. This leaves these young people vulnerable to vaccine-preventable diseases and poorer health outcomes.

This vulnerability is further amplified by overcrowded living arrangements, transient lifestyles, and multifactorial psycho-social needs. Despite these priorities, when offered immunisation catch-up in a way that is appropriate to them, most young people recognise the need for preventative health care and accept the opportunity to improve their health outcomes.

While the mainstream health system reaches a diverse cross-section of society in Australia, vulnerable groups such as young people who are homeless or at risk of homelessness need specialised programs to provide them with equitable access to preventative health care.

Health services that are co-located with housing and drug and alcohol services are well placed to encounter people that may have missed immunisations. The YPHS catch-up immunisation project has demonstrated the potential to offer immunisations opportunistically in these contexts.

Acknowledgements

YPHS would like to acknowledge the Victorian State Government Immunisation Department for their funding and support in putting the 'Vulnerable Young People Catch-up Immunisation Project' into action. Thank-you to staff at Melbourne City Mission and the Youth Support and Advocacy Service (YSAS).

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Health, Homelessness and Brain Injuries

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Women's Council for Domestic and Family Violence Services Western Australia

Domestic and family violence (DFV) is the main driver of women's homelessness in Australia. Older women's homelessness in particular is on the rise. More women than men presented to homelessness services in 2017-18 (57,000).¹

Women escaping DFV use crisis accommodation services in larger numbers but also couch surf, stay in over crowded dwellings, with friends and family for long periods and may be forced into sexual relationships with a new partner to secure a roof over their heads at night.²

Homelessness and DFV has well documented short and long-term effects on women health. Women who experienced domestic violence are three times more likely to have depressive disorders, have four times the increased risk of the likelihood of anxiety disorders and seven times the increased risk of the likelihood of post-traumatic stress disorder (PTSD).³

Nearly 6,500 women and girls were hospitalised due to assault in Australia in 2013-14, with the violence usually perpetrated by a partner or spouse, according to new analysis from the Australian Institute of Health and Welfare.⁴

Women fleeing domestic violence are at particular risk of PTSD, with an Australian study finding 42 per cent of women in a Women's Refuge suffering from PTSD. While domestic violence is a form of complex trauma in itself, PTSD is far more likely to be experienced by women who, as children, experienced sexual abuse and who were also raised in homes with domestic violence.⁵

Recent research is showing two significant areas of health impact on women that DFV and homelessness services are only just starting to respond to; Non-Fatal Strangulation (NFS) and Acquired Brain Injury (ABI).

Non-fatal Strangulation (NFS)

Strangulation is a form of asphyxia where blood vessels and/or air pathways are closed as a result of external pressure applied to the neck.⁶

This can be through using rope or chain around the neck or manually using hands, arms or feet to compress the neck. Strangulation can have significant long and short-term psychological and physical impacts. Significant physical impacts can include loss of consciousness, strokes, and seizures; as well as other short term injuries such as neck pain, red linear marks and scratches, conjunctival hemorrhage, incontinence, difficulty breathing and swallowing and voice changes.⁷

Strangulation can also lead to significant psychological impacts such as post-traumatic stress disorder, anxiety, and depression; alongside symptoms of nightmares, blackouts, memory loss and dizziness.⁸

It is important to recognise that strangulation is not simply an indicator of future health implications, but is a fatal risk in and of itself. For example, an Australian study showed that between 2008-2010, five per cent percent of all homicides were caused by strangulation, and 9 per cent of domestic homicides were caused by strangulation.⁹

Strangulation is a gendered assault with males perpetuating this abuse on females at much great rates. Studies have demonstrated that the prevalence ratio of being subjected to Non-Fatal Strangulation (NFS) in DFV is 13 times higher in women than in men.¹⁰

In 2018, the Women's Council for Domestic and Family Violence Services (WA) invited Women Refuges across Western Australia to participate in a voluntary research study on NFS. The study was for a twelve-month period between January and December 2018, and encompassed 20 Refuges, seven Outreach services, and two Coordinated Response Services.

