



Homelessness Health Strategy

2018-2021

**Artwork featured in this Strategy was created by
students from the Mission Australia's Art Program**



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Foreword

Our purpose as a Local Health District is to enable our communities to be healthy and well; and to provide the best possible compassionate care when people need it. Integral to that is improving equity in health and wellbeing and addressing systemic barriers to health equity.

As such, improving health, and access to health care, among people experiencing homelessness is a high priority for South Eastern Sydney Local Health District (SESLHD).

There are over 7,500 men, women, children and young people experiencing homelessness or at risk of homelessness in SESLHD each year. They are among the most socially and economically disadvantaged residents of our Local Health District.

It is well-established that homelessness both harms health and makes it more difficult to access the right health care at the right time. At a population level, people experiencing homelessness have a higher prevalence of a range of chronic conditions, including mental health problems, problematic drug and alcohol use, cancer and chronic viral hepatitis, and are at higher risk of both injury and trauma. For many people, these conditions are significantly exacerbated by homelessness.

This District has a proud history of providing high quality, compassionate health care for people experiencing homelessness. Many of our staff go 'above and beyond' in addressing the health and wellbeing needs of patients and in connecting patients to homelessness and welfare services. The work of these staff members has been complemented by the work of the SESLHD Homelessness Health Program Manager, who has led a number of District-wide and intersectoral initiatives to improve our understanding of the health needs of people experiencing homelessness. Together, those activities have contributed to the health and wellbeing of many individuals experiencing homelessness.

Our focus for the coming three years is to build a coordinated response to people experiencing homelessness across the District.

At a patient level, we have the opportunity to significantly improve the patient journey through the health system, by continually improving how we engage with patients, asking the right questions, providing compassionate care and implementing discharge processes that support our commitment to "no exit to homelessness". At a systemic level, we will re-examine models of care and patient pathways, identify opportunities for consultation and co-design with people experiencing homelessness, and strengthen our approach to both data and workforce development.

Working in partnership will be key to making progress toward our goals for improving the health of people experiencing homelessness. This includes collaboration across the LHD, to provide truly integrated care for each patient experiencing homelessness. It also includes collaboration with community and external partners to facilitate access to the right care at the right time and ensure smooth transitions into and out of health care. In addition, we will continue to support and facilitate the development of an Intersectoral Homelessness Health Strategy that will ensure a formalised, strategic approach to the coordination of planning, delivery and evaluation of services, with a focus on primary homelessness; initiatives to improve the health of people experiencing homelessness; flexible models of care; early intervention and transition points, including post-crisis support; and vulnerable populations.

This strategy provides the foundation upon which SESLHD services can plan and deliver our response in order to improve access, integration and experience of care for people experiencing homelessness. I offer my thanks and commendation to all those who have contributed to the development of this Homelessness Health Strategy, including both SESLHD staff and partners from outside the LHD, and look forward to supporting its implementation in the coming years.

Gerry Marr
Chief Executive
South Eastern Sydney Local Health District



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Thank you to all the people with lived experience of homelessness and all the service providers who were consulted during the development of this Strategy, for providing valuable insights into the health needs and health service responses to people experiencing homelessness.

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- Greg Stewart, Director, Primary Integrated and Community Health
- Tony Jackson, Deputy Director, Primary Integrated and Community Health
- Lisa Woodland, Manager, Priority Populations
- Jessica Harper, Homelessness Health Program Manager
- Stephanie Macfarlane, A/Homelessness Health Program Manager
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- Amanda Webster, Manager, Strategy & Equity, Child Youth & Family Services
- Elizabeth Abbott, Coordinator Older People's Mental Health and Partnerships, Mental Health Service
- Nicholas Lintzeris, Director, Drug and Alcohol Services
- Timothy Croft, Manager, Aboriginal Health Unit
- Julie Osborne, Manager, Integrated Care Unit

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Consumer Statements



Australia has fabulous health care, a world-class health care system.

It is not the health care that is lacking, it is the manner we are treated in.

I would go to a hospital only if I really had to.

I never seek help because I don't trust the system.

If you appear at ED they say its just because you want a bed.

Assumptions affect the health care they give you and your willingness to come back.

I have had a difficult time. I got kicked out of home at 15 because I was trans.

It is hard to get health services when you have no fixed address.

They want an address, unless you are accessing ED. So you go to ED. But EDs are not open to hearing your experiences.

It is very hard for people when they are put into a house with no living skills, **they feel like they are being set up for failure.**

If you come in and there are multiple things wrong with you, if you come in shaky because it's [taken a lot of courage] to come in, if you don't look right, if you can't describe your symptoms in the right way...

everything is about suspicion, about assuming you are doing the wrong thing.

So to be believed is the biggest thing.

Some people who are homeless take the attitude of

“why care about my health when I am not housed”.

When you are homeless, you fear being locked up because of mental health or because of criminal activities in your past.

People fear that they can't seek help without anything else being insisted upon them.



Strategy on a page

SESLHD Homelessness Health Strategic Framework

Guiding principles



- Person Centred Care
- Trauma informed Care
- Co-design and co-production
- Working in partnership
- Early Intervention
- Integrated care
- No exit to homelessness
- Evidence-informed decision making
- Monitoring and evaluation

Goals



- To build capacity of the health system to provide safe, person centred and integrated health care for people experiencing and at risk of homelessness**
- To provide targeted, flexible services and programs to people experiencing homelessness**

Domains of action



Flexible service delivery

ensuring models of care are flexible and appropriate to the needs of people experiencing and at risk of homelessness



Consumer engagement and co-design

working with consumers to enhance access and patient experience



Workforce capability

building the capacity of the workforce to identify, assess and respond to the needs of people experiencing and at risk of homelessness



Information and knowledge

strengthening information systems and using/developing evidence based approaches to inform service and program development



Intersectoral collaboration

supporting existing and strengthening new partnerships to ensure integrated health care across the spectrum of care

Short to medium term outcomes

Improved access	Increased integration of care	Improved patient experience
<ul style="list-style-type: none"> - People know where to go - People are supported to get where they need to go - People are identified at the earliest point 	<ul style="list-style-type: none"> - People get the health care they need - People are supported to connect with the other care and supports they need 	<ul style="list-style-type: none"> - People are treated with respect

Long term outcomes

Reduced health disparities

- People live longer, healthier lives

Principles underpinning the SESLHD Homelessness Health Strategy

Person-centred care

designing care around and with people, so that their needs and their experiences are at the centre of how we think, how we plan, how we design our services, how we invest and how we deliver care. In this context, this includes consideration of the need for flexible models of care, including outreach.

Trauma-informed care

creating safety, and addressing the impact of trauma, will inform the way we care for individuals and the way we design services and models of care.

