Care Beyond the Hospital Walls

New model of care to house a healthy community.

St Vincent's Hospital Melbourne

Submission to the Victorian Legislative Council Legal and Social Issues Committee's Inquiry into Homelessness in Victoria

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Executive Summary

For 126 years, St Vincent's Hospital Melbourne has supported the poorest and most vulnerable in the community, including homeless people. Hospitals provide a unique opportunity to create patient interventions that address both health and housing issues.

The specialist services at St Vincent's for people experiencing, or at risk of, homelessness are outlined throughout this submission. These include:

- Assessment Liaison and Early Referral Team (ALERT)
- Clarendon Homeless Outreach Psychiatric Service (CHOPS)
- The Cottage
- Prague House

St Vincent's recognises that a multi-faceted approach to ending homelessness is required. This submission is grounded in our rich experience at the intersection of homelessness and health care. It is influenced by years of research and data collection that have shaped the new ways of thinking, service delivery models and funding arrangements we propose. It calls for system-wide reform in both the healthcare and housing sectors.

The hospital's chief recommendation is the development of a St Vincent's Hospital Melbourne Homeless Health Model – Pathways Home – which calls for the creation of:

- a Specialist Outpatient Clinic in inner city Melbourne;
- the development of a Medical Respite Centre which will expand on the size and sophistication of the hospital's current 'step up/step down' service, The Cottage. Such a service would increase the opportunity for patients to stabilise their health conditions and psychosocial needs to optimise transition from health to housing; and
- supported housing units to provide long-term sustainable housing to those exiting the Medical Respite Centre.

We're confident that these reforms would make a major contribution to ending homelessness for many.

1. Introduction

St Vincent's Hospital Melbourne (SVHM) recognises the causes of homelessness – as with its solutions – are complex and diverse.

Adequately addressing the health needs of homeless people and those in tenuous housing won't by themselves end homelessness. Equally, we know the provision of housing alone (i.e. without ongoing and wrap around support[1]) does not 'solve' homelessness. However, health is a crucial piece of the homelessness puzzle: an unmanaged illness is often the factor that tips a person into homelessness or makes it difficult for them to leave homelessness behind.

As with other social determinants of health, St Vincent's views housing as a key component of healthcare.

1.1 Definition

For the purposes of this document when referring to homeless people, 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 (e.g. sleeping rough or in improvised dwellings).
2. Secondary homelessness, which is experienced by people who frequently move from one temporary shelter to another (e.g. emergency accommodation, youth refuges, couch-surfing).
3. Tertiary homelessness, which is experienced by people staying in accommodation that falls below minimum community standards (e.g. boarding housing and caravan parks).

SVHM 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.

1.2 About St Vincent's Hospital Melbourne

SVHM provides medical and surgical services, sub-acute care, cancer services, aged care, correctional health, mental health services and a range of community and outreach services.

Founded by the Sisters of Charity 126 years ago, at a time when Fitzroy was one of the most disadvantaged parts of Melbourne, St Vincent's is built on a foundation of caring for those in need. The Sisters were innovative and determined in their commitment to offering first-class healthcare to the community, especially the poor and vulnerable.

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[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.

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

Today, St Vincent's operates from 18 sites across greater Melbourne, including a major teaching, research and tertiary referral centre situated in Fitzroy, sub-acute care at St George's Health Service Kew, palliative care at Caritas Christi Hospice, as well as aged care, correctional health, mental health and community centres, pathology collection centres, general practice services and dialysis satellite centres.

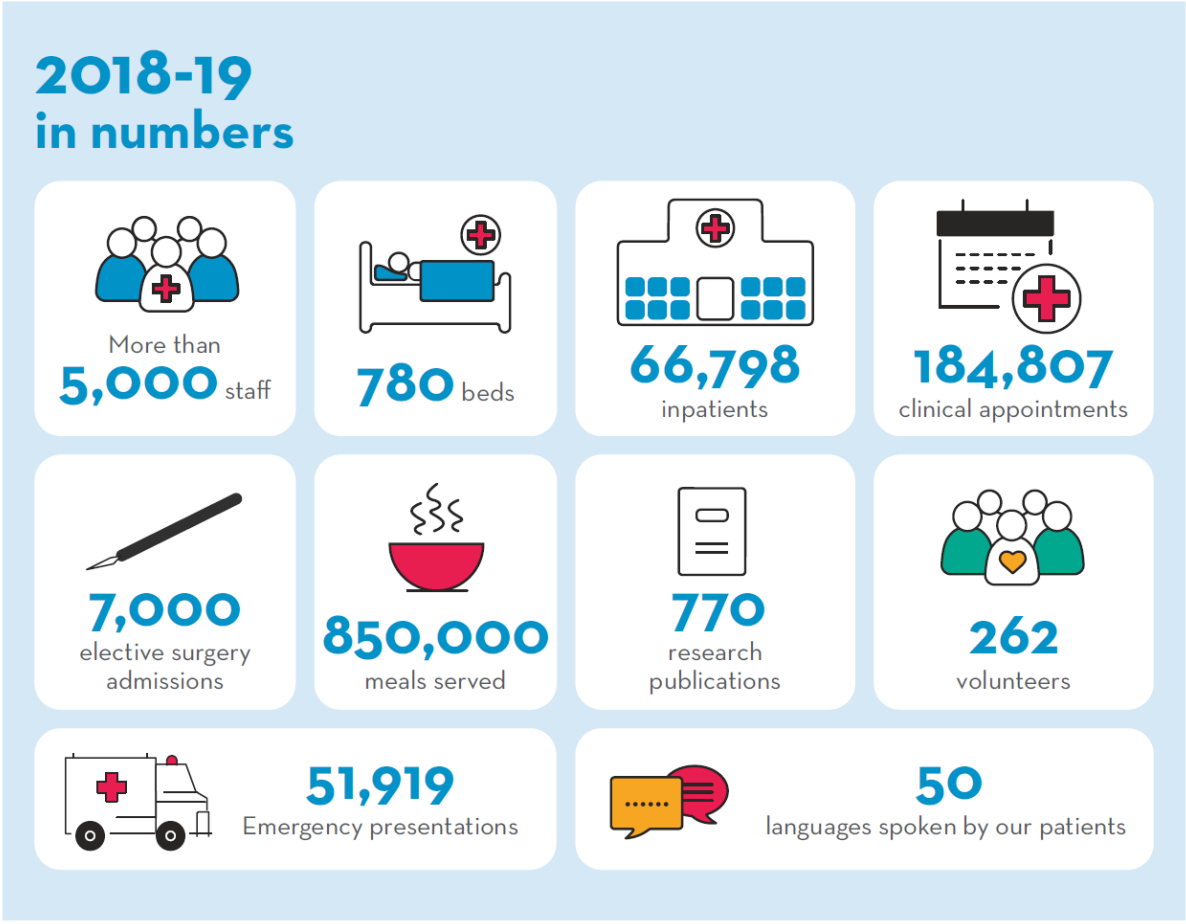

Figure 1 St Vincent's Hospital Melbourne (2018-2019)

1.3 SVHM's specialist services for people experiencing homelessness

For 126 years, St Vincent's has supported the poorest and most vulnerable in the community, including homeless people. The hospital's Mission to bring hope, love and healing is internationally recognised.

The specialist services at St Vincent's Melbourne for people experiencing, or at risk of, homelessness are outlined in Table 1 below. However, these are by no means the only services and areas within the hospital that provide care and health services to people experiencing homelessness.

Table 1: Specialist services for people experiencing homelessness at SVHM

Service	Description
Assessment Liaison and Early Referral Team – ALERT Established in 2000 as part of the Victorian Government's Hospital Demand Strategy to improve health outcomes and reduce demand on ED.	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.
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 Established 1995 **(ref Appendix 1)**	A supportive, 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.
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

Operating under the auspices of St Vincent's Hospital Melbourne since 1976	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.

2. Homelessness and health

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. In particular, hospitals are often the primary care provider for many rough-sleepers and women experiencing family violence.

> For example, a 2016 survey of rough-sleepers in the Melbourne central business district found that **nearly three-quarters (73%) of respondents identified a hospital as their primary healthcare provider**[3].

Homeless patients 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.[4]

The key 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.[5] Much of this burden is thought to be related to the experience of homelessness itself, as homelessness is associated with

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

[4] Wood, L., Vallesi, S., Martin, K., Lester, L., Zaretzky, 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.

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

poor nutrition, poorer access to health care, higher exposure to smoking and substance use, as well as challenges to adhering to medications and treatment.[6]

People experiencing homelessness also exhibit high rates of mental disorder, alcohol and drug use, trauma, cognitive impairment, suicide and other premature deaths.[7] For example, 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.[8]

The increased prevalence of chronic illness amongst homeless people has been recognised internationally. This will create a larger burden on the Australian healthcare system in years to come as there are increasing numbers of homeless people over 50 years of age.

Mortality in people experiencing homelessness is estimated to be 3-4 times the general population).[9] This rate appears to be constant across different countries, and to some extent time. A recently completed follow-up study of SVHM 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.[10]

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.[11]

A long-term study of people that presented to SVHM's Emergency Department during 2003 and were identified as being homeless at any level, showed a significantly increased rate of inpatient admissions for a ten-year period. These homeless patients maintained a higher level of SVHM ED presentations across a 15-year period compared with those patients who had stable housing.[12]

These findings showed that although homeless ED patients comprise only 4% of all ED patients, they make up 10% of all ED presentations over a two-year period.[13] It is important to understand that the majority of these homeless patients were experiencing the lesser levels of homelessness and that less than a quarter were "rough sleepers".

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

[7] Teeson, M et al, Psychiatric disorders in homeless men and women in inner Sydney. Aust N Z J Psychiatry. 2004 Mar; 38(3):162-8.

[8] *Pathways Hospital Admissions and Discharge Pilot Project: Twelve Month Evaluation Report*, Jan 2015-Dec 2015, 2016

[9] 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

[10] 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.

[11] 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.

[12] 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.

[13] Moore, et al, *Socio-demographic and clinical characteristics of re-presentation to an Australian inner-city emergency department: implications for service delivery*, BMC Public Health, 2007

In combination, these issues mean people who are homeless have significantly more complex health needs than the general population.

