



**ST VINCENT'S
HEALTH AUSTRALIA**

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

St Vincent's Health Australia

Submission to the House of Representatives Standing Committee on Social
Policy and Legal Affairs Inquiry into Homelessness in Australia

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EXECUTIVE SUMMARY

For more than 160 years, St Vincent's Health Australia has been providing compassionate healthcare to the Australian community. Reflecting our Mission to bring God's love to those in need through the healing ministry of Jesus, we are especially committed to people who are living in poverty or vulnerable.

St Vincent's Hospital Melbourne and St Vincent's Health Network Sydney provide specialist services for people experiencing, or at risk of, homelessness. These services will be detailed within this submission.

The health status of people experiencing homelessness, as well as some of the impacts of COVID-19 on homelessness and the St Vincent's response, will also be outlined within the submission. We will also share our experiences of partnerships and collaboration, and the vital role that this plays in working together as a community to address homelessness.

The conclusions and recommendations within this submission are grounded in our experience of housing-led models, patient engagement with their own care, agility and responsiveness, and strong service partnerships.

Furthermore, we will also present the St Vincent's Homeless Health Model which emphasises continuity of care along with wrap-around¹ support to ensure that the whole person can be supported, not just their medical condition. This includes:

- Specialist Outpatient Clinics
- Medical Respite Services
- Supported Housing Units

St Vincent's recognises that a multi-faceted approach to ending homelessness is required, which will be explored throughout the submission.

¹ Wrap-around care refers to a team of professionals who are relevant to the healthcare and psycho-social well-being of the patient/client (and who each have a different background and expertise) collaboratively working together with the patient to develop and implement an individual care plan.

1 INTRODUCTION

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

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

Given the scale of job losses and economic insecurity created by the COVID-19 pandemic, we expect homelessness and housing insecurity to worsen in the short-term.

We have recently seen more engagement, leadership and proactivity from state and territory governments to address the problem which is an indicator that where there is strong will and commitment anything is possible.

Even the recent COVID-19 experience has proved that Governments can find rapid solutions to better support the homeless through the provision of housing and health care services.

Commonwealth-funded entities – such as the Primary Health Networks – are working closely with our hospitals in addressing homelessness and at the macro level, the role of the Commonwealth in providing large scale safe housing opportunities could bring about major benefits across the country for this vulnerable cohort.

It is well known among governments and service providers alike that to end homelessness once and for all we need: more 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 are needed; help for them maintain their tenancy and foster good health and healthy habits; employment and training opportunities; and a renewed focus on prevention among young people and families.

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; it’s part of our DNA.

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

But like many homeless service providers, 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.

1.1 TERMS OF REFERENCE

The content included within this submission particularly relates to the following Terms of Reference of the Inquiry:

4. Opportunities for early intervention and prevention of homelessness;

5. Services to support people who are homeless or at risk of homelessness, including housing assistance, social housing, and specialist homelessness services;

6. Support and services for people at particular risk of homelessness, including:
 - a. women and children affected by family and domestic violence;
 - b. children and young people;
 - c. Indigenous Australians;
 - d. people experiencing repeat homelessness;
 - e. people exiting institutions and other care arrangements;
 - f. people aged 55 or older;
 - g. people living with disability; and
 - h. people living with mental illness;
7. The suitability of mainstream services for people who are homeless or at risk of homelessness;
8. Examples of best-practice approaches in Australia and internationally for preventing and addressing homelessness;
9. The adequacy of the collection and publication of housing, homelessness, and housing affordability related data; and
10. Governance and funding arrangements in relation to housing and homelessness, particularly as they relate to the responsibility of Local, State, Territory and Federal Governments.

1.2 DEFINITION

For the purposes of this submission when referring to people experiencing homelessness, we are using the Mackenzie and Chamberlain's definition that includes three categories in recognition of the diversity of homelessness.²

1. **Primary homelessness**, which is experienced by people without conventional accommodation (for example, sleeping rough or in improvised dwellings).
2. **Secondary homelessness**, which is experienced by people who frequently move from one temporary shelter to another (for example, emergency accommodation, youth refuges, couch-surfing).
3. **Tertiary homelessness**, which is experienced by people staying in accommodation that falls below minimum community standards (for example, boarding housing and caravan parks).

St Vincent's recognises that these categories are fluid, that people often cycle between them, and that while rough sleepers are the most visible face of homelessness they represent the smallest category among a much larger group.

² Australian Bureau of Statistics' Review of Counting the Homeless Methodology, Aug 2011

1.3 ABOUT ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Health Australia has been providing health care in Australia for more than 160 years, since our first hospital was established in Sydney in 1857 by the Sisters of Charity.

Today, St Vincent's Health Australia is the nation's largest not-for-profit health and aged care provider. We operate six public hospitals, 10 private hospitals and 20 aged care facilities in Queensland, New South Wales and Victoria. Along with three co-located research institutes – the Victor Chang Cardiac Research Institute, the Garvan Institute of Medical Research, and St Vincent's Institute of Medical Research – we work in close partnership with other research bodies, universities, and health care providers.

We are a clinical and education leader with a national and international reputation in medical research. Our areas of expertise include heart lung transplantation; bone marrow transplantation; cardiology; neurosurgery; cancer; clinical genomics; HIV medicine; palliative care; respiratory medicine; mental health; drug and alcohol services; aged psychiatry; homeless health; and prisoner health.

St Vincent's Health Australia employs around 20,650 staff and operates more than 3,000 hospital beds and 2,400 residential aged care places. In our hospitals, we provide more than 1 million episodes of care for patients each year.

St Vincent's Health Australia provides compassionate healthcare to all people. Our Mission calls us to a special commitment to people from vulnerable and marginalised backgrounds.