Co-design and co-production

consultation, co-design and co-production with people experiencing homelessness provides a unique opportunity to develop services which are informed by and responsive to lived experience. In addition, collaboration with people experiencing homelessness creates opportunities to seek out and draw upon the assets and strengths of individuals and communities.

Partnership

partnerships with non-government, other state government agencies and local government are crucial to achieving an effective response to the needs of people experiencing homelessness and to address the drivers of homelessness.

Early intervention

where possible, we work with individuals and communities to strengthen wellbeing and resilience, through early identification and response to the risk of homelessness, as well as early identification and intervention for health issues.

Integrated care (including post-crisis support)

the District is committed to providing integrated care, which includes stronger collaboration between all members of the care team working with an individual experiencing homelessness, and stronger coordination with General Practice, Specialist Homelessness Services and other community-based services involved in the care and support of that person.

No exit to homelessness

we strive to ensure that individuals do not exit from LHD facilities to homelessness. This will at times be complex as it is reliant on access to appropriate housing, but we are committed to working toward this goal.

Evidence-informed decision making, monitoring and evaluation

we are committed to being a learning organisation, one which uses the best range of local, national and international data and evidence to tailor responses to the needs of our local communities; and to regularly evaluate progress toward our goals.

Domains of action for the SESLHD homelessness health strategy



Flexible service delivery

we will develop and enhance models of care that are targeted and tailored to the needs of people experiencing or at risk of homelessness through a range of initiatives including outreach services; assertive follow up; flexible appointment systems; supported and effective referral pathways; prioritising people experiencing homelessness on waitlists; and providing opportunistic health screening and vaccinations.



Consumer engagement and co-design

we will work with consumers to enhance access and patient experience by integrating consumer consultation mechanisms into workflows and co-designing and developing services and programs with people experiencing homelessness.



Workforce capability

by delivering education and training initiatives and providing access to expert advice and support we will build the capacity of the SESLHD workforce to identify, assess and respond to the needs of people experiencing and at risk of homelessness.



Information and knowledge

we will enhance data and evidence available to inform service and program development through a range of initiatives including modifications in EMR to support early identification and intervention for people at risk of or currently experiencing homelessness; the Equity Data Indicators project; and research initiatives.



Intersectoral collaboration

we will support existing and new partnerships and the development of pathways between internal SESLHD services, primary care and Specialist Homelessness Services. In addition, we will support and facilitate the Intersectoral Homelessness Health Plan with key partners: Sydney Local Health District, St Vincent's Health Network, Family and Community Services, City of Sydney and Central and Eastern Sydney Primary Health Network.

Implementation of the SESLHD homelessness health strategy

This strategy provides the foundation upon which SESLHD services can plan and deliver their response in order to improve access, integration and experience of care for people experiencing homelessness. Annual implementation plans will be developed across the District and monitored by an Implementation Steering Committee. Key roles and responsibilities are outlined below:

General Managers and Service Directors

Identify key priorities and actions for their facility/directorate within the strategy

- Nominate representative for the Implementation Steering Committee
- Provide executive support for actions within the strategy
- Provide regular progress reports, as requested by the Implementation Steering Committee

Primary Integrated and Community Health Directorate

Chair and provide secretariat functions to Homelessness Health Strategy Implementation Steering Committee

- Through Priority Populations Unit:
 - Lead/coordinate District wide workforce development and capacity building initiatives
 - Provide support and advice to services and programs as required
 - Lead/coordinate District-wide initiatives/projects
- Support and facilitate development of the Intersectoral Homelessness Health Strategy with key partners

SESLHD Homelessness Health Strategy Implementation Steering Committee

Oversight of the implementation of the Homelessness Health Strategy

- Developing a detailed action plan
- Monitor progress
- Identify opportunities for collaboration between internal and external partners and community

The need for change

People experiencing homelessness have poorer health outcomes

There is an unacceptable gap between the health outcomes of people experiencing homelessness and other residents of South Eastern Sydney Local Health District. This reflects the convergence of the higher prevalence of many conditions among people experiencing homelessness and the ways in which homelessness exacerbates or amplifies the burden of illness.

People experiencing homelessness have poorer access to health care

In addition, people experiencing homelessness have poorer overall access to preventative health care and treatment and experience significant barriers to accessing the right healthcare at the right time. Some of these affect the majority of people experiencing homelessness (including reticence to access care due to past experiences of poor treatment by health care workers) while some are population-specific (for instance, fear of referral to child protection agencies among women who are pregnant).

Whilst there are many excellent clinicians providing excellent care to people experiencing homelessness, this is reliant on individuals rather than embedded within LHD systems. In addition, there is insufficient capacity within the broader homelessness sector, which means that at times patients are discharged to homelessness.

Consultations for the development of this Strategy also noted that people experiencing homelessness overall have poorer access to post-hospital rehabilitation facilities (as 'having an address to be discharged to' is either formally or informally an entry criteria for those facilities).

Improving outcomes and access for people experiencing homelessness will require:

- Improving identification of people who are experiencing homelessness at the earliest possible opportunity, in order to then provide patient-centred care appropriate to their needs;
- Developing pathways and models of care which are appropriate to people experiencing homelessness, including:
 - integrated and coordinated care within the health system;
 - flexible models for accessing health care; and
 - linking patients to the full range of services appropriate to their needs, including community-based health services, specialist homelessness services and potentially other welfare services;
- Reviewing current NGO funded programs and partnership models to ensure they promote no exit to homelessness strategies
- Ensuring that discharge planning is commenced at the earliest opportunity and addresses both clinical need and other relevant needs and avoids discharging patients to homelessness; and
- A multi-faceted service model which builds strength across the mainstream health service and specialist homelessness health services and supports the capacity of specialist homelessness services to identify and respond to the health needs of their clients.



Our systems do not consistently support the provision of the best possible compassionate care when people need it

Enablers which need further strengthening include:

- Increased knowledge, confidence and skill among LHD staff at all levels in engaging with people experiencing homelessness;
- Improved provision of Trauma Informed Care, allowing for greater understanding of the impact of physical and psychological trauma on engaging with and accessing services;
- Data and information systems which support early identification of people experiencing homelessness (including flags within eMR), consistent definition of homelessness across facilities; and which allow analysis of population-level trends in prevalence, occasions of service and access by people experiencing homelessness;
- Policies, practise and resources which support the 'no exit to homelessness' principle

Homelessness is a boundary-spanning issue and requires a collaborative, intersectoral response across health, housing, local government and other services

In particular, reducing homelessness is critical to improving the health and wellbeing of people experiencing homelessness; as is expanding access to post-crisis support.

There is an unacceptable gap between the health outcomes of people experiencing homelessness and other residents of SESLHD.

