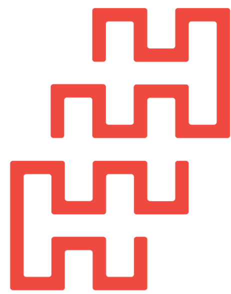

Australian Health, Housing & Homelessness Network

Ending Homelessness Through Inclusive Healthcare

Position Paper

December 2023

Acknowledgement of Country

The Australian Alliance to End Homelessness would like to acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the land on which we work. We recognise their ongoing connection to the land, and pay our respects to Elders past, present and emerging. We recognise that Aboriginal and Torres Strait Islander peoples are more likely to experience adverse health outcomes, housing insecurity, and homelessness compared to non-Aboriginal populations. We support the need for a healthier future that intertwines the wellbeing of Aboriginal and Torres Strait Islander peoples and the land, particularly concerning health, housing and homelessness throughout the country.

The Australian Alliance to End Homelessness gratefully acknowledges the exceptional and comprehensive work of Dr Jane Currie in writing this paper, along with all Australian Housing, Health and Homelessness Network members involved in its production. We would also like to acknowledge the notable work of Kirby Smith in editing and finalising this paper. FInally, we would like to thank each of the signatories for continuing to support our work.

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Recommended citation:

Australian Alliance to End Homelessness 2023, *Ending Homelessness Through Inclusive Healthcare: Position Paper*, Adelaide, South Australia

2023 AAEH

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About the Australian Health, Housing & Homelessness Network

Purpose

The Australian Health, Housing & Homelessness Network (A3HN) was established to bring together leaders from across the health, housing and homelessness sectors to better integrate policy, research and practice, aimed at supporting a health-informed end to homelessness in Australia.

Who is involved in the Network?

A broad range of stakeholders and leaders across the health, housing and homelessness sectors from all levels of health, including public, primary, secondary and tertiary, as well as mental health and alcohol and other drugs.

Coordinated by the Australian Alliance to End Homelessness (AAEH), the network was formed to ensure the health-informed implementation of the Advance to Zero (AtoZ) campaign, which seeks to end all homelessness in Australia starting with rough sleeping, one community at a time.

Through the use of a national forum, the A3HN pioneers the development of policy, furthers research and enhances practice. It enables members to share knowledge, guidelines and models of care, as well as coordinate national advocacy efforts together.

By uniting three key sectors, the network is well-placed to support those addressing the health and housing needs of people experiencing homelessness in Australia.

The opportunities for engaging with the A3HN include quarterly online meetings, a workshop at the biennial AtoZ Summit as well as the occasional online forum.

To learn more and get involved, visit aaeh.org.au/a3hn.

Foreword

> *'Visiting a GP is not a priority for people when we are sleeping rough as we are too busy managing safety, food and sleep – we are too exhausted and don't have enough [phone] credit to make appointments.'*

This was just one of the many comments we heard when the Surviving the Streets researchers, a codesign project to develop a resource to assist people to stay safe on the streets, surveyed people with present or past experiences of sleeping rough in Melbourne in 2019.[1,2] By shining a light on the human experience of homelessness, we heard how sleeping rough has an enormous impact on their health and wellbeing. A lack of quality sleep was the largest contributor to mood, physical and mental health, judgement and decision-making, and ability to get along with other people in the community. Poor sleep quality accumulates alongside other harmful impacts of homelessness including fatigue, anxiety, being run down, exacerbation of physical and mental health conditions and being more vulnerable to colds and viruses.

Challenges in accessing primary care and preventive health services result in people experiencing homelessness presenting more frequently to emergency departments to obtain treatment. Without sufficient early intervention, they can also have delays in the diagnosis of diseases, poor control of manageable conditions (e.g., diabetes, respiratory conditions) and an increased likelihood of developing chronic illnesses. Consequently, treatment is often provided at more advanced stages of disease or when they already have multiple comorbidities, which leads to higher rates of admissions and longer stays in hospital. Re-admissions to acute health services are also common, as all too often, healthcare providers have to send people back into the conditions that are adversely impacting their health. Not only are these health interventions costly and unsustainable, they do not adequately address the complex health and social needs of those experiencing homelessness. Raising awareness of these health impacts of homelessness, and sharing approaches to addressing them, is vital if we are to reduce the toll on people's health.