This is also reflected in St Vincent's role within the homelessness sector, such as board membership of the End Street Sleeping Collaboration; membership of the NSW Premier's Council on Homelessness; and representation on the Melbourne CBD Service Coordination Project (City of Melbourne), the Specialist Homeless Services Network (Council for Homeless Persons), and Everybody's Home campaign to end homelessness and boost social housing in Australia.

St Vincent's offers a number of specialist services for people experiencing, or at risk of, homelessness across Melbourne and Sydney. Our public hospitals give us a unique opportunity to create patient interventions that address both health and housing issues. The specialist services are summarised below.

1.4 HEALTH SERVICES FOR THE HOMELESS AT ST VINCENT'S HOSPITAL MELBOURNE

The specialist services at St Vincent's Hospital Melbourne for people experiencing, or at risk of, homelessness include:

Assessment Liaison and Early Referral Team (ALERT)

An integrated service aimed at reducing hospital demand, and providing coordinated care that bridges the interface between acute hospital ED and the community.

ALERT particularly targets patients with complex psychosocial and medical needs, including frequent presenters or those at high risk of re-presentation, those experiencing homelessness, family violence or disability and any patient requiring discharge planning from ED. Care coordination and discharge planning are a critical part of the ALERT team role.

The multidisciplinary nature of the ALERT team is a unique strength and this currently includes staff with backgrounds and experience in nursing, social work, physiotherapy, occupational therapy, mental health nursing, dietetics, and addiction medicine.

As part of ALERT, St Vincent's Hospital Melbourne also has an effective partnership with the Salvation Army to provide an on-site health hub (nursing and mental health) within the Salvos Bourke Street Community Hub.

Clarendon Homeless Outreach Psychiatric Service (CHOPS)

A specialist homelessness outreach service of St Vincent's Melbourne's Mental Health, specifically designed to work with people with mental illness who are homeless or in tenuous housing.

The CHOPS team has a total case load of 40 clients at any given time and is multidisciplinary comprising nurses, occupational therapists and social workers. The team provide assertive and flexible outreach including opportunistic "check ins" with clients if they are seen on the street and locating clients who have temporarily moved out of the CHOPS catchment area which is largely the cities of Yarra and Boroondara.

The Cottage

A supportive, medical step up/step down service in a home-like environment that provides holistic, pre-operative and recuperative care to clients with a nursing need as an alternative to staying in hospital.

The Cottage is a small terrace house with six beds located on the SVHM's Fitzroy campus. Staff include nurses, allied health, psychosocial and personal care workers who provide Hospital In the Home (HITH) services and assist clients to self-manage their medication and daily care where appropriate.

An independent evaluation of The Cottage demonstrated reduced reliance on the hospital system for people experiencing homelessness, including reduced likelihood of emergency presentations.

Prague House

A 45-bed, low level, specialised residential aged care facility that supports residents living with a mental health diagnosis and or an acquired brain injury to live life to their fullest potential. Many residents have a history of homelessness or have been at high risk of becoming homeless. The average age of residents at Prague House is 65, which is younger than most other aged care facilities due to the background of the residents. The staff at Prague House consists of nurses, activity staff, pastoral care, personal carers, housekeepers, cooks and administrative staff.

The ReConnect Project

St Vincent's Hospital Melbourne has been piloting a three-year project embedding a Bolton Clarke Homeless Persons' Program Nurse within Jesuit Social Service's ReConnect, a case management team supporting people released from prison. This project is an integrated partnership model with Jesuit Social Services, Bolton Clarke, the University of Melbourne and St Vincent's Hospital Melbourne. Two of the key aims of this project were to improve health outcomes of ReConnect participants; and to enhance the knowledge and capability of ReConnect staff to address participants' health needs and through a comprehensive independent project evaluation these aims have been achieved.

1.4.1 COVID-19 RESPONSE

In partnership with the Department of Health and Human Services (DHHS) Housing Division and homeless health and specialist housing providers, St Vincent's Hospital Melbourne has been part of a COVID-19 pandemic response for people experiencing homelessness, which has included establishing one of the four COVID Isolation and Recovery Facilities (CIRFs) and a Mobile Fever Clinic.

We established the Mobile Fever Clinic to overcome the barriers that people experiencing homelessness often face in accessing mainstream health services. Through an agile and flexible service model, the Mobile Fever Clinic has tested people sleeping rough, in congregate living facilities, attending drop in health clinics and drop in support services, many of whom would have been unlikely to attend a mainstream fever clinic.

The CIRFs were established to ensure people experiencing homelessness, and positive for COVID-19 but medically stable, had a supportive place to stay while they recovered from the virus. These residential sites are staffed with health and housing workers, and prepared to accommodate people experiencing homelessness. However, due to low COVID-19 numbers they have been underutilised to date, housing only a small number of people either awaiting COVID-19 testing results or needing to self-isolate due to close COVID-19 contact.

Led by the DHHS's Housing Division, we have transitioned these facilities to a model of care that is new to Melbourne, based on Australian and international models. While maintaining a number of CIRF beds, we are now offering a Respite and Recovery Facility especially for homeless persons with chronic conditions who are willing participants and who seek to be more actively engaged with their healthcare and wellbeing and future housing prospects. This also involves a longer length of stay. The model provides wrap around health and housing services, walking with people towards their own health, wellbeing and housing goals.

1.5 HEALTH SERVICES FOR THE HOMELESS AT ST VINCENT'S HEALTH NETWORK SYDNEY

St Vincent's Hospital Sydney's Homeless Health Service is a multi-speciality service that aims to support people aged 18 years and over experiencing homelessness. The Homeless Health Service is about getting the right resources, to the right people, at the right time. It is about meeting people where they are, through patience, compassion and a persistent approach. This is achieved by:

- Supporting patients to actively engage in healthcare through assertive engagement;
- Facilitating and support to access mainstream services of their choice;
- In partnership and collaborations with local community and primary health services to provide assessment, treatment, education, care coordination, support and referral;
- Identifying and facilitating access to housing and psychosocial supports; and
- Using a strengths-based, harm minimisation approach to assist clients to identify their priorities and create plans to achieve their goals.