Notwithstanding their needs, people experiencing homelessness face a number of challenges accessing mainstream health care, including:

- chaotic lives with the inability to prioritise health over daily survival needs that make it difficult for them to keep medical appointments;
- the inability to acquire a Medicare card if of no fixed abode;
- the loss or theft of identification including Medicare cards;
- high rates of mental illness which can impact on motivation and capacity and prevent them seeking healthcare;
- the inability to afford and to safely store medication;
- the stigma that surrounds homelessness making a person unwilling to present in a traditional primary healthcare setting (eg: GP surgery or medical centre);
- lack of capability and resources in mainstream health services make it difficult to support people with complex trauma and substance use issues;
- complexities associated with homelessness creating an uncertainty around prognosis; and
- perhaps, most significantly, gaps and fragmentation in existing systems mean there is often little choice regarding place of care for people experiencing homelessness

For people experiencing homelessness, accessing specialist care services is harder still. From SVHM's own experience: for homeless people with a terminal illness, having discussions and planning end-of-life care is complicated due to lack of stable housing or family connections to support implementation of such a plan, a lack of engagement with medical services, and personal concerns about stigma and discrimination; an analysis of medical and surgical outpatient service use between 2017-2019 showed that at least 75% of all patients who registered as rough sleepers did not attend arranged outpatient clinic appointments.

It is also clear that information about a person's housing status is not routinely collected by health services, therefore people are not necessarily identified as homeless and miss out on appropriate support to address holistic health needs. A recent study at a metropolitan Melbourne hospital identified that usual ED datasets identified 0.8% of attendees as homeless, whereas intensive manual screening identified 7.9% of ED attendees as homeless.[14]

2.2 SVHM's homeless client profile

An SVHM evaluation of four[15] specialist homeless health services was published in 2017 creating a profile of homeless clients from hospital records combined with contextual understanding of the empirical profile, and complemented by insights from interviews with clients and staff.

[14] Lee et al, *Homeless status documentation at a metropolitan hospital emergency department*, Emergency Medicine Australasia, 2019.
[15] ALERT, Clarendon Homeless Outreach Psychiatric Service, The Cottage and Prague House

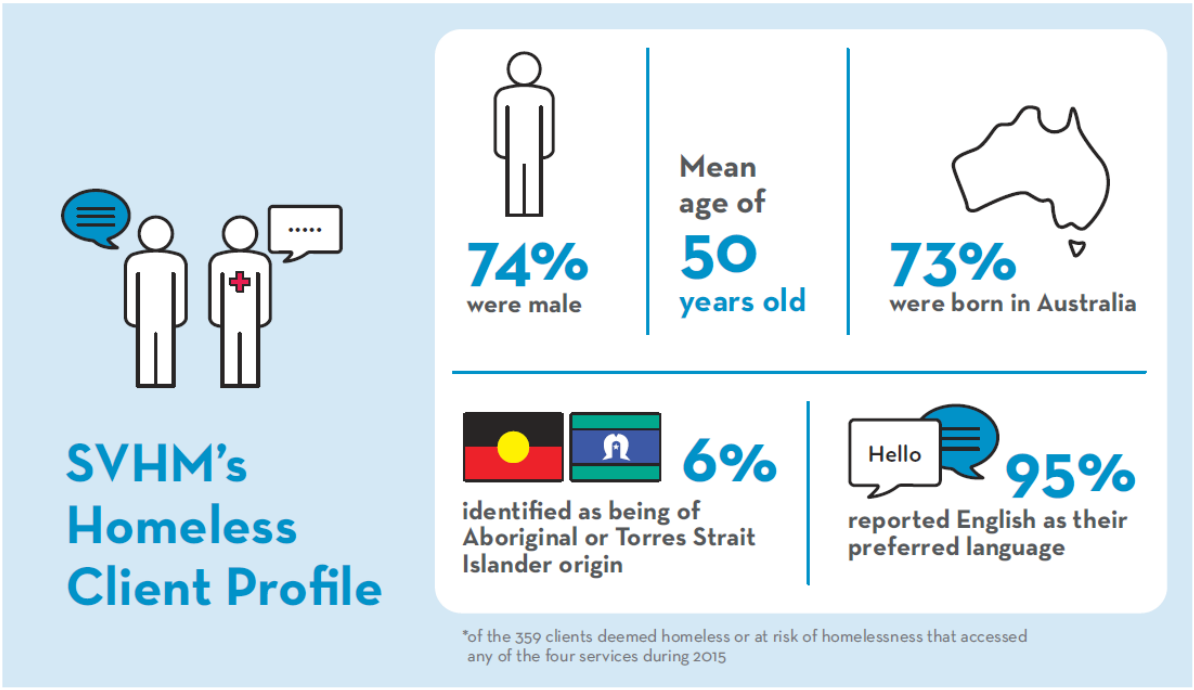

Figure 2 St Vincent's Hospital Melbourne Homeless Client Profile (of the 359 clients deemed homeless or at risk of homelessness that accessed any of the four services during 2015).

The most prevalent diagnoses upon episode commencement date were:

- drug and/or alcohol use causing mental and behavioural disorders (22%)
- schizophrenia or schizoaffective disorder (21%)
- injuries and fractures (10%)
- post-operative (non-orthopaedic) (9%), and
- other mental health disorders (8%).

Comorbidities were common among the cohort of homeless clients, congruent with the profile of homeless patients observed in other studies.

The documented primary health diagnosis of the clients rarely captured their complex needs, and interviews with clients and staff illustrated the range and intricate web of psychosocial issues they contend with. A recurring theme was the inter-relationship between complex health needs and lack of housing, whereby a multiplicity of health issues can steer people down a path of homelessness, while lack of housing often inflames or precipitates complex health needs.

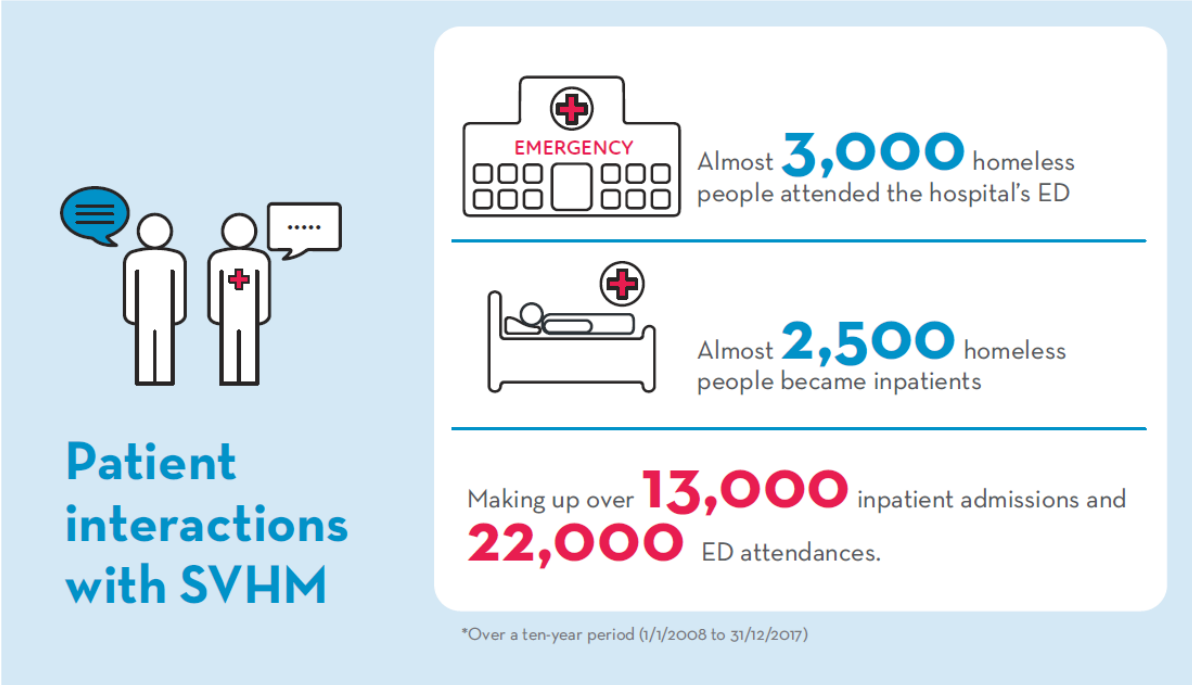

Figure 3 Examination of almost 1,000,000 patient interactions with St Vincent's Hospital Melbourne over a 10-year period (1/1/2008 to 31/12/2017)

Figure 3 represents a separate examination of almost 1,000,000 patient interactions with St Vincent's Hospital Melbourne over a 10-year period (1/1/2008 to 31/12/2017) – described internally at SVHM as the 'Big Data' project – identified that during this time almost 3,000 homeless people attended the hospital's ED while almost 2,500 homeless people became inpatients, making up over 13,000 inpatient admissions and 22,000 ED attendances. This group makes up 3% of the total ED and 2% of the total inpatient populations and over 8% of the vulnerable cohort of people we care for and excludes the larger numbers that are classified as secondary, tertiary and unstable. These latter three categories make up the larger portion of the homeless cohort.

While people experiencing homelessness are definitely over-represented in nearly all morbidity statistics, there is a recognised lack of evidence about prevalence of this population in the hospital setting.[16]

If we were to apply the findings of Feldman et al[17] and Moore et al[18] and use the figure of 10% of all ED presentations being homeless, St Vincent's Hospital Melbourne's homeless ED patient numbers over the 10 years would be closer to 10,000.

Over this decade, we also found a definite trend of increasing numbers of homeless patients well exceeding the rate of general patients, with a 44% increase in homeless ED patients

[16] Andrew Davies and Lisa J Wood, *Homeless health care: meeting the challenges of providing primary care*, Medical Journal of Australia 2018; 209 (5)
[17] Feldman et al, *Prevalence of Homelessness in the Emergency Department Setting*, Western Journal of Emergency Medicine, 2017
[18] Moore et al, *Homelessness: patterns of emergency department use and risk factors for re-presentation*, Emergency Medicine Journal, 2011

and a 58% increase in homeless inpatients over the past 10 years compared to 4% and 11% general presentations respectively.