A total of 530 new clients of DFV services answered 'Yes' to ever having experienced NFS. Of these 530 clients:

- 524 were women and six were children
- 277 had visible injuries following the NFS
- 11 of the 524 women were pregnant at the time of NFS
- The 524 women were mothers to 1,123 children
- The oldest victim was 71-years old
- The youngest was eight-months old
- 458 (86 per cent) of these clients had experienced NFS in the last 12 months
- 144 women and two children (28 per cent) were Aboriginal.

Before the survey took place, DFV victims seeking crisis accommodation were not routinely asked if they had experienced NFS. Victims themselves may not have identified that NFS had occurred or understood the potential short and long term health impacts of NFS.

Death can occur days or weeks after the attack due to carotid artery dissection and respiratory complications such as pneumonia, Acute Respiratory Distress Syndrome (ARDS) and the risk of blood clots traveling to the brain (embolisation).

Misidentification of NFS can occur due to the language the victim may use, for example, 'choking', 'holding', 'throttled', 'squeezed my neck'. Lack of visible injuries to the neck, which happen in approximately 50 per cent of cases may result in first responders not identifying that NFS has occurred.

NFS is obviously a risk factor for an Acquired Brain Injury (ABI) also called Traumatic Brain injury (TBI).

Acquired Brain Injury is an injury *'caused by a bump, blow, or jolt to the head that disrupts the normal function of the brain'*.¹¹ Most ABI are mild, and are usually labeled concussion, but repeated mild ABI are now being recognised as having a cumulative impact on long-term health.

Given the serious nature of this act of violence whereby there may be no visible signs on the victim's body, it is vital that first responders such as Police, Ambulance Officers, Emergency Staff at Hospital and Health Services must be trained to recognise and respond to victims of NFS and ABI. The WA State Government currently have a Family Violence Bill before Parliament, with one of the areas for legislative change is a stand-alone criminal offence for NFS.

Sporting codes have developed new safety guidelines for players where concussion is suspected but the Community Services and Justice sectors have been slow to recognise the links between ABI and homelessness, criminal offending and poor health outcomes.

Almost all women in a New Zealand prison study had a history of multiple TBIs; at least one quarter were from being assaulted by a parent or a partner.¹²

Victims of DFV who experience physical assaults that include NFS, repeated hits to the head, neck and face, violent shaking and penetrative head wounds may experience cumulative mild brain injuries that over time can lead to a significant disability. The head, face and trunk are the primary targets in intimate partner violence.¹³

Family violence is a significant cause of brain injury. Around 40 per cent (6,409) of the 16,296 victims of family violence attending Victorian hospitals over the 10 years from July 2006 to June 2016 sustained a brain injury.¹⁴

These injuries can be difficult to readily identify both for the victim and the medical and support service systems. Subtle head injury may result in diffuse injury to the brain that may not be observable through the use of CT scan or MRI. This can therefore be harder to assess during emergency hospitalization and cognitive, emotional, or motor symptomatology, which may appear weeks or months later, and may not be readily associated with the initial insult.¹⁵

Women's refuges and homelessness services providing crisis accommodation for women who have experienced NFS or who have an ABI have responsibility to ensure their client assessment tools are asking the appropriate questions to help identify if NFS or repeated assaults to the head have occurred, recently or in the past and to support the women to obtain medical attention and a neurological assessment.

The literature review provides evidence that, although more than 80 per cent of female victims of intimate partner violence attending hospital have facial injuries, brain injury is seldom diagnosed. Even in hospital, cases of mild traumatic brain injury in adult and child victims of family violence are often missed.¹⁶



The impact of mild ABI may only last a few months but for some 15 to 50 per cent of people persistent symptoms will continue impacting their personal well-being, family relationships and social living skills. These can include problems with memory and concentration, constant headaches, sensitivity to light and noise and ongoing feelings of frustration, anxiety and depression.

Research in New Zealand found 20 per cent of people with mild ABI were still experiencing problems



with attention and memory after 12 months. Four years later cognitive problems still persisted, including forgetfulness, poor concentration and poorer social relations.¹⁷

If the ABI is severe or has occurred multiple times the health impacts can include motor and sensory damage, cognitive disabilities, problems with communications and inappropriate or impulsive behaviors.