A number of outreach-based teams and two residential facilities are included in the service, these are:

Homeless Outreach Team

The Homeless Outreach Team uses a 'no wrong door' approach in responding to referrals to the Homeless Health Service. The team provides a range of mental health and well-being, physical

health and oral health care clinics at local services as well as street-based outreach to offer assessment, treatment, referral and care coordination to persons experiencing homelessness or at risk of homelessness. The team comprises of nursing, general practitioner, psychiatry (Consultant and Registrar), social workers, Oral Health Care Educators and Peer Support Workers. The team delivers mental health and primary health clinics, (15 per week) within specialist homelessness services and community agencies. The team work with people in primary, secondary and tertiary homelessness and covers the City of Sydney Local Government Area (LGA). Funded through NSW Ministry of Health.

Assertive Outreach Team

The Assertive Outreach Team is a multidisciplinary service consisting of mental health nursing, social work, drug and alcohol clinicians and primary health nurses to assist people experiencing primary homelessness to access mainstream and specialist health care and support. The service recognises that many experiencing primary homelessness have a range of co-occurring and complex health needs, so an integrated health model enables a more flexible and responsive service. The team works in collaboration with clients and local service providers, including housing and psychosocial supports, to build and strengthen client support networks and assist clients onto a pathway out of homelessness. This team covers the City of Sydney LGA. Funding received through NSW Ministry of Health.

Wesley Mission Partnership

Two senior Homeless Health mental health clinicians are embedded within the Wesley Mission Therapeutic Support Team who support people experiencing homelessness or at risk of homelessness and who require mental health support. The mental health clinicians provide support exclusively to the Wesley Mission team and clients of the service. The two mental health clinicians provide direct support to clients of the service through the provision of assessment, care coordination and linkages with primary health services and specialist care. The clinicians meet people where they are at by identifying their health needs and supporting them to access sustainable health care. The clinicians also provide advice, supervision and consultation to the Wesley Mission staff. This team covers nine LGAs. Funding received through NSW Department of Communities and Justice.

After Hours Homeless Outreach Team

The After Hours Homeless Outreach Team, which is led by Nurse Practitioners and includes Peer Support Workers and Aboriginal Health Workers, provide a range of nurse-led, open-access physical health clinics at a range of local services and the St Vincent's Emergency Department to offer assessment, treatment and referral to persons experiencing homelessness or at risk of homelessness. The team provide clinics at various crisis accommodations and drop-in-centres as well as in-reach into the ED to fast track people into mainstream health services and primary health care.

The team work in the evenings and weekends. Evidence indicated that a high volume of people experiencing homelessness presented to the ED in the after-hours space for various health and social needs. Due to the demand in the ED, there are times when this cohort is not seen for long periods of time leading to did not waits and vulnerable groups missing out on much needed health and social support. This team covers the City of Sydney LGA and has a focus on women's health. One of the clinics is provided at Samaritan House, a women's only service who provide accommodation for people from overseas with nil rights or access to health and accommodation in Australia. If it was not for this team, many vulnerable women would not get their health needs met. Funded through by CESPNN.

Tierney House

Tierney House is a 12 bed, short-term (2-3 weeks) residential unit that assists people experiencing homelessness to access health care. Tierney House provides a safe and stable environment where residents can access assessment, treatment and support from St Vincent's Hospital and local services. The service provides a step down unit for those leaving hospital and a step up for those in the community to be accommodated and treated, reducing the likelihood of a hospital admission. Referrals are received from across the Sydney catchment area. In 2019, there were 232 new admissions with an average length of stay of 11 days. Tierney House provided residents with a total of 3903 bed days, with an occupancy of 89%. Initial funding was provided through philanthropic support for the capital build and financial support for the Aboriginal Peer Support Worker. The operational costs are funded through the NSW Ministry of Health.

An independent evaluation of Tierney House demonstrated reduced reliance on the hospital system for people experiencing homelessness, including reduced likelihood of emergency presentations. The NSW Homelessness Strategy 2018-2023 recognises the effectiveness of this model and funding was set aside for a further 2 sites for the establishment of the Tierney House model.

Stanford House

Stanford House is a four bed residential unit that provides services for people living with HIV, who are homeless or at risk of homelessness which is cofounded with Sydney Local Health District through the non-Government Grant Program. Its core services include supported accommodation for up to three months in a safe and secure environment, specialised support, linkage with external and internal health providers for facilitating ongoing support of HIV management (and its co-occurring issues), and outreach support to former clients. Referrals are received state-wide. Funded through the NSW Ministry of Health in partnership with SLHD.

1.5.1 Partnerships and Collaborative Initiatives

The Homeless Health Service is also a member of the Homelessness Assertive-outreach Response Team (HART) which was initiated by the City of Sydney and Department of Communities and Justice in 2015 and brings together key services to help people sleeping rough in inner city Sydney to exit homelessness and access long-term housing and support. In addition, it works with the Department of Family and Community Services' Homelessness Outreach Support Team (HOST) and in the last year provided 480 episodes of medical intervention with 545 people supported into long-term housing. The service was also a key partner in the response to Martin Place's "Tent City" in 2017, ensuring the delivery of appropriate health services to contribute to the safe transition from rough sleeping to accommodation. Through this initiative, the HHS has fostered a collaborative and sound partnership with Innari, a prominent Aboriginal Homelessness service.

The Eastern Suburbs Homelessness Assertive Outreach Collaboration (ESHAC) is the same model as the HART replicated in the Eastern Suburbs and has SVHNS HHS membership as a result of the Wesley Mission Partnership which covers that geographical area.