The Big Data 10-year study identified homeless patients at St Vincent's Hospital Melbourne are on average younger by between 11 years (inpatients) and 5 years (ED patients) than the general patient population and are significantly more likely to be male (70% in ED and 54% inpatients).

Over 80% of the hospital's homeless patients had more than one vulnerability, including 50% who have drug and alcohol issues, 9% being Aboriginal and Torres Strait Islander and a concerning 64% with mental health issues.

Homeless patients who present to the SVHM's ED have quite specific complaints, including: wound infection, broken bones, alcohol intoxication, altered consciousness, self-harm and anxiety/depression. The principal diagnoses for those who are admitted into the acute ward include mental and behavioural disorders and suicidal ideation. They present with almost twice as many preventable conditions as their general patient counterparts.

Homeless patients who attend SVHM's ED are usually triaged to the same categories as the general patient population but tend to stay an average of one hour longer regardless of triage category. A similar percentage (31%) of people experiencing homelessness who attend the ED are admitted as the general patient population. However, close to three times as many people experiencing homelessness leave ED without being seen as against the general ED patient population. Eighty percent of homeless people are admitted under Emergency short stay, General Medicine and Hospital in the Home (The Cottage) units.

The top three interventions for homeless inpatients are all allied health services: social work, physiotherapy and dietetics.

Finally, a group of studies undertaken by St Vincent's Melbourne's Social Work Department concerning inpatients who are homeless illustrated high numbers of bed days taken up with complex discharge, low use of outpatient care and the possibility of improving discharge if homeless inpatients are identified and referred earlier to social work.

The evidence is clear that structurally a new normal that funds integrated housing and service delivery models is required to break the cycle of the impact of homelessness on the health and economy of the Victorian community.

2.3 Discharging from hospital into homelessness

There is no independent data source that reports on people 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. 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, over 500 people each year are discharged from acute mental health care into rooming houses, motels and other tertiary

homeless situations. Many people's first episode of mental illness develops as a consequence of the stress and dislocation of homelessness. People who are experiencing acute mental health episodes are more at risk of losing their housing, and falling into homelessness.[19]

The Australian Institute of Health and Welfare's *Specialist Homelessness Services (SHS) annual report 2017–18* indicates that of the 6,900 clients leaving care seeking SHS support in 2017–18:

- Over half (53%) were leaving either a psychiatric hospital (19%), rehabilitation facility (18%) or a hospital (15%).
- The majority were male (55% or 3,800 clients).
- Around 1 in 4 clients leaving care were Indigenous (23%).
- More than 3 in 5 had received services in the past: returning clients made up 61% (or 4,200) of this group and 39% (or 2,700) were new clients. That is, more clients had received services at some point in the previous 5 years than those seeking assistance for the first time in 2017–18.
- The majority (59%) of clients were living alone when they sought assistance.

SVHM's mission impels us in our responsibility not to discharge people into situations that contribute to their poor health. However, for us to deliver our mission effectively requires integrated housing and health solutions and new partnerships, models of care, and care navigation so that people at risk of homelessness can:

a) be discharged into secure accommodation
b) receive social supports to maintain their tenancy, and
c) gain timely access to welfare

There is a clear need for more dedicated housing services with wrap around support for those leaving hospital and psychiatric care to prevent them being discharged into tenuous, insecure housing situations (such as couch-surfing, motels and rooming houses) so as to break the cycle of re-admissions to hospital. As stated by Jenny Smith, CEO, Council to Homeless Persons:

"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".[20]

This is supported by emergency department studies that have illustrated that being discharged to homelessness was significantly associated with being readmitted within 30 days[21] and increased to less than 30 days in homeless with mental health conditions.[22]

[19] https://chp.org.au/five-reasons-why-victorias-mental-health-royal-commission-must-examine-the-role-of-housing-and-homelessness/
[20] https://vincentcare.org.au/stories/latest-news/352-from-hospital-into-homelessness, November 2018
[21] Doran, Ragins et al 2013, *The revolving hospital door*
[22] Lamarora et al, 2016

SVHM believes we can do more to improve health outcomes for homeless people by continuing care 'beyond the hospital walls' and reaching people at their point of need over a sustained period. This effort would be based on funding structures that integrate housing with supported and navigated models of healthcare which will also benefit the community of Victoria at large.

2.4 Housing is a Health Issue

To address these specific issues regarding the interrelationship of secure and supported housing to health and wellbeing, SVHM is committed to integrating health and community services in a targeted model of care beyond the hospital walls. The model is guided by the following service delivery and policy principles:

Service delivery

- Engaging with the patient or client to develop their own goals of care as the vehicle for success.
- No exit to homelessness for anyone leaving our care.
- Collaborative and goal-based care planning focused on rehabilitation and holistic health.[23]
- Integrated service delivery including 'warm referrals', i.e. patients are not simply 'handed over' at discharge.[24]
- Trauma-informed approaches to care delivery by clinicians and care staff.
- Person-centred approach to wellness beyond simply addiction or disease management.
- Pursuing a 'housing first' approach in partnership with service providers.[25]
- Care responses tailored to meet individual needs.

Policy

- Designing policy, models of care and service delivery in partnership with consumers and clients with lived experience of homelessness.
- Designing policy that allows for flexible models of care (eg: inreach and outreach) and service delivery location (ie: in community settings beyond the hospital walls).
- Putting the client and patient at the centre of policy and care delivery design tailoring service responses to fit individual needs.
- Evidence-informed resources, supports and interventions focused on sustainable outcomes.

[23] Programs within 'step up and step down' services can help clients relearn skills and undertake rehabilitation.
[24] 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)
[25] SVHM currently has partnerships with Launch Housing, Ozanam House, Salvation Army

3. Integrating health and housing to address the needs of people experiencing homelessness

As previously noted, tackling homelessness requires a comprehensive and multi-sectoral approach – one that includes both housing and health. It requires a collaborative disposition and coordination of services between government and non-government organisations.

Governments are accountable for addressing homelessness by the adequate provision of affordable housing, and have a key role in supporting initiatives that provide housing to address the needs for the most vulnerable.

3.1 The key role of hospitals

Hospitals provide a unique opportunity to create patient interventions that address both health and housing issues.

Evidence of best practice from Australia and overseas indicates that the most effective interventions for hospitals to address homelessness among its patients are those that involve comprehensive healthcare services including hospital-based care, multi-disciplinary follow-up care, and rapid specialist outreach services, all complemented with a stratified range of secure housing options that include health concierge and care navigator services.

Services provided outside the hospital walls to this patient population are crucial to ensure wrap-around support and minimise repeat crises. Growing and maintaining strong community partnerships are crucial to this success (see 3.2).

SVHM's university affiliations with Latrobe University, the University of Western Australia and the University of Melbourne have enabled the utilisation of expertise in evaluating the effectiveness of programs to create multidisciplinary collaboration and exemplary practice in this area.

Currently the three major tertiary acute hospitals covering the local government areas of Melbourne, Yarra and Port Phillip (SVHM, Royal Melbourne and The Alfred) operate in isolation from each other. This is a huge barrier to integrated care delivery for homeless persons and an inefficient use of funds.

3.1.1 Discharge

Health services (along with prisons and foster care) can identify those at high risk of homelessness when they collect the right information. In the normal course of practice, this information would be used to ensure that appropriate accommodation and support plans and structures are put in place before the person is discharged. This could include reconnecting a client with income support through Centrelink and organising community-based healthcare navigation or psychosocial and emotional supports.

Case study: Entwined health, aging and homelessness on release from prison

A frail, elderly man released from prison had no friends or family and required immediate placement in an Aged Care Facility. He exhibited confronting behaviours which posed a challenge in finding an appropriate care facility. The nurse facilitated his pathway through an urgent Aged Care Assessment and multiple aged care facilities until he was finally placed at a psychogeriatric facility. The nurse coordinated care between a General Practitioner, St Vincent's Neurologist and the Aged Care Facility to ensure continuity of care, medication management and implementation of cognitive/behavioural management strategies. The nurse also supported the client through a range of medical and diagnostic appointments, and eventually a successful guardianship application.

3.1.2 Transitional accommodation

People exiting inpatient care often need transitional accommodation or respite care – before accessing long-term, affordable housing – while they recover. These supported approaches integrate health and housing and are cost-effective as they reduce acute healthcare costs (ED representations and admissions).

It is SVHM's view that currently a significant gap in services exists to connect people who are homeless or in tenuous housing as they leave hospital and psychiatric care and who find it difficult to access and/or maintain ongoing supported housing.

This process could be improved with greater accuracy of identification in situ which would lead to:

- the provision of targeted care;
- rapid specialist support in line with a patient's needs; and
- the provision of holistic care.

This should take place in a collaborative partnership with housing services, an approach that should become the 'new normal'. All the available evidence – both here and overseas – confirms there is definite economic advantage in spending money to prevent homelessness rather than on crisis responses once people become homeless.[26]

Case study: SVHM Partnerships: Multi-morbidity, Chronic Homelessness and Burden on Health and Supported Housing

A male client in his late-30s first came in contact with SVHM in 2013. With a long history of alcohol dependence and unstable housing, he has made frequent presentations to the ED as a result of falls while intoxicated, abdominal pain and wanting clothes and food.

Contact with a wide range of services

The client has had sporadic contact with SVHM's ALERT service since 2013 while residing at VincentCare's Ozanam House where he continued to drink heavily. After falling and

[26] https://vincentcare.org.au/stories/latest-news/352-from-hospital-into-homelessness

breaking his ankle whilst intoxicated he was discharged to Stewart Lodge, but returned to street drinking. ALERT referred him to SVHM's Department of Addiction Medicine and he agreed to attempt detox. He was discharged to DePaul House, however, he only stayed one night before self-discharging. ALERT staff recommended that he could benefit from a neuropsychology assessment but this was impossible to arrange due to continuous intoxication. The client was known to Bolton Clarke's Homeless Persons Program Nurse and the Dual Diagnosis Counsellor at the Salvation Army. He had frequent contact with the police and was often picked up in an intoxicated state and kept in police custody overnight. In September 2014 he was recruited to the Street 2 Home (S2H) Program. A joint care plan meeting involving ALERT, Stewart Lodge, S2H and Victoria Police was held to discuss his housing, legal issues, behaviour modification options and future goals and strategies to reduce the burden on each service. Legal Aid is also working with the client to help him address a number of legal issues, including the accumulation of over $30,000 in fines related to drunk and disorderly charges.