Strategic Context

ABOUT THIS STRATEGY

The purpose of this Strategy is to describe the strategic priorities for South Eastern Sydney Local Health District in improving health and access to health care among people experiencing homelessness; and to describe the activities we will undertake to address those strategic priorities.

Defining homelessness

For the purposes of this document, the term 'person experiencing homelessness' is used to cover the three categories of homelessness, namely:

Primary homelessness

which is experienced by people without conventional accommodation
(e.g. sleeping rough or in improvised dwellings)

Secondary homelessness

which is experienced by people who frequently move from one temporary shelter to another
(e.g. emergency accommodation, youth refuges, "couch surfing")

Tertiary homelessness

which is experienced by people staying in accommodation that falls below minimum community standards (e.g. boarding houses and caravan parks)
(Mackenzie and Chamberlain, 1992, cited in Homelessness Australia (1), 2014.

There are over
7,500
people experiencing homelessness in South Eastern Sydney Local Health District

(Australian Bureau of Statistics, 2016)



As such,

SESLHD has 20% of the total NSW population of people experiencing homelessness

and has the single highest proportion of people experiencing homelessness of any Local Health District in NSW.

The National Census 2016 homeless person's data indicates that:



58%
are men



42%
are women



20%
are Aboriginal and Torres Strait Islander

Children and young people (0-24 years) account for 35% of those experiencing homelessness

People aged 55+ made up 16% of the total;
this has been steadily increasing since the 2006 Census



The single biggest population of people experiencing homelessness in SESLHD is located in the inner-city, with distinct groups also in the St George and Sutherland areas.

Contributing Factors

Homelessness is caused by a range of economic, social and personal circumstances. Within NSW, homelessness is caused by:

- Financial disadvantage, which accounts for 20.5% of homelessness;
- Accommodation issues, such as being in inadequate or inappropriate dwellings, which account for 24.9% of homelessness;
- Domestic violence and relationship issues, which account for 33.8% of homelessness. Women, including pregnant women and women with children, account for a significant proportion of this group;
- Mental health and substance use issues, which account for 7.5% of homelessness;
- Other factors such as transition from care/custody, lack of support and discrimination, which account for the remaining 13.3% of homelessness (Homelessness Australia, 2014).



People feel like they are being told they are in that situation because of the choices they make, but actually, society is making choices for them ... Once you are down, the system makes it very hard to get back up again.



The health needs of people experiencing homelessness

People experiencing homelessness have a higher prevalence of chronic (long term) conditions and often experience a higher burden of illness as a result of those conditions. This is because:

- Some conditions can significantly increase the risk of homelessness;
- Homelessness can cause or exacerbate existing conditions (in particular depression, anxiety and trauma); and
- Homelessness can increase vulnerability to some conditions (trauma, injury, skin conditions, wounds, respiratory conditions, depression and anxiety).

More prevalent conditions include:

- Serious mental illness: some 53% of participants in the most recent Homelessness NSW Registry Week reported a mental health issue; with nearly two-thirds of that group reporting having both mental health issues and problematic alcohol or drug use;
- Problematic alcohol and other drug use: some 72% of participants in the most recent Registry week (Homelessness NSW, 2015);
- Chronic physical health issues, including
 - Metabolic syndrome;
 - Cardio-vascular disease;
 - Obstructive Pulmonary disease;
 - Liver disease, including chronic viral hepatitis and advanced liver disease;
 - Oral health conditions; and
 - Cancers (South Eastern Sydney Local Health District, 2017).

Factors which make it difficult for people experiencing homelessness to access the right care at the right time include:

- The complexity of the health system;
- Complicated referral processes, strict scheduling of appointments and strict eligibility criteria that are largely incompatible with the chaotic nature of homelessness;
- Poorer access to General Practice; few people experiencing homelessness have sustained engagement with a single General Practitioner and/or General Practice and thus have poorer access to preventative care and ongoing management of chronic diseases;
- People experiencing homelessness are more likely to engage with the health system in crisis or acute need;
- Many people experiencing homelessness have multiple co-morbidities and thus require integrated rather than single-stream clinical care;
- Health care may not be a pressing priority for a person experiencing homelessness, given the more urgent need for shelter, safety and food;
- Some, though not all, people experiencing homelessness have limited knowledge and skills in accessing the health care that they need;
- Health service staff may feel uncomfortable communicating with people experiencing homelessness and this can create barriers to either access or retention; and
- The lack of Medicare cards and the difficulties in replacing documentation experienced by people with no fixed address.

While there is no comprehensive data on the journeys of people from homelessness to sustainable tenancies, estimates indicate that around two-thirds of people experiencing homelessness will benefit from medium-term interventions designed to address homelessness and contributing factors, while the remaining one-third will require ongoing support to access and navigate health care and to maintain community tenancy (Hecate Consulting, 2018).

The needs of sub-populations of people experiencing homelessness

People experiencing homelessness are a diverse population. Specific sub-populations of people experiencing homelessness have been identified as being at heightened risk of poorer outcomes and these are identified below as priorities for the LHD. It should also be noted that issues for sub-populations are complex and overlapping and many people experiencing homelessness are members of more than one sub-population.

Priorities for SESLHD include:



Aboriginal people

Aboriginal people are vastly over-represented in the homeless population both nationally (20%) and in SESLHD. The *SESLHD Homelessness Health Data Project* (2013) found that some 11% of patients experiencing homelessness were Aboriginal, and that Aboriginal people were particularly over represented among those experiencing primary homelessness. Contributing factors to this include the ongoing impacts of the Stolen Generation and dispossession of land, legislative discrimination and intergenerational trauma.

Aboriginal people experiencing homelessness are a diverse population but many experience multifaceted disadvantage, including high rates of socio-economic disadvantage; higher prevalence of trauma (including intergenerational trauma), mental health conditions, chronic disease (e.g. cardiac, respiratory, diabetes, cancer), domestic violence and problematic drug and alcohol use.

It is recognised that Aboriginal people who are homeless may have first experienced homelessness at a younger age than other homeless people who are non-Indigenous. As such, there are more homeless Aboriginal people under 18 (42%) than non-Aboriginal people (20%) (AIHW, 2014). There are complex contributing factors at play for Aboriginal people, including over representation in out of home care and the juvenile justice system. Aboriginal women are over represented in Specialist Homelessness Services, with domestic violence the most commonly reported reason for seeking assistance. (AIHW, 2014).

It is well-established that accessing health care can be more difficult for Aboriginal people, owing to a range of historical and systemic factors, including racism and fear of racism. These difficulties are only amplified by homelessness.



Women

There is growing recognition of the specific experiences and needs of women experiencing homelessness. Women at particular risk include:

- Women who are experiencing homelessness due to domestic and family violence;
- Older women who are experiencing homelessness due to a range of factors, including poverty or disability;
- Young women;
- Aboriginal women;
- Pregnant women and women with children.