The DLL Intersectoral Homelessness Health Strategy 2020-2025 is a collaboration between South Eastern Sydney Local Health District, Sydney Local Health District, St Vincent's Health Network, Central and Eastern Sydney Primary Health Network, NSW Department of Communities and Justice and the City of Sydney. The Strategy aims to improve the health outcomes for people experiencing homelessness. The collaboration was an important foundation for the regions local response to the COVID 19 response.

1.5.2 COVID-19 RESPONSE

The existing partnerships with the Department of Communities and Justice (DCJ), Specialist Homelessness Services (SHS), City of Sydney Homelessness Unit, Homelessness NSW and other Local Health Districts have provided the foundations for the coordination of service delivery across the Sydney Homelessness sector in response to COVID-19 and the establishment of the Sydney Taskforce. The Taskforce role included the review of the delivery of accommodation and health support for people sleeping rough and those experiencing homelessness in large congregate care homelessness facilities in the inner city of Sydney area during the COVID-19 pandemic. To fast-track the response subgroups of the Taskforce were established with SVHNS HHS representation on the following:

- 1) Outreach working group to coordinate the outreach response
- 2) Accommodation supply, sourcing and placement
- 3) Aboriginal homelessness working group
- 4) Support and care coordination group
- 5) Accommodation exits working group
- 6) Food and food security working group

Prior to COVID-19 the Homeless Outreach Team were providing twice weekly outreach patrols with external partners inclusive of SHS and DCJ. Since COVID-19 the SVHNS HHS outreach services have been undertaking twice daily outreach patrols with key stakeholders engaging people who are sleeping rough who have health, housing and psychosocial needs. This presence on the streets has enabled an increase in access to healthcare inclusive of the provision of education and information pertaining to COVID-19, housing, psychosocial support. Over 400 people have been supported through this initiative into temporary accommodation (TA) across the Inner City and Eastern Suburbs.

The SVHNS HHS now provides an additional four health clinics at the TA providers across the Inner City. A Registered Nurse and Peer Support Worker provide these clinics with our DCJ and SHS partners. These clinics are in addition to the usual 15 that are provided each week at the various drop in centres and crisis accommodations in the inner city. These clinics focus on physical health, mental health, and drug and alcohol. Our Oral Health Worker provides four clinics per month. The HHS are providing additional mental health support to our health colleagues at the Kirketon Road Clinic.

The SVHNS HHS provide flu vaccinations at the various clinics as well as via outreach wherever possible. The HHS often receive phone calls from services requesting flu vaccinations be provided to their residents and consumers. The number of flu vaccinations that have been provided this year is over 100 (as of the 31st May 2020).

SVHNS HHS has established an external accommodation pathway for people who are experiencing homelessness, who have nowhere to isolate while awaiting results for COVID-19, or are once confirmed to have COVID-19, so they can recover from the virus. This accommodation has been established with the NSW Ministry of Health and an external accommodation provider. In the case a person experiencing homelessness has COVID-19, the HHS will provide support in the community in conjunction with the SVHNS Virtual Care Unit (assess and triage patients who are suspected to have, or are at high risk for, COVID-19).

The City of Sydney Homelessness Unit has identified approximately 70 people still experiencing primary homelessness during this health crisis. Those still rough sleeping are not a homogenous group. Barriers for this cohort include:

- high and complex needs requiring supported accommodation via NDIS or aged care;
- visa issues/ineligibility for social housing;
- untreated mental illness;
- other disabilities (acquired brain injury);
- substance dependency;
- trauma resulting in a lack of trust in services; and
- a small proportion who just do not want accommodation, particularly those who have had negative experiences in housing in the past.

Since the COVID-19 response some of those placed in TA have been asked to leave or have left of their own accord. Given the rapid rollout, and sometimes with an often brief health engagement on the street, it was not sufficient time to gather a full picture of what the persons needs are, and for some, they were very guarded due to the complexities outlined above. The only way we can often help break down some of these barriers, build trust and rapport, and get a clearer picture of what is going on for the person, is by providing consistent and persistent outreach – if at all possible with the same clinician. We feel strongly that it is not appropriate to use coercive measures to push people into accommodation or hospital. However, we do acknowledge that in certain circumstances this may be required for some people, after careful assessment.

SVHNS HHS recognises the importance of clear communications and has supported SESLHD in the provision of weekly bulletins to SHS staff and Taskforce members outlining and updating procedures relating to COVID-19 responses. DCJ provides regular updates to SHS and these resources are available on the DCJ website.

Further, in the context of COVID-19, there has been a focus on the need to have mobile outreach clinics available to provide support to people where they are. Mobile outreach clinics are an established mode of reaching difficult-to-engage and vulnerable populations, such as those experiencing primary homelessness.

The SVHNS HHS cares for clients on the streets, in parks and other public places, in hostels or even in hotels since the COVID-19 outbreak. Access to supplies, technology and health information systems are key challenges when delivering outreach care. The HHS strive to provide high quality clinical care to all their patients, however, this is challenging in public places where it is difficult to deliver primary care interventions with privacy and dignity. The HHS works with various non-government agencies (NGOs), some of these NGOs provide basic rooms for the teams to deliver care to patients, but facilities vary in terms of safety, access supplies and technology.

SVHN has sought funding for an Integrated Care Mobile Clinic Project which will commission a purpose-built vehicle, similar to a compact motorhome, which will facilitate the provision of high quality clinical care in out-of-hospital settings. The Project will deliver a mobile clinic vehicle that offers a portable, safe, private clinical space that can be taken to the patient, fitted out with the necessary clinical equipment, supplies and technology. The mobile clinic vehicle will be designed to provide wide-ranging services, such as primary care interventions, case management, as well as access to specialist mental health and alcohol and other drug consultations, or other clinical services via Telehealth and virtual health.