Accommodating women with a disability from an ABI requires specialised advocacy and case

management. Too often these women can be labeled as difficult clients who break the rules and fail to follow through on case plans.

Women with an ABI may frequently be late to appointments, forget or lose important documents, find it difficult to sit still, only focus on one part of the question or conversation, and have trouble remembering timelines and important dates of incidents.

Services can assist clients with an ABI by:

- structuring meeting in quiet calm spaces
- keeping meetings short or taking regular breaks during a meeting
- writing information down
- repeating information
- having physical reminders (a phone call/an alarm) of important events and times for clients
- encouraging clients to keep notebook to jot down questions, directions, important names/numbers etc.

Meet with clients in quiet calm places with minimal noise and light distraction, keep meetings short or take regular breaks if the meeting will be lengthy. Clients may tap or fidget with an object such as a pen, phone or clothing. This calming, repetitive action that is a necessary tool to aid concentration and focus. If prevented from doing this, the individual will have to exert considerable energy trying NOT to fidget or tap, making them unable to focus or prone to shutting down.

Allow person to have the pen or similar object of their interest to assist with their need to actively process information. A woman with an ABI may appear to be disorganised, aggressive, temperamental, or confused. If her behaviors are misunderstood which often happens, she may have difficulty obtaining and remaining in accommodation, be refused services and support, lose custody of her children and spiral further into trauma and homelessness.

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How to Source Food and Eat Well when Homeless: A Needs Assessment

How the lived experiences of those who use health and homelessness services are being integrated into health and homeless service delivery/program design.

Spike Chiappalone, Peer Worker and
Susie Whitelock, Allied Health Worker and Dietitian, *cohealth* central city

Food security is the reliable and regular access to nutritious food that is safe, meets a person's cultural and biological needs and is obtained in a socially acceptable manner. There is no doubt that people who experience homelessness face major food security challenges. One of the major responses to the food security needs of the homeless is the Café Meals Eat Out Program. The Café Meals Program has successfully been running in the City of Melbourne for over 10 years, providing \$2 dine-in café-style meals to people who are homeless or in insecure accommodation.

The lived experiences of those who use health and homelessness services has been integrated into health and homeless service delivery and program design at *cohealth* central city. One way this has been done by the food security team at *cohealth* is through a consumer consultation process which involved a 34-question survey. This provided clients the opportunity to have input into the food security program, and how it could best meet their particular needs.

The consumer survey was conducted at the end of 2019 and was completed by 24 current clients of *cohealth* central city who are members of the Café Meals Program. Participants ages ranged from 31 to 70 years with 67 per cent being primary homeless, 19 per cent secondary homeless and 14 per cent at risk of homelessness. More than half (59 per cent) said they ran out of money to buy food weekly or fortnightly, which is a concern given most people receive their income fortnightly, meaning a majority do not have enough money for food for at least part of every pay cycle.

The foods that respondents stated they could not get or had difficulty getting when homeless were fresh foods, primarily fruit and vegetables and 'healthy foods'. When asked if they would buy food from the Queen Victoria Market if it was at a reduced cost, 68 per cent said they definitely would, 26 per cent said they probably would, with only one respondent saying they would not. The most commonly cited foods people would like to be able to get were fruit and vegetables, as expected, followed by meat, fish, cheese, nuts and vegan protein.

Respondents were asked where they currently source food, with the most common responses, in order, being: the food van, other free meals services, supermarket vouchers, food parcels and buying it. In comparison, when asked what could assist them the most to source the foods they needed, the most common responses were food parcels (33 per cent), free meals services (27 per cent) and supermarket vouchers (20 per cent), with the food van, the option currently being utilised the most, absent. A final open-ended question gave participants the opportunity to comment on any other things that would assist them in eating better and responses from this included having somewhere to cook and prepare food and having access to a fridge.

Foods for special diets (for example, gluten free or vegan) were also found to be hard to get, and 30 per cent of respondents stated they did follow such a diet, so this is obviously an issue for the one third of people in this group that have special dietary requirements. Some stated they just had to eat what they could get, which could make them sick, while others went hungry.