Specific additional issues for women experiencing homelessness include:

- Poor access to the continuum of care (from routine screening such as breast and cervical screening, to diagnosis to treatment and care);

- Vulnerability to violence, abuse and exploitation;
- Access to antenatal care for pregnant women experiencing homelessness;
- Sexual and reproductive health (particularly for young women experiencing homelessness); and
- Chronic disease, including higher rates of heart disease, osteoporosis and earlier onset of the health issues associated with ageing.

Many women experiencing homelessness are accompanied by children and require access to services which can support both them and their children (such as Child and Family Nursing). It is acknowledged that many Specialist Homelessness Services target men, and there are relatively fewer services for women and children. There are few services that are able to provide crisis and temporary accommodation to women who have substance use and/or chronic mental health issues and/or who do not have access to Medicare.



Young people

Access to the right care at the right time can be a particular issue for young people as:

- Medicare activity-based funding models and appointment-based service models may not be a good fit for how young people experiencing homelessness engage with services;
- Young people experiencing homelessness may not place a high priority on health and access to health services, owing to multiple competing priorities;
- Youth homelessness services may place a lower priority on health care than on other issues and thus may not prioritise health in care planning;

- There is insufficient care coordination capacity within the system to meet the needs of the population of young people experiencing homelessness;
- Young people who identify as LGBTIQ often experience stigma and discrimination which is an additional barrier to engaging with health services.

Around 60% of young people in Specialist Homelessness Services have been in the Out of Home Care system, highlighting this group as a particular priority due to the multiple vulnerabilities they may experience; a range of evidence shows that they are at higher risk of progressing to long term homelessness.



I got a place 2 weeks ago. (I'm 24 now and this is) the first proper home I've had since I was 15. Nine years. It's hard to feel warranted (deserving) to have a place. It's unnerving to get a house. You fear putting down roots, fear being ripped up. Need to relearn how to live in a house. It's a big change, in a house by myself.



People with disability

People with disability (including people with intellectual disability and people with traumatic brain injury) are over-represented among those experiencing homelessness. In general, people with disability have poorer health outcomes and greater difficulty obtaining health services, and this is exacerbated by homelessness. Issues for this population can include:

- Higher prevalence of some physical and mental health conditions;
- Limited understanding across health services as to effective communication with people with disability (NSW Health, 2012);
- Less developed health literacy;

- Socio-economic disadvantage;
- Lack of clarity about services and how to access those services to which they are entitled, particularly given the changes to the service landscape associated with the current disability reforms and introduction of the NDIS;
- Disability service gaps created by the withdrawal of Ageing Disability and Home Care (ADHC) and subsequent lack of services for people with a disability who are not eligible for the NDIS but have a disability and require disability supports; and
- Thin market for disability support services created by the free market based system, in particular for people with complex needs.



People from culturally and linguistically diverse backgrounds

People from culturally and linguistically diverse backgrounds are overrepresented in those living in severely overcrowded dwellings. In 2016, 54% of this group were born in an Asian country, compared with 33% born in Australia.

People from culturally and linguistically diverse backgrounds who experience homelessness may find it difficult to access health care due to:

- Socio-economic disadvantage;
- Language and cultural barriers;

- Cultural shame and stigma related to homelessness; and
- Lack of knowledge about services available and how to navigate those services.

People who have arrived in Australia as refugees or asylum seekers may find it particularly difficult to access health care. It is essential that people who do not speak English well are offered language support through professional interpreters when accessing health and community support services.



People leaving Juvenile Justice and Department of Corrective Services facilities

People exiting jail are significantly over-represented among those experiencing homelessness, with some 53% of NSW Registry Week respondents indicating that they had been in prison (Homelessness NSW, 2015).

Health issues for this population can include:

- Higher prevalence of some physical and mental health conditions;
- Disruptions in access to care following the transition from Justice Health to community providers; and
- Variable health literacy and knowledge/skill in navigating health services.



People with a history of injecting drug use

People with a history of injecting drug use make up a sub-set of people experiencing homelessness and are particularly vulnerable to primary homelessness and very poor health outcomes.

Many people within this sub-group have had poor experiences with health care providers in the past – due to stigma related to injecting drug use – and are at risk of late presentation for very serious health issues.



I have a heart condition and I use meth. When the ambo came they were really nice. Then they said “Oh its meth” then it all changed. The hospital didn’t investigate my heart because of the meth. The attitude was “this is something you are doing to yourself. Stop using the drugs and you will be ok”.





Older people experiencing homelessness

People who are homeless have an increased likelihood of experiencing the effects of ageing more rapidly than others in their age cohort. This is often exacerbated by pre-existing physical and mental health conditions.

Older people in this context are usually defined as those aged 55 and over. There is a growing number of older single women who are experiencing homelessness for the first time in later life. Despite having aged care related needs, being under 65 acts as a significant barrier to accessing aged care related services, in particular, residential aged care.

Health issues for this population include:

- Increased risk of falls
- Vulnerability to assault and prolonged physical recovery from injuries
- Declining cognition resulting in increased difficulty navigating complex systems and remembering important appointments
- Declining physical health; increased health needs but difficulty in accessing appropriate age related services
- High prevalence of some physical and mental health conditions



Carers

People experiencing homelessness may be carers.

They may require specific supports and services to assist them in their caring role, and/or additional supports for the person for whom they care while until they are able to find appropriate accommodation. Carer involvement may strengthen discharge planning and facilitate engagement with community care and support services. Carers of people experiencing homelessness may also have significant needs in relation to information, support and their own health needs.



You are treated as the lowest of the low, they will give you attention later on, they will treat everyone else first and make you wait to “prove” you are serious about needing help.



Under served geographic areas

Consultations for the development of this Strategy noted that there are different issues in different geographic areas of the LHD:

- The majority of people experiencing homelessness are concentrated in the northern (“inner city”) sector of the LHD. However, this sector has the highest coverage of specialist homelessness services;
- Maroubra, Malabar, Botany have been identified as areas of high need; and
- There are smaller but distinct populations of people experiencing homelessness in the St George area (particularly in the beach suburbs) and in the Sutherland area (including the Royal National Park area); which would benefit from assertive multi-agency outreach services.

Planning and policy context

There is currently no specific policy framework for improving the health of people experiencing homelessness at either a state or national level. As such, there is no agreed set of priorities and no state/national initiatives which address homelessness health.