A case study of a patient's journey during COVID-19 is included at Appendix A.

Research

SVHNS' Infectious Diseases Department has submitted a proposal to undertake a longitudinal research project with people experiencing homelessness in Sydney, incorporating evaluation of a model for rapid detection, monitoring, and prevention of COVID-19, and characterisation of other health outcomes. The research will be focusing on the following hypothesis: *the NSW-first model for rapid detection of COVID-19 cases, isolation, clinical and accommodation support, and monitoring is feasible and facilitate high screening coverage in inner Sydney homeless populations.*

The research would enrol patients through homelessness shelters and outreach mobile clinics at 8-10 sites across the three Sydney local health districts. An enhanced COVID-19 "screen, test, isolate, and prevent" model will be co-designed and implemented with the Intersectoral Homelessness Health Senior Collaborative Alliance, which includes representatives from three LHD/SHN (St Vincent's Hospital, South Eastern Sydney LHD, Sydney LHD) and service providers (including the Kirrketon Road Clinic), Central and Eastern Sydney Primary Health Network (CESPHN), and City of Sydney. Other partners will include the Department of Community and Justice (DCJ), non-government agencies and peer-based groups (PIAC/StreetCare).

2 HEALTH AND HOMELESSNESS

2.1 THE HEALTH STATUS OF PEOPLE EXPERIENCING HOMELESSNESS

The link between homelessness and health is well-documented and people at risk of homelessness can be frequent users of hospital services. Our long history and experience in the field has taught us that housing is a health issue.

Homeless persons generally have a range of complex needs that affect potential access to safe and affordable housing. Health issues among people who are homeless invariably cluster with, and are exacerbated by other social determinants of health, including trauma, poverty, unemployment and social disconnection. This challenges traditional clinical boundaries and health system responses.³

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

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

Physical health issues including respiratory tract infections, skin infections, poor oral and foot health, musculoskeletal disorders, and blood-borne viruses (e.g. hepatitis B, hepatitis C) are all common among people experiencing homelessness.⁴ Much of this burden is thought to be related to the experience of homelessness itself, as homelessness is associated with poor nutrition, poorer access to health care, higher exposure to smoking and substance use, as well as challenges adhering to medications and treatment.⁵

³ 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, Western Australia.

⁴ Hwang S, *Homelessness and health*. CMAJ. 2001 Jan 23; 164(2): 229–233.

⁵ Hwang S, *Homelessness and health*. CMAJ. 2001 Jan 23; 164(2): 229–233.

A profile of chronically homeless people in Brisbane found more than one-third had asthma (compared to one-in-10 in general Australian population); one-in-five were diabetic (compared to one-in-20 in general Australian population); while one-third had heart disease; and one-quarter had liver disease.⁶

The increased prevalence of chronic illness amongst homeless people has been recognised internationally, as well as locally. This burden on the Australian healthcare system is anticipated to increase in years to come, as the number of homeless people over 50 years of age increases.

Mortality in people experiencing homelessness is estimated to be 3-4 times the general population.⁷ This rate appears to be constant across different countries, and to some extent time. A recently completed follow-up study of St Vincent's Hospital Melbourne patients verified this estimate in an Australian population. Most importantly, this study showed that all levels of homeless patients experienced this same increased rate of mortality, however this increased rate was not seen in those patients that were publicly housed with rental assistance.⁸

Significantly, people experiencing homelessness are disproportionately higher users of acute health services compared to non-homeless people, including more frequent emergency department visits and inpatient hospital admissions and longer hospital stays.⁹ A 2016 survey of rough-sleepers in Melbourne's CBD found that nearly three-quarters of respondents identified a hospital as their primary healthcare provider¹⁰.

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

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.¹¹

2.2 HOMELESSNESS AND MAINSTREAM HEALTH SERVICES

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

A recent report by the Sydney Health Community Network¹² 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

⁶ Pathways Hospital Admissions and Discharge Pilot Project: Twelve Month Evaluation Report, Jan 2015-Dec 2015, 2016

⁷ O'Connell et al, A public health approach to reducing morbidity and mortality among homeless people in Boston, Journal of Public Health, Management and Practice, 2005

⁸ R J Seastres, J Hutton, R Zordan, V Sundararajan, K Kiburg, J Mackelprang, G Moore, Long-term health outcomes of homeless and non-homeless patients at an Australian metropolitan hospital: a 15-year cohort study Poster presentation, SVHM Research Week 2018.

⁹ Fazel, S et al. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. Lancet, 2014 Oct 25; 384(9953): 1529–1540.

¹⁰ Micah Projects Inc. De-Identified Vulnerability Index-Service Prioritisation Decision Assistance Tool data for Melbourne 2010-2016. Brisbane: Inc MP; 2017

¹¹ Wood, L., Gazey, A., Vallesi, S., Cumming, C., & Chapple, N. (2018). Tackling health disparities among people experiencing homelessness - the impact of Homeless Healthcare: Evaluation Report October 2018. Perth: The University of Western Australia.

¹² Sydney Health Community Network, Enhancing primary health care services for people experiencing primary homelessness in the Central and Eastern Sydney Primary Health Network Region, February 2018

not captured. They can easily fall through the cracks and miss out on appropriate support to transitional care.

A study at a metropolitan Melbourne hospital that used ED datasets identified 0.8% of attendees as homeless, whereas intensive manual screening identified 7.9% of ED attendees as homeless.¹³

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

While the woman was referred to emergency accommodation by authorities, she was unable to access the service until she had received a test for COVID-19. However, at the mainstream health service she attended, she was turned away from receiving a test because she was asymptomatic.

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

For homeless people, accessing specialist care services can be harder still.