The A3HN brings together leaders from across the health, housing and homelessness sectors to better integrate policy, research and practice aimed at supporting a health-informed end to homelessness in Australia. We recognise the catalytic role these sectors have by working together and shifting us beyond awareness-raising activities to collective action. This cross-sector collaboration will enable us to achieve better health outcomes for those experiencing homelessness and move us closer towards our common goal: to make homelessness rare, brief and once-off.

The Ending Homelessness Through Inclusive Healthcare Position Paper, developed by the A3HN, describes the significantly poorer health of people who experience homelessness and the action required to tackle this complex problem so we can improve health and accelerate efforts to end homelessness across Australia.

Homelessness is a *health emergency* and is entirely *preventable*.

Lisa McKenzie
Co-Chair, A3HN
Vice President, Asia Pacific Institute for Healthcare Improvement

Nicole Bartholomeusz
Co-Chair, A3HN
CEO, cohealth

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[1] cohealth 2019. Rough Sleeping Harm Minimisation Project (2019): Surviving the Streets Survey. see *Parity Magazine* 2020 vol. 33, no.2, pp. 17-9.

[2] Mullins RM, Kelly BE, Chiappalone P, Lewis VJ 2021. 'No-one has listened to anything I've got to say before': Co-design with people who are sleeping rough. *Health Expectations* vol. 24, no. 3, pp. 930-9. https://doi.org/10.1111/hex.13235

Executive Summary

In 2019, the AAEH called a health equity forum, drawing together experts in homelessness from policy, health and housing services, and academia. This forum led to the establishment of the A3HN and the first Position Paper, published in 2020. The Paper was revisited at the Australian Zero Homelessness Summit in October 2022, at which A3HN members discussed the most pressing issues to ensure inclusive healthcare for people experiencing homelessness. Such issues include the exigent need for responsive changes in policy, the critical absence of real-time data to measure the true extent of homelessness in Australia, and the need to enhance local capacities across the health, housing, and homelessness sectors. This updated Position Paper details the strategic direction supported by the A3HN to improve health outcomes for people experiencing homelessness in Australia.

Experiencing homelessness brings with it a serious and detrimental impact on health and is known to reduce life expectancy by up to 30 years.[3-5] Through the work of the communities involved in the AtoZ Campaign and the A3HN, we have estimated that approximately 424 people die in Australia each year whilst experiencing homelessness.[4] This number is likely to be a significant underestimate as there are no national systems in place to measure data regarding homeless deaths. International evidence reports as many as one in three deaths while homeless were attributable to conditions that could have been prevented or treated.[5]

Despite living in the 'lucky country', one with a high average income and a well-established social welfare system, the experience of homelessness strips many people's ability to access even the basic health services they need to achieve wellbeing. As a key social determinant of health, experiencing homelessness has a profound negative effect on one's wellbeing, including, but not limited to, mental ill-health, poor oral health, skin and respiratory issues, and interrelated alcohol and other drug use.[2] In addition, a lack of available health services for people experiencing homelessness leads to many of these Australians remaining vulnerable to poor health outcomes.[11]

Throughout Australia, there are a number of best practice initiatives that employ successful strategies to increase access to healthcare and improve health outcomes for vulnerable Australians. Examples include outreach health care, specialist homelessness primary care, dedicated hospital homeless teams, multidisciplinary outreach services, Housing First approaches, and organisational partnerships. These initiatives demonstrate comprehensive, collaborative, and integrated approaches to homelessness health responses in Australia, and can help pave the way forward for similar efforts across the country.

> *"The test of our progress is not whether we add more to the abundance of those who have much, it is whether we provide enough for those who have too little."*
>
> – Franklin D Roosevelt

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[3] Wood L, and Vallesi S 2021. Deaths Among People Experiencing Homelessness: Each One, a Life. *Parity Magazine* vol. 34, no.7, pp. 31-4.
https://api.research-repository.uwa.edu.au/ws/portalfiles/portal/151048386/Deaths_among_homeless_Each_one_a_life.pdf

[4] Pearson D, Vallesi S, and Wood L 2021. Dying homeless in Australia: we must measure it better. *Parity Magazine* vol. 34, no.7, pp. 13-5.
https://api.research-repository.uwa.edu.au/ws/portalfiles/portal/151048454/Dying_Homeless_in_Australia.pdf

[5] Aldridge RW, Menezes D, Lewer D, Cornes M, Evans H, Blackburn RM, Byng R, Clark M, Denaxas S, Fuller J, Hewett N, Kilmister A, Luchenski S, Manthorpe J, McKee M, Neale J, Story A, Tinelli M, Whiteford M, Wurie F, and Hayward A 2019. Causes of death among homeless people: a population-based cross sectional study of linked hospitalisation and mortality data in England, Wellcome Open Research vol. 4, no. 49. https://doi.org/10.12688/wellcomeopenres.15151.1