Overall, the responses indicated that where and what foods people experiencing homelessness currently source do not align with what would best meet their needs. This discrepancy leads to inadequate nutritional intake, of fresh foods in particular, people running out of money to buy food and people having to source food that is unhealthy, unsuitable or from services that operate only at set times and locations. Our clients often tell us that this restricts them to attending these places and thus keeps them entrenched in the homeless culture.

The second systematic way in which the lived experience of homeless and health service clients is being integrated into health and homeless service delivery and program design is through the assessment or intake process. To be eligible for the Café Meals Program, all clients complete a food security assessment with the dietitian or a member of the food security team. For many people coming in and discussing their food security issues, this is less stressful than discussing the other challenges in their lives and this initial discussion can be the beginning of their relationship with *cohealth* central city, and in some cases, with any service.

The assessment process involves the completion of an intake form, a 60-minute consultation where the client identifies their food security challenges. This provides the team with an understanding of how often a client is eating, how often they run out of money to buy food and what their major obstacles are to eating the food that they would like. The assessment also provides the team with an understanding of where a client is eating, their dietary requirements and any other health, nutrition or other concerns they may have.

This process enables the team to get a clear picture of the food security, health, social and legal challenges that each individual faces and provides the team with the data that allows them to make the important dental, medical, allied health and other referrals to supports and linkages that are crucial to improving an individual's health outcomes.

The dedicated funding of food security programs enables clients to not only source good quality food, but also benefit from being able to access health services and social activities offered by cohealth. On a personal level, ongoing engagement with the food program can lead to clients improving their skills around budgeting and healthy meal

planning, increase their confidence and their ability to become food independent. Improved food security and nutritional intake ultimately leads to improvements in health and well-being, while having the skills to budget and the knowledge to be food independent helps clients maintain their housing on limited budgets (when they eventually get it) and survive the homeless experience. All these outcomes lead to a greater sense of self confidence, improved quality of life and community participation.

The consumer feedback obtained from the survey and during the intake process, as well as from anecdotal evidence obtained when engaging with clients on the street, has given

us an understanding of where the gaps are for homeless people trying to source food. This data was used to write a proposal which has been sent to funding bodies, requesting support so we can broaden the food security response we offer at cohealth central city. In the submission, we put forth the case that people experiencing homelessness struggle to find fresh food and foods for special diets, they find food parcels the most useful but would also purchase subsidised food from the Vic Market if this were an option, and some would make use of a kitchen if one were available. At the time of this report, we have not heard back on the outcome of our submission but we hope to hear some good news soon — watch this space...



Toby Hall

CEO, St Vincent's Health Australia



As a provider of public health services in the inner cities of Sydney and Melbourne, St Vincent's Health's hospitals regularly care for homeless people with the most complex, and often heartbreaking, stories.

Malcolm*, a rough sleeper with an acquired brain injury following a car accident, with no family and little capacity to work.

Ziggy*, who was recently diagnosed with cancer and is receiving palliative care from our hospital's outreach service while living on the streets.

Jason*, who has alcohol use disorder and makes around 30 presentations to our hospital's Emergency Department (ED) every year.

With the support of our partners, we help them all, but together we struggle to deliver long-term, sustainable change.

How can we do a better job?

There's no doubt Australia is at a crossroads in its fight against homelessness.

Despite innovative partnerships among community and health service organisations and their

continued best efforts, homelessness is on the rise and becoming more deeply entrenched.

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

On the government and policy side, it's true we have recently seen more engagement from state and territory governments to address the problem, in some way making up for lost years of inaction.

But while Commonwealth-funded entities — such as the Primary Health Networks — are working with our hospitals on homelessness at the coalface, at a macro level the federal government has so far not seized the moment and taken on a leadership role, particularly on housing, which would mean any improvements across the country could be shared.

Underpinning this situation is the widespread knowledge among governments and service providers alike about how to end homelessness once and for all: more social and affordable housing 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're needed, to help them maintain their tenancy; employment and training opportunities; and a renewed focus on prevention among young people and families.

The solution is indeed within our grasp.

But Australia's homeless, community and health organisations are not waiting for the necessary political will to materialise. As always, they

are on the ground doing the required hard work in its absence.

St Vincent's Health Australia is one of them.