Cost to SVHM

In six months prior to his first contact of 2015, there were 35 ED presentations where the client was seen, equating to an estimated cost of $28,700 based on the average cost of ED presentations and hospital admissions for the homeless. Additional hospital admission for this period equated to $3,645, resulting in a total estimated cost for this six month period of $32,345 (ED: $28,700 and hospital $3,645). In six months after this initial contact and being housed in Ozanam house, there was a small reduction in the number of ED presentations (down to 30), with the total estimated cost of the 30 ED presentations plus 3 hospital admissions was $28,245 (ED$24,600 and hospital $3,645).

This gives a total cost to the health system of approximately $60,590 in this 12 month period. This represents potential savings to the health system if his situation is able to be managed effectively and ED presentations and admissions reduce. More widely there are potential cost savings for the police and legal system if incidents associated with intoxication can be ameliorated.

3.1.3 Outreach services

There is strong evidence pointing to the success of non-traditional service models taking healthcare into the places where homeless people are; this increases access to healthcare, improves health outcomes, prevents unnecessary hospitalisations and maintains long-term tenancy.

SVHM delivers a range of these outreach models including:

- assertive outreach teams for people experiencing primary (rough sleeping) and secondary (boarding houses, crisis accommodation) homelessness;
- clinics at hostels, The Salvation Army, Melbourne's Medically Supervised Injecting Room and other services accessed by people experiencing homelessness; and
- follow up with clients who may have exited a homeless health service but who may need further ongoing support.

These models are successful because of the strong commitment of SVHM's medical, nursing and allied health clinicians and the shared vision of our partners in housing, local government, non-government agencies, primary health care and social services.

Case study: CHOPS assertive outreach at St Vincent's Hospital Melbourne

The Victorian Government-funded Clarendon Homeless Outreach Psychiatric Service, or 'CHOPS'[27], is a specialist outreach service designed to work with people with mental illness who are homeless or in tenuous housing – wherever they are located – treating their illness before it reaches crisis point and requires hospital admission.

A recent evaluation of CHOPS compared 77 of its clients and their interactions with St Vincent's in the six months before they accessed the service and then six months after, and found it delivered:

- A 43.9% decrease in the number of presentations to our Emergency Department among the group.
- A large reduction in the number of unplanned inpatient admissions (from 46 to 14 admissions).
- A decrease in the number of planned admissions per person – 374 down to 86 (77% decrease)
- An overall reduction from 988 to 492 days spent in an inpatient unit (50.2% decrease).
- The average cost to St Vincent's Melbourne in providing public health services to these patients reduced by more than half. This resulted in a $1,000,153 total reduction across the 77 CHOPS clients surveyed. In the six months prior to them receiving CHOPS' support, the hospital spent $23,166 per person; in the six months after being supported by CHOPS, this dropped to $10,177, a decrease of $12,989 per person over six months.

As an 'outreach' service, the CHOPS team – which includes six primary clinicians – spend much of their time on the road in inner Melbourne, identifying their patients wherever they may be: in homeless shelters, boarding houses, or the street, to provide them with care and treatment for their mental health.

By reaching out to people who are in tenuous housing and treating their mental health needs before they get out of hand, CHOPS helps people avoid hospital and maintain their tenancy. By doing the same for people who are already homeless, CHOPS can help stabilise their mental health so they are ready to take the step back into long-term accommodation.

From an economic and community wellbeing point of view the evidence suggests it is significantly cheaper to invest in staff to provide community-based assertive inreach, care navigation and outreach services, integrated within supportive housing environments, than to have repetitive hospital ED presentations. We know that:

- people experiencing homelessness are over-represented in ED presentations and hospital admissions;
- that we grossly 'under-count' the number of homeless people within health services due to short comings in Victorian Admitted Episodes and Victorian Emergency Minimum datasets ; and

[27] An ABC News report on CHOPS' work can be accessed at https://www.abc.net.au/news/2018-09-16/outreach-services-for-mental-health-patients-melbourne/10251382

- Independent Hospital Pricing Authority costs the average hospital admission at ~$5000.

SVHM's dialogue with Launch Housing has addressed the need for rapid response from alcohol and other drug and mental health services to attend to those whose health needs are declining and who are in unsupported or tenuous housing.

Societal factors such as complaints from neighbours and behavioral issues can be addressed if our housing and health partnerships are resourced to deliver responsive interventions before they become crises. At SVHM, both ALERT and CHOPS generally see people after an issue has become a crisis.

3.1.4 Lived Experience Workers and Care Navigators

Lived experience workers are increasingly familiar – and key – members of interdisciplinary healthcare teams tasked with addressing the treatment needs of vulnerable populations.

Drawing on their lived experience of homelessness, alcohol and drug addiction, and mental illness, they assist others to gain their own sense of confidence and hope about their journey to recovery and self-determination.

Sometimes referred to as 'peer support worker's or 'care navigators', the role varies between organisations and healthcare settings. They are an important element of an interdisciplinary team's approach and bring the wisdom of experience to many aspects of service delivery including intake interviews, service promotion, group programs, case review and care navigation.

The capacity to be accompanied by a peer ensures that the correct messages are conveyed to services. Outcomes are more positive than previously realised. Genuine peer support is 'hearing' a person as a human being, with all the ups and downs they may have experienced in life, and genuinely listening to their personal story.

The early results of SVHM's Safe Haven Café Peer Support Workers initiative were very positive.

Case study: Peer Support Workers at SVHM's Safe Haven Café

People with lived experience of homelessness hold expertise that is incredibly valuable. Employing people with lived experience in peer worker roles to support others brings a tremendous range of benefits. Peer workers know what it is like to have been homeless and can share experiences of personal recovery with consumers. People who are living well despite their period of homelessness represent hope that is often missing in client's lives.

SVHM's Safe Haven Café[28] is an after-hours drop in centre at the hospital that is modelled on a successful UK service and which has been shown to reduce social isolation for vulnerable people and help them maintain their mental health on an ongoing basis.

[28] Watch this video for further background on SVHM's Safe Haven Café https://www.youtube.com/watch?v=q-0I2xf4Tzo

Designed to provide mental health patients with a support option other than the hospital's Emergency Department, Safe Haven allows people to explore what options may be available to support them, and identify relevant local services.

The recruitment of Peer Support Workers at Safe Haven (ie: someone with a lived experience of mental illness) was viewed as an opportunity to engage people who presented to ED on a whole new level.

The objective was to ensure that patients felt appropriately heard, understood and offered suitable options. The plight of those sleeping rough and the complex psycho-social elements that go with that existence can often be misunderstood by staff that have not had similar life experience.

The ability for staff to identify such concerns and then engage the Peer Support Worker to attend and provide the necessary support and comfort meant that clinicians see much more positive outcomes.

3.2 Funded Partnerships: the key to success

A successful new normal recognises the value-add of funding partnerships that understand the complexity of this cohort's health and social needs.

Case study: Launch Housing

SVHM currently partners with Launch Housing to provide priority crisis accommodation access to women experiencing homelessness. Women presenting at SVHM ED with health and psychosocial issues, homeless and agreeable to be housed are offered accommodation directly from the Emergency Department.

This partnership includes accommodation support workers from Launch Housing as well as health-focused outreach from St Vincent's Health Independence Program. This ensures there are wrap around expertise accessible to the client from multiple services and through formal partnerships ensuring collaboration in the individual's care.

SVHM's partnership with Launch Housing has been in place for seven years. Our evidence shows that a person with our support:

- more consistently and securely engages with Launch Housing's services
- better engages in their own care attending to both their health and social needs.

One of the key elements in the SVHM/Launch Housing partnership is the opportunity the ALERT team has in the ED/acute hospital setting to engage, provide a safe environment and gain trust at a pivotal moment in a vulnerable, homeless woman's life. This is especially true for women experiencing family violence concurrently with homelessness. These women have greater barriers in accessing family violence services due to their homelessness. The partnership with Launch Housing ensures there is personalised, unique and timely response with as little red tape as possible to get a homeless woman housed and in a position to move forward with their goals whether it be health or psychosocial.

Following a recent internal review by Launch Housing of priority access to crisis accommodation to external services, only the St Vincent's priority access bed partnership has continued. This is due to strong partnership built on shared commitment and improved outcomes for this vulnerable cohort manifest in this shared service model.

Currently in the absence of sustainable recurrent funding, SVHM has accessed short-term grants from St Vincent's Health Australia's Inclusive Health Program. These small grants have allowed the hospital to establish creative and effective partnerships with:

- **The Salvation Army**
  To provide an on-site health hub (nursing and mental health) within the Salvos Bourke Street Community Hub.

- **Launch Housing** (formalised in a Memorandum of Understanding)
  To collaborate on initiatives that improve understanding of the health needs of homeless persons, improve coordination of care (primary, acute and mental health care) for homeless persons, increase access and utilisation of all levels of health care by Aboriginal and Torres Strait Islander persons.

- **Jesuit Social Services**
  To embed a community health nurse within the ReConnect program for persons released from prison to provide direct clinical nursing assessment and care, and to increase clients' health literacy and patient activation (which is defined as the knowledge, skills and confidence to manage one's own healthcare).

- **Ozanam House and Sacred Heart Mission**
  To prioritise access to GP clinics for vulnerable persons

New funding partnerships would allow us to devote additional clinical time that complex patients often require to stabilise their health and put appropriate discharge plans in place. Eventually, and ideally, this complexity, length of stay, and potential for patients to be stranded, would reduce and simplify.

3.3 No wrong door to healthcare for homeless people

People experiencing homelessness should be able to access any mainstream health service and have their needs identified and addressed. Access to mainstream health services is not the crux of the problem for people who are unable to prioritise healthcare over basic survival needs. Mainstream services are not currently configured to meet their needs.

Comprehensive screening and data collection, and a well-trained, compassionate health workforce are key to delivering better 'case identification', gathering richer information, experiencing fewer missed opportunities to help and create tailored care pathways for vulnerable clients.