There are, however, a number of related state policies which have informed the development of this Strategy including:

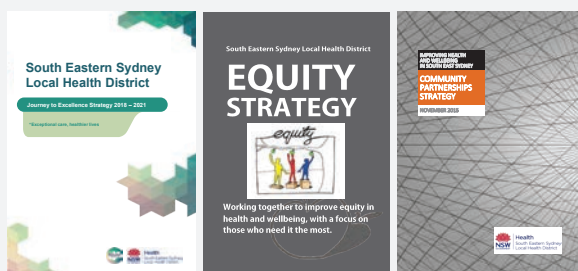
- NSW Youth Health Framework;
- Living Well (NSW Mental Health Commission)
- NSW Older People's Mental Health Services Plan 2017-2027
- Healthy, Safe and Well - A Strategic Health Plan for Children, Young People and Families 2014-2024;
- The National Plan to Reduce Violence against Women and their Children 2010-2022
- NSW Premier's Priorities 2016-2018



In addition, this Strategy has been informed by and aligns with the following South Eastern Sydney Local Health District planning documents:

- *South Eastern Sydney Local Health District Journey to Excellence Strategy 2021*
- *SESLHD Equity Strategy;*
- *SESLHD Community Partnerships Strategy;*

This Strategy and Action Plan will also be complemented by the *Intersectoral Homelessness Health Strategy for the South Eastern Sydney and Sydney regions 2018-2023* (forthcoming). That Strategy will articulate the shared goals, vision and priorities of this LHD, Sydney Local Health District, the Department of Family and Community Services, Central and Eastern Sydney Primary Health Network, St Vincent's Hospital and the City of Sydney.



Service system context

Reports from service providers suggest that there has been an increase in the number of people experiencing homelessness accessing health services in recent years.

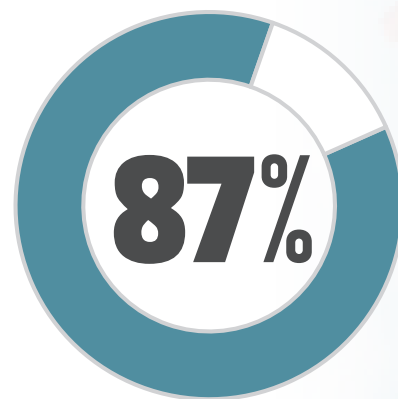
There are multiple means by which people experiencing homelessness access health care in south eastern Sydney:

- **Mainstream Emergency, inpatient and outpatient services** provide the vast majority of occasions of service for people experiencing homelessness (as for other residents of the Local Health District). This includes care provided by the Local Health District and St Vincent's Hospital, located in Darlinghurst;
- **Mainstream Community Health Services** also provide a number of essential health services to vulnerable populations and people experiencing homelessness. This includes services such as the Child and Family Nursing, Counselling, Violence Prevention and Response, Sustaining NSW Families and Drug & Alcohol Services;
- **Mainstream General Practice** (funded by the Australian Government via Medicare). As previously noted, a small number of General Practitioners in the area are highly experienced in working with people experiencing homelessness recent reports suggest that the majority of people experiencing homelessness have sub-optimal access to primary health care;
- **Specialist homelessness health outreach services** – including the service provided by Kirketon Road Centre (KRC) and the St Vincent's Homeless Health Service;
- **Centre-based homelessness health services** – including the Primary Health Clinic at the Matthew Talbot Hostel and the Wesley Mission Therapeutic Support Team;
- **Specialist health services provided in homelessness services** – including the Oral Health Clinic (an initiative of the LHD's Oral Health Division) and the Health Clinic operating at Mission Australia (an initiative of St George Hospital under the leadership of Dr Mark Brown) in Surry Hills; and
- **Mobile outreach services.**

The SESLHD Homelessness Data Project (2013) report found that people experiencing homelessness account for 1.5% of clients accessing LHD services. The majority (53%) of those were experiencing secondary homelessness, with only 20% experiencing primary homelessness. In relation to service utilisation data, people experiencing homelessness:

- Had lower admitted and Emergency Department encounters than the sample population and had higher non-admitted encounters than the total sample population;
- 87% of clients experiencing homelessness were seen by the four Key Programs of Drug and Alcohol, KRC, Mental Health, and Emergency Departments.

A comprehensive list of health services currently available for people experiencing homelessness is available in the *Enhancing Primary Health Care Services for People Experiencing Primary Homelessness in the Central and Eastern Sydney Primary Health Network* (Sydney Health Community Network, forthcoming).



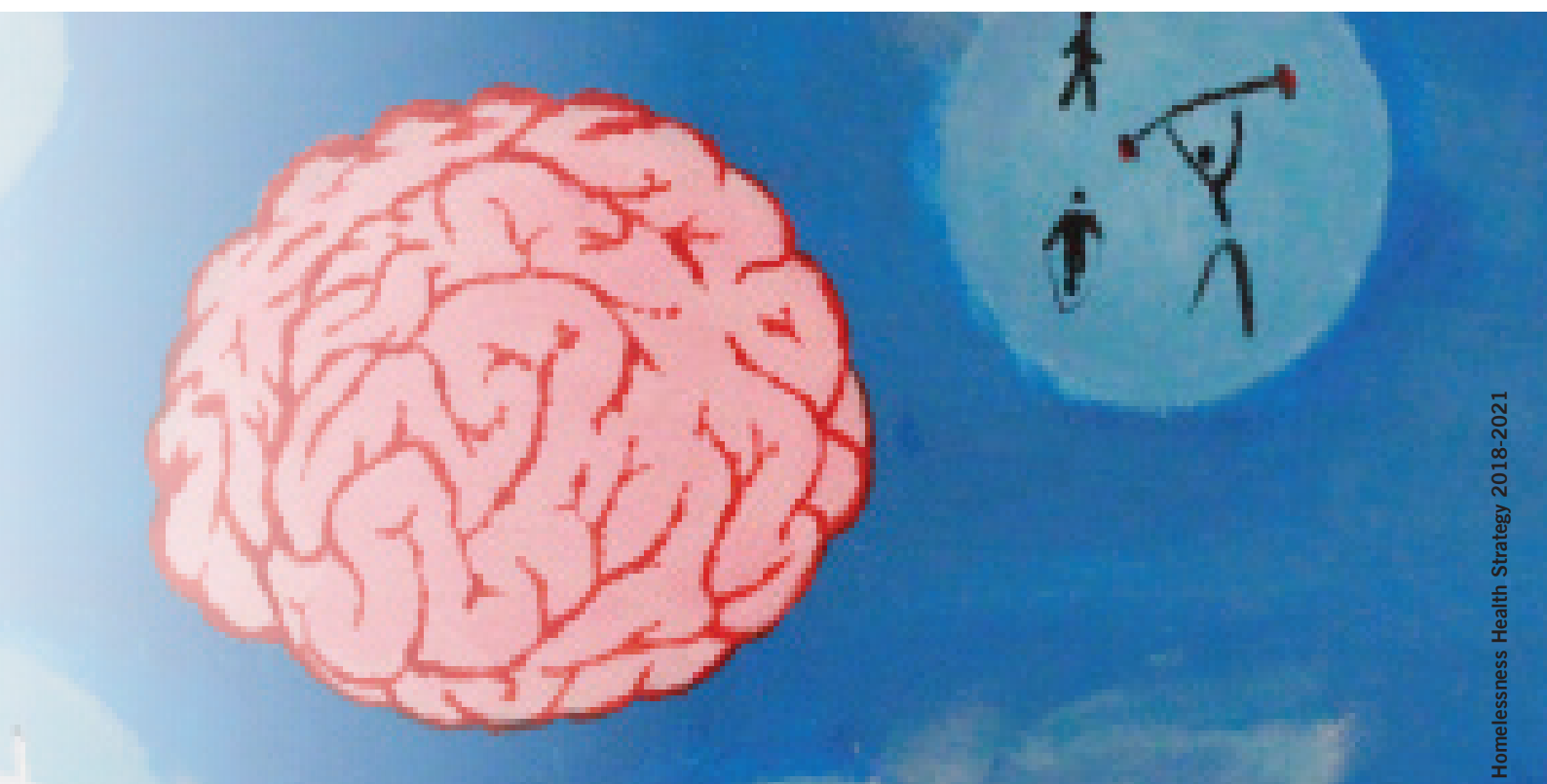
of clients experiencing homelessness were seen by the four Key Programs of Drug and Alcohol, KRC, Mental Health, and Emergency Departments