Our hospitals — particularly St Vincent's 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 more than 180 years go; it's part of our DNA.

For example, among our efforts in homeless health, we operate two of Australia's only medical respite services for homeless people, providing residential short-stays and an opportunity for convalescence, where we can monitor a person's health and help them with their housing and a range of other non-health matters.

But like many homeless service providers, we can see beyond funding and policy limitations to what else could be done or done better; how, with the right partnerships and financial support, we could help end homelessness, certainly in the communities around our inner city public hospitals.

Housing is a health issue

St Vincent's Health recognises the causes of homelessness are complex and diverse. Adequately addressing the health needs and vulnerabilities of homeless people and those in tenuous housing won't by themselves end homelessness.

But health is a crucial piece of the homelessness puzzle: an unmanaged illness can be the factor that tips a person from insecure housing into homelessness or from climbing back into long-term accommodation.

The link between homelessness and health is well-documented: people experiencing homelessness have significantly more physical and mental health problems, often struggle with a range of co-morbidities, and die earlier than the general population.

Homeless people are also 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.¹

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.²

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.³

Mainstream health services are just 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.

All of the above presents a massive challenge for traditional clinical boundaries and health system responses.⁴

For starters, hospitals aren't very 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.



Hospital discharge can be similarly challenging.

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.⁷

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.

A recent report by the Sydney Health Community Network⁵ 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 simply not captured.

A study at a metropolitan Melbourne hospital that used ED datasets identified 0.8 per cent of attendees as homeless, whereas intensive manual screening identified 7.9 per cent of ED attendees as homeless.⁶

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

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.

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.⁸

St Vincent's Health Australia's mission impels us not to discharge people into situations that contribute to their poor health.

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.'*⁹

However, for us to deliver our mission effectively requires new models of care, new partnerships and a new approach to care navigation.

There is a clear and desperate need for more dedicated housing services with wrap around support for those

leaving hospital and psychiatric care to prevent them being discharged into tenuous and insecure housing situations so we can break the cycle of re-admissions to hospital.

A way forward — St Vincent's Health Australia's 'Pathways Home' model

Hospitals provide a unique opportunity to create patient interventions that address both health and housing issues, but with the resources they could be doing so much more.

With a focus on both Sydney and Melbourne's inner cities — where its two major tertiary public hospitals are located — St Vincent's Health has developed a best-practice homeless health model which proposes developing three complementary services to better support patients who are homeless or living in insecure housing.

Described internally with the working title, *Pathways Home*, our model aims to continue care long after a homeless patient has been discharged from hospital and to reach them at their point of need over a sustained period and ultimately help them maintain accommodation long-term.

To deliver on our *Pathways Home* vision, St Vincent's has identified that the following new services will be required:

- A speciality homeless persons outpatient clinic, operating in the communities around both our inner Sydney and Melbourne public hospitals, and staffed by experienced clinicians to ensure those with complex needs have access to the medical support they need.
- An expanded medical recovery facility for homeless persons — improving on the 'step up and step down' respite services already in operation at both St Vincent's Melbourne and Sydney — to provide a longer length of stay of between two to eight weeks.¹⁰
- The service would focus on people with the most complex medical, recuperative and behavioural needs and who

struggle to be housed by existing services and where they are sometimes excluded from entry.

- The facilities would offer 'in-reach' support to its residents by existing homeless teams, social workers with family violence expertise, and AOD and mental health specialists.
- New supported accommodation — most likely delivered in partnership with an existing housing provider — to integrate healthcare within a supportive, long-term housing environment.

St Vincent's Health's *Pathways Home* model could provide an opportunity for our staff to see beyond the presenting crisis of the people we serve. It would allow them to walk alongside patients for longer periods so they can learn what is truly important to them and be responsive to their needs and issues.

The model would allow time to build trusting relationships, so clinicians can treat the underlying chronic physical health conditions in a flexible, responsive, and sensitive manner while influencing the patients' other social determinants of health through our community partnerships.

We are confident that these reforms, in addition to other improvements — such as training our health workforce to more effectively identify and support homeless people in our hospitals, and engaging lived experience workers more widely in both our specialised homeless and mainstream health services — would make a major contribution to ending homelessness for many in Sydney and Melbourne's inner city.