For example, one of the growing cohorts of people experiencing homelessness are women aged over 55. Hospitals are likely not picking this group up in data collection because often they don't look like a stereotypical homeless person. Our anecdotal experience is that women of this age are too proud to disclose to staff that they are on the brink of homelessness or already sleeping in their cars.

Just as there should be no wrong door to healthcare, so is there no single profile of a homeless person. SVHM sees women and men, young and old, with diverse needs: young substance users, older women, older persons with cognitive impairment and acquired brain injury, survivors of family violence, women with children, etc.

Understanding this requires increased education and awareness for all healthcare students of the complexities and issues surrounding homelessness and homeless patients.

4. Recommendations

SVHM's specific focus as a health service provider, is a commitment to three specific policy goals:

1. **'No exits into homelessness'.**

2. **Tailored and supportive access to healthcare for people experiencing homelessness or who are in tenuous housing and who are unable to access mainstream models of care.**

3. **Creating new models of care and service delivery to improve holistic wellbeing (physical, social and emotional) for those experiencing homelessness in any of its forms (or those at risk of homelessness).**

SVHM's expertise in providing health services to vulnerable populations has identified that Victorians who are homeless or at risk of homelessness experience are in danger of falling through the cracks and gaps in the service system which prevent them achieving long-term and sustainable housing and positive health outcomes. We have identified many opportunities to:

- modify and reform existing service models,
- create new ways to access care; and
- formalise and fund partnerships that bring secure housing and supported healthcare together.

The following recommendations – working in concert with the broader macro reforms, at both state and federal levels, necessary to tackle Victoria's housing and homeless problem – would better support people achieve their housing goals by addressing their health needs.

4.1 Pathways Home: SVHM's Homeless Health Model

With a focus on Melbourne's CBD and inner northern suburbs, SVHM 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.

The SVHM Pathways Home model aims to achieve its goal of 'no exit to homelessness' by increasing opportunities to stabilise and treat the hospital's most complex patients, along with facilitating access to supported housing, rapid specialist alcohol and other drug treatment services, and mental health outreach support.

The long-term benefit is improved health and wellbeing outcomes for the hospital's most vulnerable patients, resulting in increased sustainable housing options, along with a decrease in crisis and ambulatory presentations to ED.

The three new services envisaged under Pathways Home are:

1. Specialist Homeless Persons Outpatient Clinic

SVHM proposes the development of a funded service for homeless patients, staffed by specialist clinicians to ensure those with complex needs have equitable access to the specialised medical support they need. The Specialist Outpatient Clinic would address the key factor that those with no fixed abode often encounter that they do not have their physical health issues addressed due to the chaotic nature of their lived experience.

Figure 4 illustrates the outpatient appointments per hospital unit for persons with no fixed place of abode over a 3-year period. These results reflect the outpatient services required for the acute and chronic illnesses that occur most often in this population.

The most striking impression from the SVHM graph below is the extraordinarily high rate of those patients that did not attend (green areas). For most clinics this level is approximately 75% of those referred, far higher than standard DNA clinic rates. The referral source for these appointments was not available, but is presumed to be a mixture of ward discharge, emergency department and general practitioner referrals. There are notable omissions from these outpatient services in that drug and alcohol, mental health outpatient and oncology clinics are not included. This data only represents the public clinic system at St Vincent's. With all these limitations it is apparent that there is a public service need for acute and chronic medical conditions that is not being met.

The most common units to be referred homeless patients are the plastics and orthopaedic units. This reflects the high rate of acute injury and infection that occurs disproportionately in homeless populations[29] [30].

Typical chronic illnesses seen in homeless populations are also represented in the graph in that there are high numbers of cardiology, gastroenterology, and respiratory appointments booked. These include the chronic illnesses suffered proportionately causing much of the premature mortality in the homeless population[31]. Many of these illnesses are amenable to health interventions.

Previous studies have shown that providing homeless people with a familiar service with familiar providers and assistance in negotiating and attending the health service may reduce the barriers to outpatient care[32] [33].

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[29] Jessica L. Mackelprang, Janessa M. Graves & Frederick P. Rivara (2014) Homeless in America: injuries treated in US emergency departments, 2007–2011, International Journal of Injury Control and Safety Promotion, 21:3, 289-297

[30] Didier Raoult, Infection in homeless people, The Lancet Infectious Diseases, Volume 12, Issue 11, 2012, Pages 822-823

[31] Aldridge RW, Menezes D, Lewer D et al. Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. [version 1; peer review: 2 approved] Wellcome Open Research 2019, 4:49

[32] Julia Zur, Sabriya Linton & Holly Mead (2016) Medical Respite and Linkages to Outpatient Health Care Providers among Individuals Experiencing Homelessness, Journal of Community Health Nursing, 33:2, 81-89

[33] Serena Luchenski, Nick Maguire, Robert W Aldridge, Andrew Hayward, Alistair Story, Patrick Perri, James Withers, Sharon Clint, Suzanne Fitzpatrick, Nigel Hewett. Lancet 2018; 391: 266–80.

Figure 4 Number of outpatient attendance by hospital unit for patients registered as "no fixed place of abode". July 2017 to December 2019, SVHM. Green bars - Did not attend outpatient appointment. Grey bars - Attended outpatient appointment.

2. Medical Respite Facility for Homeless Persons

A Medical Respite Service, located close to SVHM's Fitzroy campus to complement its current 'step up and step down' service (ie: The Cottage), to provide a longer length of stay for patients who are homeless or at risk of homelessness.

The Medical Respite Service – which would focus on those with complex medical, recuperative and behavioural needs that struggle to be housed by existing services and where they are sometimes excluded from entry – would offer a longer length of stay between two to eight weeks[34] and offer 'in-reach' support to its residents provided by existing homeless teams, social workers with family violence expertise, and AOD and mental health specialists.

Such a service would increase the opportunity for patients to stabilise their health conditions and psychosocial needs to optimise transition from health to housing. It would also allow staff and patients the opportunity to build rapport and focus on achieving goals that are most important to the patient, such as securing suitable housing.

Through a longer length of stay, coupled with wrap-around support, it is envisaged these patients will gain access to the health treatment they have historically been

[34] A systematic review of "medical respite" found that it can result in improved health and housing outcomes for service users who are homeless, as well as reductions in hospitalisations and hospital readmissions (Doran, Ragins, Gross, & Zerger, 2013; Doran, Ragins, Iacomacci, et al., 2013).

unable to approach, thus allowing more time for recovery and sustained health improvements.

An expansion of 'step up, step down' medical respite services across other Victorian hospitals serving large homeless populations would have significant impacts on health economics state-wide. It is envisaged that SVHM's proposed medical respite facility would be an integrated part of the hospital's overall homeless health service, optimising continuity of care between acute, outpatient, and community based services.

3. **Integrated Healthcare Housing Partnerships**

To complete its homeless health model, SVHM proposes the establishment of a development integrating healthcare within a supportive, longer term housing environment. Such a development would be in partnership with an existing housing service.

This funded development brings housing and healthcare navigation together to address the hospital's goal of 'no exit to homelessness'. As with the other services, the supported housing would focus on the most 'at risk' homeless populations such women and men with complex medical and behavioural needs who struggle to be housed by existing services, those escaping family violence, persons leaving prison, and Aboriginal and Torres Strait Islanders.

SVHM's Pathways Home model will provide an opportunity for our staff to see beyond the presenting crisis of the people we serve. It will allow staff to walk alongside patients for longer periods so they can hear what is truly important to them, focus on the person, and be responsive to their needs and issues.

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

4.2 Systemic Reforms

This submission calls for system-wide reform in both the health and housing sectors.

4.2.1 Healthcare Reforms

I. SVHM recognises that even the most effective screening, identification, and discharge planning for homeless people in hospitals will have limited benefit without adequate housing options in the community, St Vincent's supports policy settings that assist hospitals:

   i. Build strong partnerships with homelessness services and housing service providers in their areas;

ii. Develop integrated pathways engaging expertise from both housing and health; and
iii. Deliver early referrals, so that there is enough time to organise community supports prior to a patient's discharge.

II. Increased accountability for progress. The Victorian Government should work towards routinely collecting data on discharge destination, and providing annual reports on their progress in reducing exits from state care (eg: prisons and foster care) into homelessness.

III. Reflecting the reliance of most homeless patients – and those in tenuous housing – on income support, and the challenges facing healthcare social work teams in representing their often complex issues to Centrelink while in their care, the Commonwealth Department of Human Services should establish a pilot, in conjunction with state health departments, that aims to expedite Centrelink payment applications for inpatients to avoid discharge delays and patients being stranded.

IV. Funding for research to build an evidence-base into the risk factors for homelessness following hospitalisation (eg: benefit of early identification, discharge planning, etc), including for Aboriginal and Torres Strait Islander patients. The Sax Institute has found that "no studies" explicitly measure the risk factors for homelessness among people discharged from hospital.[35]

V. Expansion of assertive outreach health services, including mental health, to support clients in tenuous housing (including public housing), or those already homeless.

VI. Piloting new models of palliative care for people at risk of, or experiencing, homelessness, at an earlier point in their illness and in environments acceptable to homeless people (e.g. shelter/hostel/boarding house-based hospice care).

VII. The Victorian Government to establish a 'health-solutions incubator' fund to focus on testing new approaches to help homeless and vulnerably housed people regain their independence.

VIII. Victorian Government to fund pilots that use Peer Support Workers or 'care navigators' – people with lived experience of homelessness – in mainstream health services that serve large numbers of people experiencing or at risk of homelessness, to improve their journey through the system and achieve a better health outcome.

IX. Improve data collection in Victorian health services regarding a patients' housing status and security including:

- Routine, evidence-based screening that overcomes unconscious biases of health staff about who 'looks' homeless.

[35] The Sax Institute, *Homelessness at Transition*, November 2017

- Consistent recording and coding of housing status to address significant underreporting in the health system.

- Where possible, harmonise data collection and recording with other agencies commonly accessed by homeless people and investigate information sharing models.

X. Specialist training for health staff in hospital and primary care setting in areas with high homeless populations to better identify and respond to the unique needs of homeless people.

XI. The Independent Hospital Pricing Authority to support a study into the additional costs associated with providing healthcare to people experiencing, or at risk of, homelessness. This study would determine whether a weighting should be applied to these patients similar to Aboriginal and Torres Strait Islander patients.