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

Hospital discharge can present other serious challenges to those experiencing homelessness.

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.¹⁴

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

However, anecdotally we know the problem is a serious one. For example, due to the chronic shortage of affordable accommodation in Victoria, it's estimated over 500 people each year are discharged from acute mental health care into rooming houses, motels and other tertiary homeless situations.¹⁵

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".¹⁶

¹³ Lee et al, *Homeless status documentation at a metropolitan hospital emergency department*, Emergency Medicine Australasia, 2019.

¹⁴ Australian Institute of Health and Welfare's *Specialist Homelessness Services (SHS) annual report, 2017–18*

¹⁵ <https://chp.org.au/five-reasons-why-victorias-mental-health-royal-commission-must-examine-the-role-of-housing-and-homelessness/>

¹⁶ <https://vincentcare.org.au/stories/latest-news/352-from-hospital-into-homelessness>, November 2018

All of the above presents a massive challenge for traditional clinical boundaries and health system responses.¹⁷

2.3 THE IMPACT OF COVID-19 ON HOMELESSNESS

St Vincent's has seen first-hand the impact of the COVID-19 pandemic, not only in the Australian community as a whole, but also specifically among people who are experiencing homelessness. Our successes have underscored the importance of:

- Personalised care and support for patients, delivered collaboratively and more efficiently;
- Creative and agile approaches to funding for promoting strong purposeful partnerships;
- A multi-disciplinary workforce committed to supportive and navigated care where the patient's voice is heard.

Australia's COVID-19 response for people who are homeless has also brought both major challenges and opportunities in terms of healthcare.

For example, providing hotel accommodation to thousands of homeless people in NSW and Victoria has revealed the true scale of the homeless problem in both those states.

Having thousands of vulnerable people accommodated for a period has also allowed housing and health service providers to conduct a range of screenings and vulnerability checks at a scale they might not normally have been able to achieve among a vulnerable population group that is transient and notoriously difficult to engage.¹⁸

As we know, Australia's response to COVID-19 brought a number of dramatic changes in a very short space of time to the area of healthcare, one of which was the explosion in telehealth services – a development that is only likely to grow in the years ahead.

For Australia's homeless population, telehealth presents a number of unique challenges, not least of which relate to access to technology (for example, mobile devices) and telecommunications networks.

If health services are to take a 'telehealth-first' approach then authorities must consider the need for digital equity in the way of distributing mobile devices or providing telehealth hubs for vulnerable people. The establishment of dedicated digital hubs in accessible services, or through the mobile clinic as being proposed in Sydney, provide an opportunity for patients to access virtual care with support and ensuring their privacy and confidentiality can be maintained. Further, patients will need support to enhance their digital literacy skills to fully enable their access. There are instances such as those with acquired brain injury or suffering from other disabilities or where physical assessment is required that a face to face consultation will need to remain.

¹⁷ 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, Western Australia.

¹⁸ <https://www.abc.net.au/news/2020-06-08/housing-homeless-in-pandemic-has-worked-lets-make-it-permanent/12330442>

3 ST VINCENT'S HOMELESS HEALTH MODEL

St Vincent's Health Australia has developed a homeless health model which recommends the development of three complementary services to better support patients who are homeless or living in insecure housing. This targets the wider social determinants of health to ensure that we are addressing the wider needs of the people we serve, to prevent the cycle of crisis health events that result in emergency department visits.

The model focuses on an integrated hospital and community services system model, guided by the following principles:

- no exit to rough sleeping for anyone leaving our care.
- collaborative care planning.
- integrated service delivery including 'warm referrals' – patients are not simply 'handed over' at discharge.¹⁹
- focus on rehabilitation in line with patients' own goals.²⁰
- engagement as a distinct mechanism.
- trauma-informed/psychologically-informed approaches to care delivery to provide appropriate care and support, and tackle stigma and discrimination (from mainstream hospital staff).
- person-centred care approach not disease management.
- tailoring our service responses so that they fit people and not programs.
- take a 'housing first' approach²¹ by offering stratified/transitional housing options.
- our homeless patients are at the centre of policy design and care delivery.
- resources, supports and interventions are informed by evidence and focused on sustainable outcomes.
- care responses are individually tailored to meet the needs of people experiencing homelessness.
- Peer Support Workers embedded within the service development and delivery models.

St Vincent's Health Australia's Homeless Health Model puts the individual at the centre of their care, and it ensures continuity of care along with essential wrap-around support. Importantly, this model also facilitates the opportunity to address social determinants by linking to education, employment and social engagement opportunities as appropriate. A sustained solution that has genuine economic benefit is a partnership in which the homeless person is an active participant in their own healthcare leading to recovery, rehabilitation, self-determination and resilience and ultimately independence.

The three new services envisaged under the model are:

1) Specialist Homeless Persons Outpatient Clinic

A speciality homeless persons' outpatient clinic, operating in the community around our hospitals, and staffed by experienced clinicians to ensure those with complex needs have access to the clinical, allied health and ancillary supports they need. The service would be flexible and will outreach into

¹⁹ Maintaining continuity of care during critical transition periods while responsibility gradually passes to existing community supports that will remain in place after the intervention ends. (Herman et al., 2011 p714)

²⁰ Programs within Step Up Step Down services can provide 'reablement' which is the relearning of skills and undertake rehabilitation. 'Resettlement' is focused on the housing component but focused on doing things with not for people.

²¹ In the USA the term 'Housing-led Schemes' refers to programs that focus primarily on securing accommodation for people who are homeless on discharge from hospital. They are usually staffed by "Housing Link Workers" (ideally co-located at the hospital) possessing specialist knowledge of housing legislation and local housing options. Staffing roles include addressing broader health and well-being outcomes by means of advocating for and supporting people who are homeless to engage with the full range of local primary care, mental health, drug and alcohol and social care services.

the local community and be supported through virtual health modalities. The service will include Peer Support Workers who have a lived experience.