It would also stop this same vulnerable group cycling time and again through our hospitals' EDs and requiring re-admission after re-admission, outcomes which reflect the failure of our broader health and housing systems to adequately respond to homeless peoples' unique needs.

Conclusion

St Vincent's Health's *Pathways Home* is one of our organisation's priorities but we won't be able to do it by ourselves. We will need partners — government, non-government,

and corporate support — to help us fully realise our ambition.

Inspired by St Vincent's Health's founders, our peers and partners, as well other emerging international approaches — such as the Healthcare Anchor Network movement in the United States¹¹ — it's the direction our health system needs to take so we can truly say homeless people are getting the best care possible in our hospitals and other health care settings.

We hope it will inspire similar initiatives in other inner city health services serving large homeless populations.

* Not their real names.

Endnotes

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Meg Ady

Community Health RN,
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I wonder what it feels like to be homeless? I've experienced a kind of homelessness by choice, backpacking around Africa and Central America in my twenties, and in the process of international moves, in my thirties. What must it be like, to not have a safe place to live or a group of trustworthy people to depend on? While I have been working with homeless youth in Melbourne for nine years, and have lots of knowledge about transience and trauma, my privilege separates me from their actual lived experience.

An Indigenous young woman I visited this afternoon said: *'We just want to stop being pushed under the rug like we don't matter. Because the truth is, everybody matters. If one Aboriginal person makes it, we all do.'* A Somali young woman I drove to a doctor's appointment this morning said: *'I started to doubt myself. I started thinking about how to lighten my skin so that people wouldn't look at me like my skin was a weapon.'*

This reminded me of Ruby Hamad's words, in *White Tears, Brown Scars*:

'It is about the way in which women of colour who attempt to

address an issue that is detrimental to them in some way almost invariably come up against a wall of white fragility so immovable, so lacking in empathy, so utterly unrepentant, that the first few times it happens, you naturally assume you are imagining it, and that you are the problem...'

Reading this, at the Fairfield Library, was like a punch in the stomach. Despite my leftist leanings and job as a homeless youth nurse, I am still this entitled white woman, assuming rights and privileges at the expense of somebody less valued in our society. Privilege is very insidious. Because my voice is usually listened to and not dismissed; because when I walk into a room, people turn and smile and make me welcome, I assume these things to be my right. Processing my thoughts about this, a non-white friend told me she is the last person to have opportunity to speak in workplace meetings, and usually, her opinions are treated as a joke.

Capitalism can be a draining system in which to live

Capitalism values whiteness and devalues colour

Capitalism values straightness and devalues all other sexualities and options

Capitalism values men and devalues all other genders

Capitalism values not being Aboriginal, and devalues being Aboriginal

Capitalism values being able and devalues being disabled

Capitalism values being healthy and devalues being sick, being

traumatised, being imperfect, being homeless, being human

Capitalism values doing, and devalues being

bell hooks, in *Ain't I a Woman? Black Women and Feminism* comments:

'Dominator culture has tried to keep us all afraid, to make us choose safety instead of risk, sameness instead of diversity. Moving through that fear, finding out what connects us, revelling in our differences, this is the process that brings us closer, that gives us a world of shared values, of meaningful community.'