XII. As a major provider of health services to prisoners in Victoria, St Vincent's calls for both an improvement in, and access to, health services among the state's prisoner population, particularly in the areas of mental health and alcohol and other drugs; better coordination and planning around prisoner discharge, including the continuity of healthcare; embedding of community health nurses in transitional services designed to support people exiting prisons (e.g. Jesuit Social Services' ReConnect program).

XIII. Victorian Government to work in partnership with NGOs to better address the full range of social determinants of health for homeless people by establishing linkages and pathways to a range of programs to address key issues, such as education and employment.

XIV. DHHS to work towards improving the confidence and effectiveness of Victoria's mainstream healthcare workers in working with homeless patients, by developing and implementing a training module on vulnerable populations and social determinants of health.

4.2.2 Better outcomes for mental wellbeing

Access to affordable and permanent housing continues to remain a significant challenge for people living with mental illness. Yet, the ability to maintain good mental health and recover from acute mental illness is directly impacted by a lack of permanent safe accommodation options. Insecure tenancy can exacerbate health and welfare issues for those involved, and have a negative effect on the safety and development of families and children. There is also a flow-on impact to the broader community services sector.

Individuals and families facing mental health issues can be at higher risk of losing tenancy, given the significant challenges they face in terms of maintaining their homes, keeping up with rental payments, behavioural difficulties and sustaining a safe and stable household environment.

Studies have shown that around three quarters of Australian men and women who are homeless have at least one mental illness compared to 20% in the general population.[36] SVHM's own data confirms that the prevalence of mental illness among its homeless patients is extremely high.

The following 12 recommendations are extracted from the many recommendations made by SVHM in its submission to the Royal Commission into Victoria's Mental Health System[37] and would improve both the health and housing outcomes for people living with mental illness. They are based on the principle that while treatment of a mental health condition is important, the provision of supported housing and employment are equally as crucial to ensuring a long term successful outcome.

I. Funding: An increase in the funding to mental health programs and services across the state, but in particular to those areas where the funding today does not match the needs of the catchment population. Funding models should ensure stability and sustainability over time.

II. Jurisdictional boundaries: A state-wide approach to mental health services to ensure that consumers receive the appropriate level of care in the correct geographical locations via a co-ordinated approach, whilst also facilitating the sharing of resources and information.

III. Integration of care: Better integration and resourcing across tertiary health services and primary health services. This will address the current gap in service delivery between the two types of care, to ensure that people can access the right help and treatment quickly and easily, and ensure continuity of care.

IV. The development of more specialist mental health services to provide integrated treatment and management of mental health needs alongside other needs, whether that be for a neurodevelopmental disorder, personality disorder, or geriatric support.

V. Policy change which acknowledges the difficulties that vulnerable populations have in accessing generic mental health services, which we hope would lead to improved rates of consumers seeking help early and thereby reducing the reliance on EDs and acute levels of care.

VI. Clearer referral pathways, as well as better collaboration and planning between services to ensure continuity and consistency of care and support, to help reduce the chances of an individual experiencing a gap in support during their time of need.

VII. Investment in Information and Communication Technology (ICT) solutions: Further investment in ICT will allow clinicians to have the right information, at the right time, which will improve care and support that can be offered to consumers and their loved ones. This investment will facilitate integration of care across jurisdictional boundaries.

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[36] Teesson, Hodder and Buhrich, *Psychiatric disorders in homeless men and women in inner Sydney*, Australian and NZ Journal of Psychiatry, March 2004.

[37] St Vincent's Hospital Melbourne's full submission can be found here: https://rcvmhs.vic.gov.au/download_file/view/317/389

VIII. Specialist / tailored care: The development of more specialist mental health services to vulnerable populations (eg: LGBTQI, Aboriginal and Torres Strait Islanders, young people, prisoners, etc), to provide integrated treatment and management of mental health needs alongside other health and social support needs.

IX. Community- care beyond the hospital walls: An increase in services being provided within the community, which acknowledges the difficulties that vulnerable populations have in accessing health services. In addition, further investment in support structures that help create a sense of community (for example, upgrading aging infrastructure to deliver an environment that promotes health and wellness for all by providing safe and therapeutic spaces).

X. Early intervention: Expansion of services known to support early intervention; such as the Police and Clinician Emergency Response (PACER) service, which places a mental health clinician with Victoria Police who are responding to people in the community with disturbed behaviour. Further consideration of how to support Ambulance Victoria in their early response to crisis situations should also be explored.

XI. Housing support for people living with mental illness: Embed housing services within our AMHS; provide more accommodation options within the community, e.g. low-income housing in inner metro areas, so that consumers can continue to live within their community which will enable continuity of their care and treatment.

XII. Employment: Embed specialist mental health expertise within employment services to support people with mental illness obtain employment.

4.2.3 Housing Reforms

St Vincent's Health Australia recognises that a multi-faceted approach to ending homelessness requires reform and policy considerations at both state and federal levels, covering areas as diverse as Australia's taxation system, housing and rental, along with health and other drivers of homelessness, principally involving:

I. *Resetting the tax system to support first time buyers*

- 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; and

- Prioritise first home-buyers over property speculators by resetting the tax system.

II. *A national housing strategy*

- A coherent National Housing Strategy that includes new capital investment to generate 300,000 new social and Aboriginal housing properties; and 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.

III. *A better deal for renters*

- Nationally consistent protection for renters through legislative protections against evictions, rent rises, discrimination and landlords who refuse to maintain properties.

IV. *A national commitment between federal and state/territory governments to end homelessness with a target to halve homelessness in five years and end it in 10.*

- 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.
- Commits to ending homelessness in 10 years from the plan's introduction by taking action to prevent homelessness and delivering rapid access to the housing and support people need if they do lose their own home.
- Recognises holistic, person-centred care and positive health outcomes including access to stable and supported housing which facilitates navigation of and equitable access to healthcare.

V. *Relief for chronic rental stress*

- 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; and
- Review the way Rent Assistance is calculated to make eligibility and payments fairer.

5. Conclusion

Overcoming or properly managing your illness can only be achieved with stable, long-term, accommodation. In other words, health needs housing; and for the vulnerable homeless for whom SVHM cares every day, we can't achieve one without the other.

The homeless people SVHM treat don't have a GP and are often without a Medicare card. They don't keep medical appointments because of their complex needs and often chaotic lives. The stigma of being homeless keeps many away.

For most, the absolute basics of life – food, shelter, a place to sleep safely – take precedence. Health often falls down the list of priorities until an illness becomes so bad it drives them to our Emergency Department for relief. What often ensues is a protracted admission for an illness or injury that could have been managed weeks earlier by proactive primary care.

The sad irony is that an unmanaged illness is often the factor that makes it difficult for them to leave homelessness behind. Fundamentally, health care settings have a responsibility not to discharge people to situations that are contributing to poor health. However, for hospitals to deliver on this responsibility requires appropriate housing solutions, so people can be discharged into accommodation and receive timely access to welfare and other social supports to maintain their tenancy.

In Australia, experts estimate the shortfall in social housing (subsidised housing for low income and vulnerable people) is 437,000 properties, while for affordable housing (low cost rental properties for low and middle-income earners) the figure is 213,000.[38]

In Victoria alone, the Council to Homeless Persons estimates the current social housing shortfall to be around 103,000 properties.[39]

Unless there's enough social housing in the community, homeless people – and rough sleepers in particular – tend to circulate again and again back to inner-city hospitals for the health care they need.

The only way to break that cycle for this cohort is to take a 'housing first' approach: having immediate access to social housing, so that once an individual is housed we can provide the necessary health and social service support to help them maintain that accommodation.

The housing is not an end in itself – it's actually just the beginning – but it provides the security and foundation around which health and social services can be provided with regularity and certainty for someone to maintain their tenancy.

St Vincent's recognises the recent Victorian Government commitments to build 6000 new social housing units and create a $1 billion social housing growth fund.[40]However, we also recognise the time it will take for this accommodation to become available and the current shortfall in social housing compared to the identified need.

In the absence of the necessary social housing being forthcoming, St Vincent's has made a series of recommendations in this submission to address the health needs of people experiencing homelessness, and in doing so, help them achieve long-term and sustainable housing.

The hospital's chief recommendation is the development of a St Vincent's Hospital Melbourne Homeless Health Model – Pathways Home – which calls for the creation of:

- a Specialist Outpatient Clinic in inner city Melbourne;
- the development of a Medical Respite Centre which will expand on the size and sophistication of the hospital's current 'step up/step down' service, The Cottage; and finally

[38] Dr Laurence Troy, Dr Ryan van den Nouwelant and Prof Bill Randolph, *Estimating need and costs of social and affordable housing delivery*, UNSW City Futures Research Centre, March 2019
[39] Council to Homeless Persons, Victorian pre-budget submission 2019-20.
[40] https://www.vic.gov.au/our-plan-create-more-social-and-community-housing

- supported housing units to provide long-term sustainable housing to those exiting the Medical Respite Centre.

St Vincent's Hospital Melbourne has a plan to make an impact. It wants to end the cycle of homeless, of patients presenting to its ED or being admitted, only to find themselves homeless again despite the hospital's best efforts.

We encourage the members of the Victorian Legislative Council Legal and Social Issues Committee – along with all members of the Victorian Parliament – to accept and prioritise these reforms and to bring relief and security to our community's most vulnerable members.

Appendix 1 – The Cottage, a detailed case study

Description of service model

Established in 1995, St Vincent's Hospital Melbourne's The Cottage is a supportive, home like environment for people who are homeless or at risk of homelessness.

The Cottage is a step up, step down service which provides holistic, 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 hospital's campus in Fitzroy. The Cottage focuses on building rapport and trust between clients and staff, enabling staff to establish a safe environment and platform from which they can address clients' health issues.

Staff at The Cottage include nurses, who provide Hospital in the Home (HITH) services to clients and assist clients in managing their medication, and personal care workers. Both the nurses and personal care workers at The Cottage develop rapport with clients, assisting them to self-manage their medication and daily care where appropriate.