2) Medical Respite Facility for Homeless Persons

SVHA can demonstrate that alternative models to hospitalisation can bring about substantial savings. An independent evaluation²² of Tierney House in 2016 found that patients who had contact with Tierney House reduced their ED presentations by 7.8% per month and admissions by 8.6% compared to other homeless people with a reduction of the average length of stay of 3.5 days per hospital admission for Tierney House clients, (relative to other homeless people).

The evaluation found that the service is effective in improving access and engaging clients in their care, as well as demonstrating cost-effectiveness, including a net cost-benefit of \$8,276 per person over two years, (n=283 patients). Tierney House can only provide accommodation support for 12 residents for approximately two weeks. We know that there is far greater demand and that for some a longer length of stay is required due to the complexity of their health and co-occurring disability needs.

It is proposed we complement our current homeless service response by adding a Medical Respite Service that will provide a longer length of stay to our current Step Up/Step Down services. This will facilitate increased opportunity for patients to stabilise their current health conditions and psychosocial needs. It will allow staff and patients the opportunity to deepen their engagement to focus on achieving the goals that are most important to the patient. This will also increase the opportunity to source suitable housing.

The Medical Respite Service will fill the gap in current transitional housing services where many patients with complex needs are excluded entry. Through a longer length of stay, coupled with wrap-around support, it is envisaged these patients will gain access to the health treatment including specialist outpatient appointments that they have historically been unable to, thus allowing more time for recovery, and increasing the likelihood of sustained health improvements.

3) Integrated Healthcare Housing Partnerships

The ready supply of supported permanent housing where the client becomes a resident and is an active contributor to, and participant in, maintaining their health and wellbeing that enables them to flourish in our community.

When implementing this approach, we propose a specific focus on the most at risk populations such as Aboriginal and Torres Strait Islanders, women (including the emergence of older women in poverty and mothers with children fleeing family violence), those exiting prison, youth, those experiencing domestic and family violence, and patients with behavioural issues who have limited access to many community based residential services. St Vincent's also recognises the significance of responding to extreme weather events. For example, St Vincent's Hospital Sydney's Homeless Health Service has an 'extreme weather protocol', such as a heat wave, where there are a range of responses enacted (such as sun screen, shelter, water, monitoring for dehydration, etc.). Services tailored to respond to extreme weather events for people who are homeless requires a multi-agency response with health services playing a co-ordinated and lead response.

²² St Vincent's Homeless Health Service Evaluation Report. July, 2016.

We continue to seek government funding support for these three new service models to stop the cycle and to help end homelessness in Australia.

4 RECOMMENDATIONS

St Vincent's recognises that the causes of homelessness – as with its solutions – are complex and diverse. Adequately addressing the health needs of people experiencing homelessness, and those in tenuous housing, won't by themselves end homelessness.

Equally, the provision of housing alone – that is, without ongoing and wrap around support – won't either.

This submission recognises that both immediate action is required to address homelessness in Australia, including as it relates to an ongoing response to the COVID-19 pandemic, as well as solutions for the medium- to long-term.

4.1 HOUSING

We believe that health and housing are completely intertwined – one influencing the other. Addressing homelessness requires a comprehensive and multi-sectoral approach. As such, any model to support the housing and health needs of vulnerable people who are homeless or in insecure housing requires a three way partnership – between the individual, and housing and healthcare providers.

Recognising the crucial role of housing, St Vincent's Health Australia is a member of the *Everybody's Home* campaign which set out recommendations in five key areas:

Support for first home-buyers

Calling for governments to:

- Reduce negative gearing and capital gains tax exemptions to reset housing taxation and deliver fairer outcomes and encourage investment in the social and affordable housing Australia needs.

A National Housing Strategy

The Federal Government needs to develop a coherent National Housing Strategy that includes:

- New capital investment to generate 300,000 new social and Aboriginal housing properties.
- A new tax incentive or direct subsidy to leverage super fund and other private sector investment in 200,000 low cost rental properties for low and middle-income earners.

A National Housing Strategy will determine the respective roles of federal, state and local governments and identify the full range of instruments required to achieve this.

In a submission to the Commonwealth for its consideration as part of its post-COVID economic stimulus plan, the Social Housing Acceleration and Renovation Program (SHARP) – supported by *Everybody's Home* – proposed to government that investment in social housing will create jobs and improve social outcomes following the pandemic.

SHARP estimates show that if the Commonwealth, backed by state/territory and community housing provider contributions, were to invest \$7.7 billion in social housing infrastructure, it could deliver 30,000 additional social housing units and renovate many thousands more existing properties to high environmental standards. The proposal envisages this occurring in four overlapping ‘waves’ – starting with social rental property maintenance and upgrading, leading on to large scale new housing development projects, and it can be implemented immediately.²³

A better deal for renters

Calling on all Australian states and territories to change tenancy laws to protect tenants against evictions, unfair rent rises, discrimination and landlords who refuse to maintain properties.

That includes:

- Getting rid of ‘no grounds’ evictions.
- Limiting rent increases to once every 12 months.
- Tighter regulations around applications for rentals to stop discrimination.
- Minimum property standards to make sure all rental properties are liveable.
- Nationally consistent protection for renters through legislative protections against evictions, rent rises, discrimination and landlords who refuse to maintain properties.

Immediate relief for Australians in chronic rental stress

Calling on the Federal government to:

- Increase Commonwealth Rent Assistance while more social and affordable housing is being built.
- Provide renters with a catch up increase of 30% or about \$20 a week for those in the highest rental stress.
- Review the way Rent Assistance is calculated to make eligibility and payments fairer.