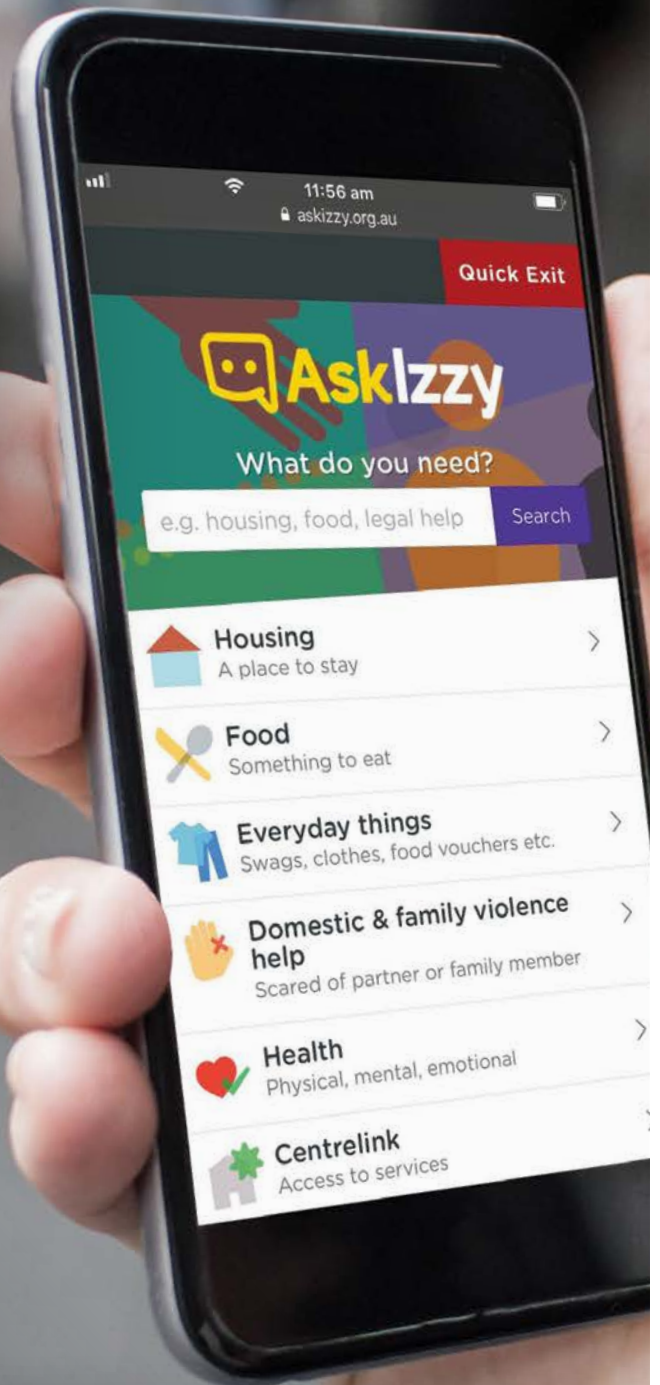
Relationships are at the heart of significant work with people who are experiencing homelessness — the relationship between me and the homeless young person who sat in the front seat of my car, playing their music, looking shyly out the window; the relationship between me and the doctor, to whom I am taking her to discuss her mental health, her fear, her desire to be dead rather than alive; the relationship between me and the psychiatrist to whom she is being referred. Both these doctors will bulk bill the consultation fee to Medicare, with no charge to the client — because they want to help.

I think reflecting and musing about self, and what people's situations and thoughts and poverty and experiences of abuse mean to me, is crucial to the process of being helpful. Ironically, sometimes focusing all my attention and energy on myself, strengthens me to be patient and kind and accepting of others, and to be present in a way which honours them, does not assume to understand them, and helps connect them with healing and health.

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Homelessness in Australia: An Introduction provides thought-provoking, up-to-date information about the characteristics of the homeless population and contemporary policy debates.

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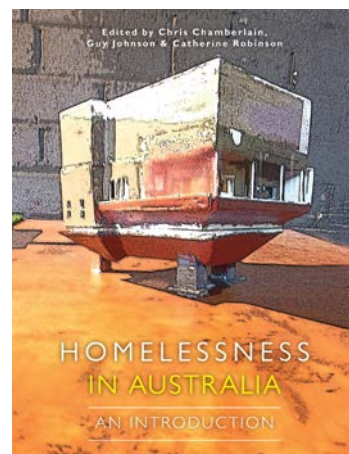
Part 2 is about contemporary policy issues and discussions. It has chapters on: the debate about definition and counting; gender and homelessness; young people; older people; Indigenous homelessness; domestic and family violence; people with complex needs and the

justice system; trauma as both a cause and consequence of homelessness; and people who are long-term or 'chronically' homeless.

Part 3 includes a piece on the 'failure of the housing system' and a chapter on 'reforming the service system'.

People will find the essays in *Homelessness in Australia* both illuminating and challenging.

This important new book will be required reading for all people committed to ending homelessness in Australia.



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