The Cottage includes the provision of:

- Six bed, residential homelike, recuperative setting on St Vincent's Melbourne's Fitzroy campus;
- Staffed by Personal Care Attendants 24/7 in addition to St Vincent's at Home nursing service (during the day);
- Assistance with medication routine and management;
- Dietary advice and physiotherapy;
- Links to ALERT, Social Work, Department of Addiction Medicine and external housing/health/welfare agencies;
- Referrals to crisis housing and accommodation; and
- Length-of-stay of 5-7 days although can be negotiated longer as required.

Client profile

The client population for The Cottage are males and females over 18 experiencing homelessness and/or social isolation and/or lack of a reliable caregiver with (a) a clinical nursing need, and (b) homeless or in insecure housing.

Cottage clients need to be medically stable and have a post-Cottage discharge plan in place prior to entry.

The Cottage is unable to assist clients who are unable to abstain from substance use or are currently intoxicated, have a recent history of violence, or an acute mental health need.

Demographic profile

During 2015, 139 patients were supported by The Cottage, of these, 103 were supported by The Cottage only, with the other 36 supported by both The Cottage and ALERT.

Of the clients supported by The Cottage, three quarters (75%) were male with an average age of 54 (range 24 – 81 years). Nearly one third (30%) of clients were aged between 45 and 54 years old (Figure 1).

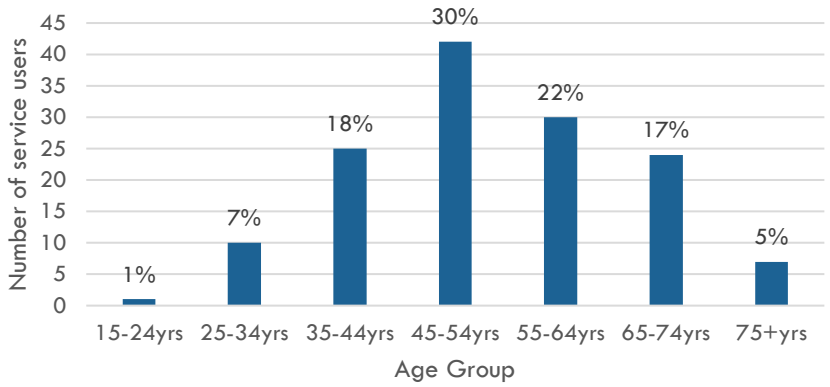

Figure 1: Age Distribution of The Cottage Clients (Number and Proportion)

Of the four services, The Cottage had the most clients born outside Australia (31%). Of these, 13% were born in Europe, and 8% of clients were born in Southeast Asia (Figure 2).

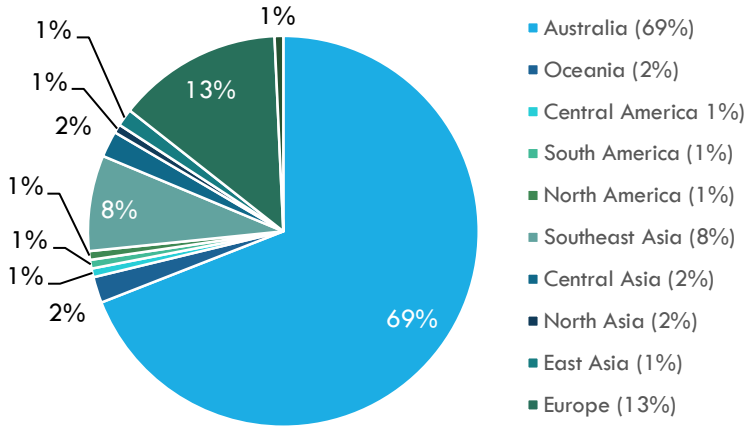

Figure 2: Country of Birth of The Cottage Clients (%)

The majority of The Cottage clients preferred language was English (91%); no Cottage clients required the use of a translator.

Six percent (n=8) of The Cottage clients identified as Aboriginal or Torre Strait Islander. The majority of Aboriginal clients were female (n=5, 63%).

When asked about their usual accommodation, 23% of The Cottage clients were recorded as homeless or usually accommodated in a public place, whilst 68% indicated that they were in independent living. Again, it cannot be ascertained from the dataset what constitutes independent living for these clients, as the majority have been clearly identified by staff from

The Cottage as being homeless or at high risk of homelessness. When asked about who they lived with, two-thirds (65%) of The Cottage clients reported living alone, 12% lived with others and 8% with family, and the remainder did not provide a valid response.

Housing status at entry to support

At the time of its evaluation, all Cottage clients were deemed to be homeless or at risk of homelessness. While The Cottage is not exclusively for people experiencing homelessness, a review of the 2015 client records by the Data Manager and Cottage staff confirmed that nearly all clients were either primary, secondary or tertiary homeless. Even the few exceptions (eg: a client who had a place to live, but lived alone and hence unable to care for himself following medical treatment) were deemed to be vulnerable to homelessness due to factors such as lack of social support.

Presenting health problems

Of the 167 episodes of care provided by The Cottage, the most common reason for an episode at The Cottage was for recovery post-op for a non-orthopaedic procedure (23%), substance use causing mental and behavioural disorders (19%) and, injuries or fractures (9%) (see Figure 3 below).

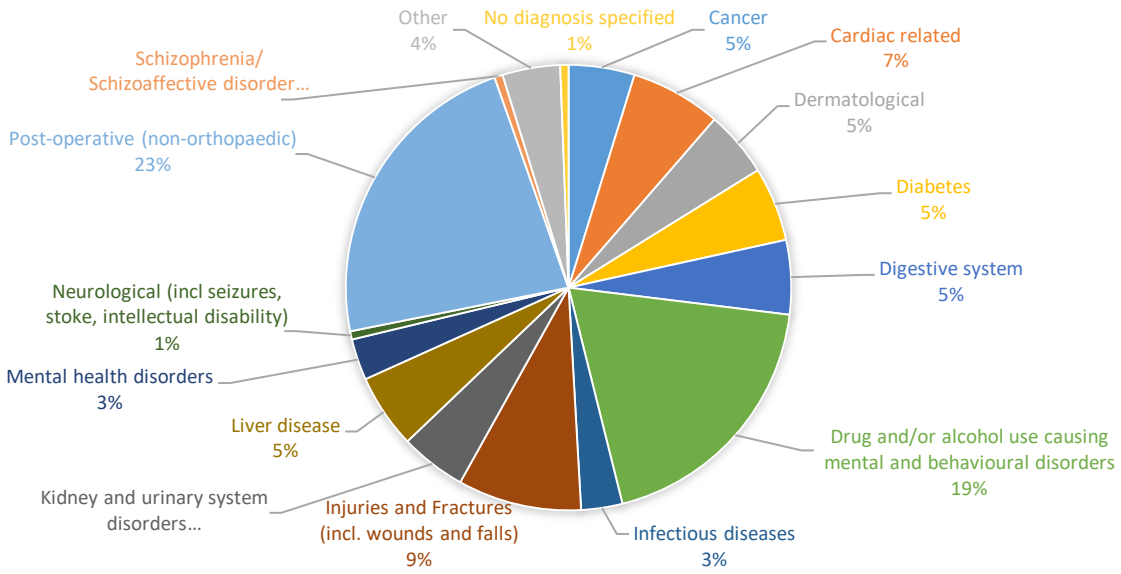

Figure 3: The Cottage Diagnosis Descriptions

In addition to the main health condition per episode of care, other factors affecting health are recorded for Cottage clients (Table 2). The Cottage clients had on average 11 factors affecting their health (min 1, max 22). The most common factors affecting their health included daily living issues (85%), carer issues (75%) and social isolation (74%).

Table 2: Factors Affecting Health of Cottage clients

	The Cottage (%)
Carer issue	74.8
Concern about intervention / treatment	42.4
Daily living issue	84.9
Employment issue	39.6

Environmental issue	68.3
Eviction Issue	3.6
Family & other relationships issue	63.3
Financial issue	14.4
Homelessness	31.7
Isolation issue	74.1
Issues due to medication	56.8
Issues in self-management	3.6
Learning issue	37.4
Legal issue	0.7
Need for emergency accommodation	3.6
Need for sheltered accommodation	3.6
Need for supported accommodation	48.9
Other housing issue	10.8
Tenancy issues	10.8
Unsuitable accommodation	44.6

* Please note many clients had multiple factors recorded and a number were both ALERT and Cottage clients

The Cottage service delivery

There were a total of 167 episodes of care at The Cottage during 2015. Data on the number of contacts (ie: clinically significant actions such as meeting with the client or making a phone call on their behalf) is not available in the same format for The Cottage as it is a bed-based facility with nursing care. Contacts instead are routinely recorded as one per day and one per night of stay (ie: maximum of two contacts in a 24 hour day/night period) regardless of the actual number of literal contacts between clients and staff, which are typically more regular in a bed-based stay service. As such, there is very little heterogeneity in the number of contacts per client, so the average number of contacts per client has not been computed.

In 2015, eight clients had at least two separate episodes of care at The Cottage, with one client having four separate episodes (i.e. admitted and discharged on multiple, separate occasions). Episodes of care that had contact in 2015, were an average of 9 days (per episode) long.

Over half (56%) of clients spent one week or less at The Cottage, with 29 (17%) clients staying for one night only (Figure 4).

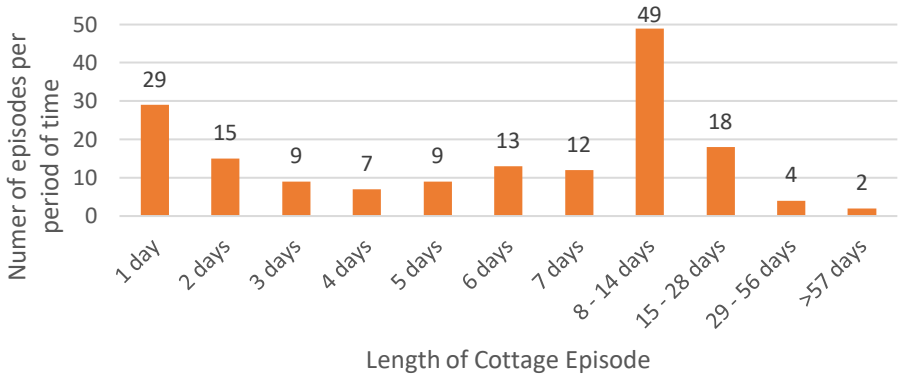

Figure 4: Number of The Cottage Episodes per Length of Time

A unique aspect of The Cottage is that its service is not 'stand-alone' as it provides a vital place for continuity of care for people who have just been in the hospital setting, or are awaiting a hospital or other treatment/procedure. This has been a hallmark of The Cottage service model since its inception.