Within SESLHD, the Homelessness Health Program Manager (located within the Priority Populations Unit) provides leadership and coordination of the response to people experiencing homelessness. The role of the Program Manager is to work with internal and external partners to:

- Build the capacity of SESLHD services and programs to deliver equitable, inclusive health care;
- Build the capacity of external service partners to achieve better health outcomes;
- Facilitate the development of new models of care across health and partner agencies;
- Support the development of targeted models of care to improve access and outcomes for people experiencing homelessness;
- Address gaps in evidence through contributing to targeted research; and
- Advocating for improvements in health services and systems;

There are a number of key challenges in the service system response to people experiencing homelessness:

- Whilst the bulk of health resources are located within mainstream primary health, community health and hospital systems, these systems can be the most challenging for people experiencing homelessness to access;
- There has been a reduction in dedicated health services within or outreaching to homelessness services, with health clinics at the Haymarket Foundation and Foster House either closing or significantly reducing capacity in the past two to three years;
- Non-government organisations play a key role in direct service delivery and in overarching leadership and advocacy. Whilst this has many advantages, it requires a high level of coordination between organisations to maximise impact and minimise duplication;
- Likewise, despite the relatively small number of specialist homelessness health services, coordination and collaboration between those services and between the specialist homelessness health services and mainstream facilities is at times sub-optimal. This can adversely affect continuity of care for individual patients and misses opportunities for more strategic collaboration.



What is working well?

The LHD has many individual clinicians who are passionate about improving health outcomes for people experiencing homelessness; and a number of services have been able to develop and implement models of care which have improved access for people experiencing homelessness.

The following are case studies of either initiatives or models of care that have improved access for people experiencing homelessness to quality, compassionate care at the time they need it.

Social work

Social workers play an integral role in improving access to health care for people experiencing homelessness. Social workers often take a lead in advocating for patients, assisting patients to navigate the health and homelessness service systems, and connecting patients to community-based care. Social workers are also a lynchpin in the intersectoral response to people experiencing homelessness, collaborating with partner organisations to provide integrated care for individuals and to work systemically to address barriers to care.

Health Clinic – Mission Australia Centre

In 2012, Professor Mark Brown, a renal physician from St George Hospital, established a health clinic at the Mission Australia Centre in Surry Hills. That clinic, which operates as an official outreach clinic of St George Hospital provides:

- General physician and nursing care;
- Hepatitis C treatment (via outreach by the Hepatology CNC); and
- Mental health care.

The Clinic has been recognised as an innovative service response to the needs of people experiencing homelessness and has been successful in reducing unnecessary Emergency Department presentations by providing more timely access to care in the community.



The need for more outreach and for proactive follow up after discharge

“you need more follow up, like a call after you are discharged”.



Oral health

It is widely documented that people experiencing homelessness are highly vulnerable to poor oral health outcomes, and that poor oral health can contribute to a decline in both physical health and psychological wellbeing. It is also well documented that people experiencing homelessness are less likely to access oral health care until the point of crisis.

In response to these identified needs, Oral Health established the Special Needs Dental Service as an outreach clinic within the Mission Australia Centre in Surry Hills (a Specialist Homelessness Service).

The Special Needs Dental Service is staffed by dentists, oral health therapists and a welfare officer; the welfare officer is able to support individuals into the service and during their journey through the service ensuring the continuity of care by maintaining effective partnerships with crisis services in the area, and can also support clients by making referrals to other agencies as required. Individuals are able to access the service via multiple entry points, including via self-referral, mental health, youth programs, drug and alcohol and specialist homelessness services. Patients requiring more complex work than is able to be provided in the Mission Australia Centre outreach clinic (e.g. general anaesthesia) are referred on to St Vincent's Hospital via a partnership agreement between Oral Health and the hospital. The service is also able to refer patients to private providers for specific needs such as dentures.



When people (do have good experiences of health care) they get really really excited, they are really really grateful.

For example, when someone gets dentures, you can see the change of energy, the change of persona.



KRC

Kirketon Road Centre (KRC) has a long-standing history of working with clients experiencing homelessness. Currently, up to 40% of KRC's core client population is experiencing homelessness.

Care for clients experiencing homelessness is incorporated into all aspects of KRC's work, including:

- Tailoring client care to address any additional barriers which might occur for people experiencing homelessness, for instance additional support with pharmacy access and treatment prompts;
- Street-based outreach to engage clients;
- Providing outreach clinics at key sites accessed by people experiencing homelessness, including Edward Eager Lodge, NSW Users and AIDS Association (NUAA) and the Matthew Talbot Lodge; and
- Collaboration with key Health, government and NGO partners on both individual client care and intersectoral initiatives.