A plan to end homelessness by 2030

Calling on governments to put together a national action plan to end homelessness that:

- Addresses all the drivers of homelessness, including the lack of affordable housing, poverty and family violence.
- Rapidly rehouses people who are homeless and helps them stay there.
- Addresses the over-representation of Aboriginal people in the homeless service system.
- Commit to ending homelessness by 2030 by taking action to prevent homelessness and delivering rapid access to the housing and support people need if they do lose their own home.

4.2 INTEGRATED HEALTH CARE RESPONSE

St Vincent’s Health Australia is a participant of the Australian Alliance to End Homelessness, which identifies the following needs:

A national 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 nation-wide and consistent

²³ http://shelter.org.au/site/wp-content/uploads/200504_joint-release-building-the-recovery-SHARP_supporting-partners-final.pdf?fbclid=IwAR1I3AYm3aemo3XIVQOS_nsj2Bw2cOiQ8as_gY6suJ2i_6jCxRo_dXSHdrA

commitment of ‘no exits into homelessness’ for people temporarily sheltered as a result of COVID-19; as well as people with mental illness who are discharged from institutional care, including hospitals and prisons.

Health and homelessness pilot

An assertive intervention pilot embedded in community homelessness services in every state and territory, featuring flexible medical and outreach service delivery – including primary healthcare and psychiatric response, 365 days a year complementing acute services. The pilot would cost \$2.5 million per city, plus evaluation costs.

A network

The Federal Government should establish a Health, Housing and Homelessness Network with a broad range of health, and community organisations, professionals and people with lived experience.

Funding certainty

Existing funding arrangements between Primary Healthcare Networks, 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.

Funding Equity

The Federal Government must widen policy provisions to allow medical practitioners to bulk bill patients who have no fixed address and enable bulkbilling for street based and outreach consultations.

A Taskforce

Recognising the urgency of this job, the Federal Government should call a special taskforce of the new National Cabinet of health and housing ministers to consider, support and drive the implementation of these recommendations.

4.3 INCOME SUPPORT

St Vincent’s recommends the Federal Government increase income support permanently to reflect the real costs of living in Australia.

St Vincent’s Health Australia has previously joined with leading health, aged and community organisations in calling for an immediate increase in the Newstart payment²⁴. With the introduction of the JobSeeker Payment, St Vincent’s continues to support a permanent increase to the level of income support. This enables greater opportunity for people to rise above the poverty line.

4.4 HEALTH SERVICE FUNDING

St Vincent’s recommends that the provision of health services to people experiencing homelessness should attract greater price weighting.

²⁴ St Vincent’s Health Australia submission to the Senate Standing Committee on Community Affairs’ inquiry into the Adequacy of Newstart and related payments and alternative mechanisms to determine the level of income support payments in Australia (13 September 2019).

The health models for those experiencing disadvantage/homelessness does not incorporate homelessness as a measure of complexity in the National Weighted Activity Unit (NWAU). This complexity recognition would assist with developing and sustaining appropriate health models.

In addition, St Vincent's would recommend future funding support for nurse practitioners and allied health workers to promote healthcare in the community. This is essential to providing wrap around support services.

4.5 TELEHEALTH AND DIGITAL HEALTH

St Vincent's recommends that the Federal Government support telehealth and digital initiatives that are tailored to meet the needs of people experiencing homelessness.

For example, providing mobile devices to people experiencing homelessness can help to improve access to telehealth, although it is not a sustainable solution for all, as it also requires an electricity port for people to recharge and access to data. Other solutions, such as setting up telehealth spaces in existing homelessness hubs and access points that clients frequent, should be explored.

5. CONCLUSION

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

The Federal Government has a critical role to play in addressing homelessness in Australia – national leadership is required.

In responding to homelessness, now is the time for root and branch reform; the time for setting, and acting upon, a long-term vision; the time for meaningful change.

Tackling chronic homelessness means we need to provide immediate access to accommodation, and the essential wrap around support services that people need. This has, perhaps, never been more important than now as we respond to the COVID-19 pandemic, and when there is an unprecedented movement of people from homelessness to temporary hotel accommodation.

Now, we must look to what comes next.

St Vincent's has often said that a multi-faceted approach to ending homelessness is required. This submission is no different. First and foremost, a 'housing first' approach is required, providing people experiencing homelessness with immediate long-term accommodation and then supporting them with services, particularly healthcare.

Together, as a community, and across governments, we must continue to work collaboratively to end homelessness in Australia.

APPENDIX A

CASE STUDY – ST VINCENT’S HOSPITAL SYDNEY

During the COVID-19 response the Homeless Outreach Team (HOT) was alerted to a young man ‘Tom’ sleeping rough in a park. There were significant concerns about Tom’s welfare as he was sleeping exposed, on his own, in a very isolated area of Sydney.

Tom declined assistance any time that services or housing went out to see him and appeared to have some underlying mental health issues. HOT went on targeted outreach to see Tom a few times and started engaging with him. After the HOT nurse and peer worker built up a rapport with Tom he accepted support to enter into Temporary Accommodation through the COVID-19 response provided by the Department of Communities and Justice.

Tom had become so isolated and unwell that he had had no income at all, no Medicare card, and no ID. As his hotel room was being arranged for him, Tom asked for the services supporting him to contact his mother as he missed her. Tom had become estranged from his family due to his poor mental health and described shame and guilt stopping him from contacting them in the past.

Nothing prepared the services for the response of overwhelming joy from his family that Tom had contacted them. They immediately drove to Sydney from their town in regional NSW to see him.

Supported by HOT staff and other support services, Tom reunited with his family which was an incredible privilege to be a part of. Tom is now reunited with his family, he is on his way to moving into long term stable accommodation, he is receiving treatment and support for his health issues, and he has ID, Medicare and is receiving income support via Centrelink.