Outcomes

Health outcomes

An evaluation looked at changes in hospital usage for The Cottage clients who had accessed service in 2015 and who had commenced their episode of care after the 1st of January 2011. Hospital usage was compared for the six months prior to, and six months post episode commencement date. Types of hospital use examined included ED presentations, unplanned and planned inpatient admissions, and the LOS for each of these.

The overall number of ED presentations for Cottage clients increased from 103 to 112 presentations; with a small decrease in the number of people presenting to the ED from 53 to 52 individuals.

Although there was an increase in total presentations, the overall length of ED presentation reduced from 6.0 to 5.7 hours. There was a slight increase in number of presentations per person observed for Cottage clients from 1.0 to 1.1 presentations per person over the whole sample, however this was not significant.

Overall the majority of clients arrived to ED via ambulance (56% pre, 36% post); the interpretive caveat is that use of ambulance can also be related to the time of presentation, as due to staffing at SVHM, any ED presentation after 4.30pm will usually require ambulance transport regardless of acuity due to staffing levels.

There was an observed decrease in the number of Cottage clients admitted to an inpatient unit as a result of an ED presentation (from 75 to 56 admissions) and an increase in the total days spent in an unplanned inpatient admission (from 472 to 506 days). This resulted in a decrease in the number of admissions per person from 0.7 pre to 0.5 post, however this was not significant. Of those who were admitted to an inpatient unit from ED, the majority were admitted to the emergency short stay unit (43% pre, 38% post).

There were no significant differences in Cottage client admission unit pre and post service involvement.

Comparing data six months pre to six months post Cottage episode start date, significant increases were observed in the number of outpatient appointments attended for Cottage clients (from 2.4 to 3.5, $p<0.05$) and ALERT/Cottage clients (from 1.1 to 5.6, $p<0.01$) (Figure 5).

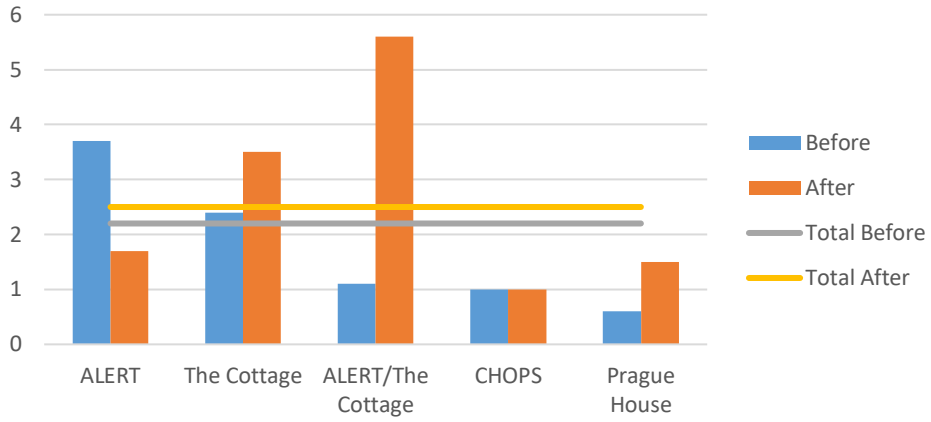

Figure 5: Number of Outpatient Appointments Attended 6 Months Pre/Post Episode Start Date

The increase in appointments was significant for ALERT/Cottage clients only ($p<0.01$). This finding is congruent other studies, which find that in the first year of housing and support provision, the use of some health services among formerly homeless clients actually increases as a result of previously unmet needs being addressed, with broader decreases in health system utilisation and costs in the second year of support as health issues were stabilised.

Housing outcomes

The majority of clients were discharged from emergency to what is referred to in hospital records as 'home/private accommodation/hostel' (76% pre, 73% post). Unfortunately however, this discharge classification is somewhat euphemistic, as it transpired that 'discharged to home' is also used for patients who are in fact being discharged without a home to go to.

This is a systemic flaw in the discharge destination data collected at Australian hospitals, whereby 'discharged to homelessness', or to 'no known address' is not routinely recorded. The average number of discharges to home/private accommodation/ hostel per person increased from 2.5 pre to 2.7 post.

As the core business of St Vincent's Melbourne is that of health care provider, it is particularly reliant on external organisations to assist client access to housing or other supports that are beyond the scope or expertise of the hospital's homeless health services.

Repeatedly, the quality and safety of some housing options is raised by Cottage clients as well as by St Vincent's Melbourne and external stakeholders. The inappropriateness of

many boarding houses was an important issue and difficulty encountered by staff and clients. While these problems are beyond the remit of St Vincent's Melbourne to address, they are critical issues impacting on the hospital's homeless patients and are a shared frustration by staff and external services.

In recent years, there are fewer external housing options available for St Vincent's Melbourne's homeless health clients. The hospital recognises that this is not an isolated issue, but a state-wide problem.

External housing options that are available to clients of The Cottage and other hospital services are not adequate given the complex needs of some patients.

Cost benefit analysis

The change in use of St Vincent's Hospital Melbourne services – comparing the six months prior to support commencing with the six months post – among The Cottage clients provided an average cost increase of $2,980/person/six months, predominantly due to an increase in planned inpatient admission days.

Among clients of both The Cottage and St Vincent's Melbourne's homelessness coordination service, ALERT, there was a small cost decrease of $3,529 per person over six months.

For clients supported by both ALERT and The Cottage, the decrease in unplanned inpatient costs is in part offset by an increase in planned inpatient costs and outpatient visits.

This reflects improved planning and management of health service use to address ongoing health issues. An initial increase in use of outpatient services has been observed in several other studies of changes in health service use among homeless people receiving support, in response to increased access to counselling for alcohol and other drugs or mental health.

From an overall health cost perspective, outpatient care is typically far cheaper than ED presentations or inpatient bed days, so the observed increase in outpatient costs should be seen in this light.

Appendix 2 – Best practice examples of homeless health services

Australia

Royal Perth Hospital

Royal Perth Hospital are establishing a Recovery Centre based on the Boston Medical service model (see below) to stabilise people medically, provide social support, housing and then provide after-hours outreach to support people once housed. The aim is to provide continuity of care with the same teams involved in the different aspects of care. Royal Perth argue this can save between $2 and $10 million on health, police and prison costs.

For more information see article, 'Hospital collaboration with a Housing First program to improve health outcomes for people experiencing homelessness' https://www.emeraldinsight.com/doi/full/10.1108/HCS-09-2018-0023

International

Boston Health Care for the Homeless (USA)

The integrated care model at Boston Health Care for the Homeless Program (BHCHP) unites a number of medical and other health care staff including physicians, nurse practitioners, nurses, case managers and behavioral health professionals. These staff work collaboratively with patients in a variety of settings - on the streets, at the Barbara McInnis House, in shelter-based clinics, in hospitals and in housing - providing regular contact and uninterrupted care.

Barbara McInnis House is a 104-bed medical respite facility. It provides short-term medical and recuperative services for homeless people who are too unwell for life in shelters or on the streets, but who are not sick enough to occupy a hospital bed. BHCHP provides respite care to increasingly acute patients who would otherwise have no place to go for pre- and post-operative care; for care while enduring chemotherapy and radiation therapy; for recuperation after an injury; and even for end-of-life care. The average length of stay is about two weeks and referrals come from virtually every hospital in the greater Boston area as well as directly from BCHCP clinicians.

The Stacy Kirkpatrick House is a step-down respite facility, hosting patients previously recovering from surgeries, long-term treatments, and other ailments at the Barbara McInnis House. The Stacy Kirkpatrick House offers 20 medical respite beds and is run by BHCHP nurses and operations staff. BHCHP's step down model allows for medically frail patients to transition from round-the-clock care at the Barbara McInnis House to low-risk care at the Stacy Kirkpatrick House, and finally to long term housing facilitated by our case managers on staff. This respite centre is also home to multi-disciplinary outreach teams including a medical specialist, and a targeted outpatient clinic for homeless people.

https://www.bhchp.org/

St Mungo's (UK)

St Mungo's in the UK (like Sacred Heart, Wesley Mission and Micah in Australia) are a homeless charity, and therefore much closer to a housing service rather than a health service. They provide a range of services for homeless clients including accommodation, health services, outreach services, offender services, training and employment services, recovery services and care services. Different people need different forms of accommodation, so they have a variety of property options to refer to. It is often very hard to address any health or other social issues until housing is secured.

St Mungo's operate a range of accommodation services, from basic emergency shelters or hostels, through to supported and semi-independent housing, to help people at every stage of their recovery from homelessness through to supporting them to find a detox placement, semi-independent accommodation or a private rented home.

St Mungo's take a Housing First approach which flips the traditional model on its head – instead of focusing on recovery first then finding independent accommodation, Housing First offers the security of having a home, which can boost people's motivation and enable them to focus on their recovery. They welcome dogs in their accommodation settings, which is hugely important for homeless people. St Mungo's also operate as a regular housing association so they can easily transition people into long-term accommodation. They provide an outreach health service similar to ALERT at SVHM taking supporting people to access health care and have a focus on mental health. They also employ peer workers and focus on provision of Palliative Care that is a key need in the Australian setting.

https://www.mungos.org/

St. Michael's Hospital (Canada)

St Michael's in Toronto, Canada, has a Centre for Urban Health Solutions that drives research on the health effects of health inequality, including homelessness. They see themselves as international leaders in the care of homeless people. Like many others, they have participated in studies that showed the benefits of placing homeless people in housing as the crucial first step to reintegration. They were also the first hospital in the world to name a research Chair in Homelessness, Housing and Health.

The Emergency Department is the front door to the inner city, with one in five patients being homeless. One third of their psychiatric patients are homeless – three times the Toronto hospital average. They report to have pioneered a series of innovations to help homeless people, including shelter programs, outreach teams and a coordinated care program.

https://maphealth.ca/