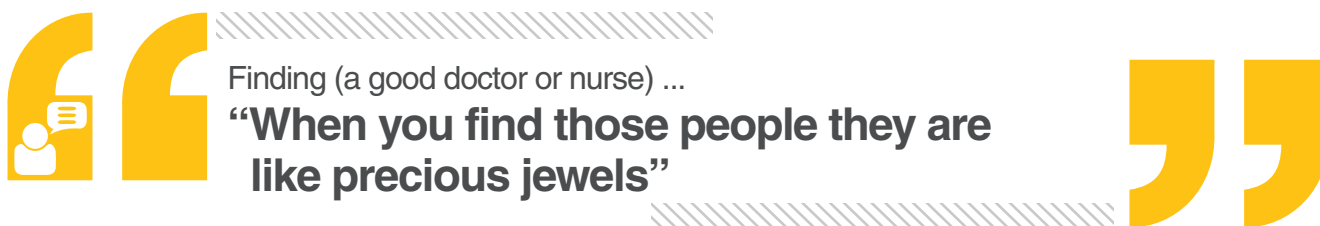
Drug and Alcohol Services

Homelessness is a key factor in a client's ability to engage with treatment for substance use disorders. Drug and Alcohol Services (DAS) provides a wide range of services for people experiencing homelessness and has made significant inroads into building models of care, clinical capability and data systems that support provision of high-quality patient-centred care for people experiencing homelessness.

At the beginning of an encounter with DAS, all clients complete an Australian Treatment Outcome Profile (ATOP) questionnaire. Within this are questions regarding experiences of homelessness or risk of homelessness in the 28 days prior to completing the ATOP. In 2017 14% of DAS clients reported experiencing homelessness at the beginning of their encounter, whilst 4% identified being at risk of homelessness. Of this group, 16% were female and 10% were over the age of 50. This does not include clients who are already engaged with the service.

The work undertaken by DAS includes:

- Engaging and retaining people experiencing homelessness in the Opioid Treatment Program;
- Regular identification of and response to homelessness and risks of homelessness through monthly ATOP's;
- Case management and advocacy for clients experiencing homelessness; and
- Increased capacity to provide outreach and care coordination to clients who face multiple barriers to engaging with or sustaining engagement with treatment (this group often includes people experiencing, or at risk of homelessness).



Mental Health Service

The Mental Health Service (MHS) is a key service in the provision of care to people experiencing homelessness; offering integrated care across inpatient and community settings. Initiatives include:

- Early identification and flagging of homelessness in electronic medical records;
- Early consumer engagement to identify appropriate accommodation and support;
- Partnership with housing and community managed organisations to provide accommodation and psychosocial support services;
- Development of escalation process with Family and Community Supports/Centrelink and Mental Health Services
- Implementation of Housing and Accommodation Support Initiative (HASI) and Enhanced Adult Community Living Support (EACLS) programs to assist transition of mental health consumers from inpatient to community settings and from Justice Health settings to the community;
- Partnerships with housing providers and emergency housing;
- Participation in "pop up" community initiative - housing, community managed organisations, mental health, Centrelink, births, deaths and marriages working collaboratively to provide documents, housing and wraparound services to people who are homeless or at risk of homelessness; and
- Housing and Mental Health Agreement (HAMHA) to provide a coordinated response to people who are homeless or at risk of homelessness

Sustaining NSW Families Housing Support Program

The Sustaining NSW Families Housing Support Program targets women who are receiving rent assistance, living in social housing or temporary or crisis accommodation in the St George and Sutherland area, who are identified as being psychosocially vulnerable or as having issues adjusting to parenting. This program is a three year, FACS funded initiative providing targeted sustained nurse home visiting program for families, up until children are two years old.

Safer Pathway

Safer Pathway is part of the NSW Government domestic and family violence *'It Stops Here'* (2014) reforms. The framework includes the operation of Safety Action Meetings (SAMs).

These meetings aim to:

- Support partnerships between key agencies (Housing NSW, Dept. Education, NSW Police, FACS etc.) to safeguard victims and their children who are at serious threat from domestic and family violence and reduce the threat of further harm;
- Utilise interagency collaboration to prioritise the needs of women and children at risk of serious harm through increased access to proactive supports that will increase safety including access to safe accommodation and housing.
- Include key SESLHD services such as Mental Health, Drug & Alcohol, Social Work and the Safer Pathways Senior Clinician.



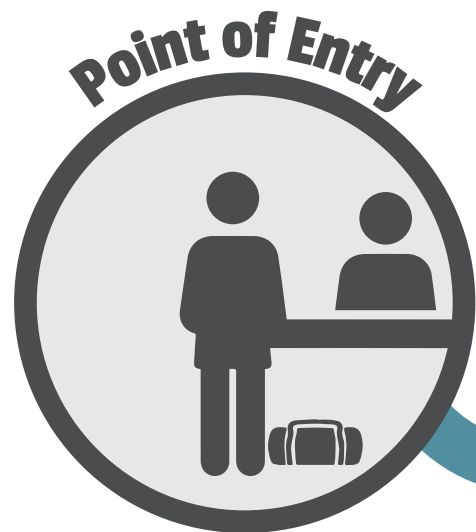
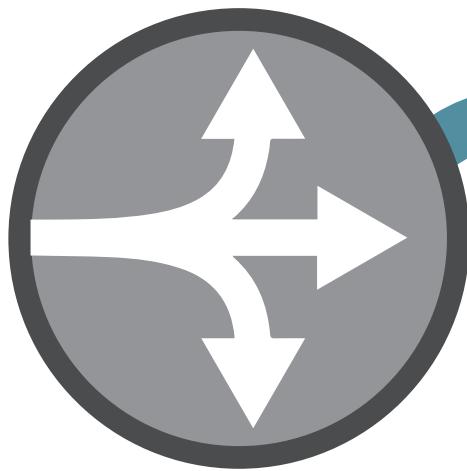
Services require so much information. If for example you are fleeing DV – it feels so unsafe. You are trying to keep safe and now they are asking me for all this information before I can get help. And then you need someone to verify stuff. Often you need someone with you to fill stuff out and there is no one who is with you.



Patient journey

**Where there IS
a specific patient
pathway in place for
people experiencing
homelessness**

- Patient identified at first presentation as experiencing homelessness
- Discharge planning (where appropriate) commenced early
- Social work engagement at commencement



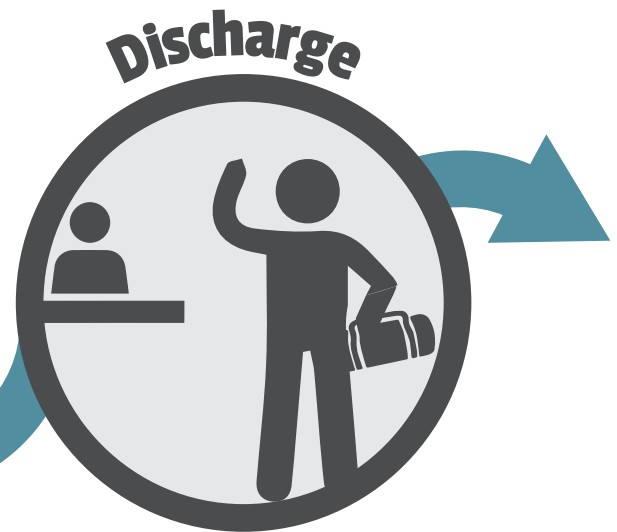
**Where there is NOT
a specific patient
pathway in place for
people experiencing
homelessness**

- More likely to present late and with advanced disease
- More likely to enter via Emergency Department
- May not be identified as experiencing homelessness during initial assessment

Whilst each patient is unique and their journey to and through health care is unique, there are some particular trends in access and engagement for people experiencing homelessness. Most striking is that access and engagement is significantly improved in those services that have either a specific patient pathway for people experiencing homelessness or are able to provide care navigation support for people experiencing homelessness.

- Stronger focus on providing integrated care with multi-disciplinary team
- Orientation to ongoing care (in community-based facilities such as Drug and Alcohol and KRC)

- Discharge planning occurs throughout engagement (where appropriate)
- Patients engaged in care for longer duration



- May receive treatment for one of multiple co-morbidities rather than integrated care

- Discharge planning commenced close to discharge, limiting options for securing accommodation
- Some patients continue to be discharged to homelessness
- May re-present within a short period of time

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Appendix One

Achievements under the previous SESLHD Homelessness Implementation Plan

Over the period 2012-2016, the South Eastern Sydney Local Health District's response to the health needs of people experiencing homelessness was guided by the *South Eastern Sydney Local Health District Homelessness Action Plan*, and the associated *Homelessness Implementation Plan*. Progress against those plans was coordinated and monitored by the SESLHD Homelessness Action Plan Implementation Working Party.

Key achievements against the five priority areas of that *Homelessness Implementation Plan* included:

PRIORITY AREAS OF SESLHD HOMELESSNESS IMPLEMENTATION PLAN 2012-2016	KEY ACHIEVEMENTS
1. Improved access to health services	<ul style="list-style-type: none"> • Mapping of key barriers to health system access undertaken, including consultation with people experiencing homelessness via the <i>Street Care Consumer report</i> • Specific initiatives to improve access to diagnosis, treatment and care in: <ul style="list-style-type: none"> - Mental Health - Drug and Alcohol Service - HIV and Related Programs - Youth Health - Oral Health
2. Supported partnerships and intersectoral activities within health and the homelessness sector	<ul style="list-style-type: none"> • Strengthened communication between SESLHD clinical services regarding homelessness health initiatives being undertaken, thus creating opportunities for both peer learning and increased coordination and collaboration; • High profile intersectoral collaboration, including the Bridging the Gap Forum and representation of SESLHD at a range of intersectoral committees on homelessness; • Development and rolling-out of the HETI Learning Pathway <i>Healthcare Responses to Homelessness</i>
3. Supported 'no exits to homelessness' approach to health service delivery	<ul style="list-style-type: none"> • Increased SESLHD participation in intersectoral care planning and service provision processes; • Increased referral pathway options for people experiencing homelessness
4. Improved access to and utilisation of homelessness data and evidence-based responses to homelessness	<ul style="list-style-type: none"> • Completion of the Homelessness Health Data project, which mapped currently available data and identified priorities for future development of data and analytics systems; • Increased identification of people experiencing homelessness within SESLHD services, including Drug and Alcohol, Mental Health, HARP, Oral Health • Data disseminated and used to inform service development
5. Effective management of the Homelessness Health Program and its resources	Resources of the Homelessness Health Program used in accordance with agreed LHD priorities as articulated in the <i>SESLHD Homelessness Implementation Plan 2012-2016</i>

Appendix Two

Strategy Development Process

Oversight of the development of the plan occurred via Steering Committee which was chaired by Dr Greg Stewart and whose membership included representatives of key clinical services and clinical streams within SESLHD. The development of the *South Eastern Sydney Local Health District Homelessness Health Strategy* was informed by a multi-faceted process which included:

- A desktop review of relevant literature; and
- Consultation with key informants, including people who are currently or have previously experienced homelessness, staff within SESLHD, and key partner organisations.

KEY INFORMANTS	
Priority Populations Unit	Lisa Woodland, Manager, Priority Populations Unit Jessica Harper, Homelessness Health Program Manager Joanne Corcoran, Multicultural Health Service Coordinator Chris Gallant, Women's Health Program Manager Sanya Sharota, Youth Health Coordinator
Kirketon Road Centre	Wendy Machin, Clinical Services Manager
HIV/AIDS and Related Programs Unit	Tracey Brown, Coordinator Viral Hepatitis & Harm Reduction Program
Special Needs Dental Service	Claire Phelan, Director, Oral Health SESLHD
Mental Health Services	Liz Abbott, Coordinator OPMH and Partnerships
Drug and Alcohol Services	Nicholas Lintzeris, Director James Clarke, Senior Social Worker, the Langton Centre
Aboriginal Health Unit	Timothy Croft, Manager Margaret Broadbent, Deputy Manager
Multicultural Health Service Advisory Committee	Aggregated feedback from Committee members
Child, Youth and Family Health	Amanda Webster, Manager, Strategy & Equity
Planning Unit	Alison Sneddon, Senior Health Service Planner
Equity Coordinator	Evan Freeman, Equity Coordinator
Emergency Departments	Andrewina Piazza Davies, Clinical Stream Nurse Leader, Sutherland Hospital
Hepatology and Gastroenterology	Lisa Dowdell, Clinical Nurse Consultant, St George Hospital Liver Clinic
Social Work	Sarah Benaud, Social Work Manager, Sydney Hospital/Sydney Eye Hospital Ripley Corbett, Social Worker, General Medicine Unit, Medical Assessment Unit and Aged Care Team St George Hospital

KEY INFORMANTS	
St George Hospital / Outreach Clinic at Mission Australia Centre	Prof Mark Brown, Director, Dept. Renal Medicine
Community Health Information Management Unit	Shane Simpson, Manager, Belinda Lee, Clinical Business Analyst
Central and Eastern Sydney PHN	Brendan Goodger, Manager, Population Health and Chronic Disease Hanna Pak – Program Officer
Homelessness NSW	Katherine McKernan, CEO Dougie Wells, Senior Project Officer
Matthew Talbot Hostel	Julie Smith, Team Leader, Primary Health Care Clinic David Kelly, Senior Operations Manager, Health
Neami	Shane Jakupiec, Regional Manager Tamara Sequeira, Service Manager, National Way2Home
Mission Australia Centre	Rachel Francois Diana Jazic, Branch Manager
St Vincent's Homelessness Health Service	Kate Origlasso, Service Manager Matt Larkin, previous Service Manager
Focus groups of people experiencing homelessness	1. Convened by Homelessness NSW 2. Convened by KRC



Health
South Eastern Sydney
Local Health District