Recommendations

On October 28th 2022, at the Australian Zero Homelessness Summit convened by the AAEH, members of the A3HN gathered to discuss the key priorities in resolving the inequity in health access for people experiencing homelessness across Australia. The Summit strongly supported the following recommendations:

Recommendation 1: Funding stream

Establish a dedicated ongoing block funding stream through Primary Health Networks (PHNs) to better address the urgent healthcare needs of people experiencing homelessness, incorporating existing funding programs and growing funding for new initiatives to better meet demand.

We believe that this homelessness health equity funding stream should:

- ➔ be provided with maximum flexibility to fill the medical and outreach service gaps in local communities and to respond to the unique health needs of the people experiencing homelessness.
- ➔ consider how best to widen Medicare policy settings to allow a broader range of medical practitioners to bill for street-based and outreach consultations, but also ensure these services are integrated into community-wide efforts to end homelessness through PHNs.
- ➔ ensure existing funding arrangements between PHNs and health and homelessness services provide more funding certainty with a baseline commitment for a five-year period, rather than the short-term, ad hoc funding arrangements that so many are subject to. This will give services the certainty they need to operate with the greatest effectiveness.
- ➔ enable better linkages and service coordination with the alcohol and other drugs sector, the mental health sector, the National Disability Insurance Scheme, settlement services, and others.
- ➔ provide funding to operate the A3HN, which brings together these sectors to build capacity and understanding regarding evidence-based practice and programs, provide policy advice, problem-solve, and support the efforts of communities seeking to address the health inequities faced by people experiencing homelessness – particularly through the AtoZ Campaign.

Recommendation 2: Working group

Establish a Department of Health and Aged Care working group with PHNs and community health and homelessness sector representatives to consider how to better meet the health needs of people experiencing homelessness within new and existing Commonwealth policy frameworks – including the National Housing and Homelessness Plan.

The Working Group should:

- ➔ develop a framework for how PHNs can better meet the needs of people experiencing homelessness and bring together existing evidence-based practices in Australian and international contexts.
- ➔ consider how to establish screening of homelessness in health services as a step towards developing a no-exit-to-homelessness policy.

- support the development of a nationally consistent homelessness deaths and life expectancy gap data reporting framework.

The AAEH is in discussions with the Department of Health regarding funding to support the implementation of these recommendations and the operations of the A3HN more broadly.

Key insights from the A3HN at the Australian Zero Homelessness Summit

The discussions at the 2022 Summit focused on building capacity to provide sustainable solutions to improve access to healthcare and health outcomes for people experiencing homelessness in Australia. The A3HN members provided multiple examples of best practices (see Page 12) that illustrated opportunities to strengthen service provision and facilitate cost savings while improving access to healthcare.

Policy, data, and capacity were the three key themes discussed by A3HN members at the Summit. Of most urgency was the stated need for a national working group that considers how better to meet the health needs of people experiencing homelessness within new and existing Commonwealth policy frameworks, including the National Housing and Homelessness Plan. Members stated, *“Policy is the driver…we need to have a policy framework in place”.*

Such a working group would identify the requirement for health systems to incorporate principles of health equity at all system levels to ensure that the social determinants of health are addressed, using both a preventive and responsive approach that spans community and hospital-based care. Members identified the strong link between policy and resources, stating: *“… if policy doesn’t have commitment and resources behind it, it becomes unsustainable and falls apart. [There needs to be] agreement between the State and Commonwealth”.*

A3HN members highlighted the critical absence of contemporaneous (or real-time) data that identifies the number of people experiencing homelessness in Australia. Members stated the requirement for *“…standardised approaches to [collecting real-time] data, [is important for] making homelessness visible.”* Discussions included the challenge of responding to homelessness when its full impact is not measured in real-time, and that the different types of homelessness, such as street sleeping and living in crisis accommodation, can be difficult to identify without proactive screening processes in place. Members recommended establishing *“data systems flagging homelessness at different points of entry: hospitals, prison, community/other and Centrelink.”*

Models of care with proven success in improving access to health services were also discussed. Examples, discussed in detail on Page 12, included multidisciplinary community teams that provide assertive outreach to people experiencing homelessness and connect them with health services and coordinate care thereafter. Hospital in-reach teams that comprise specialist multidisciplinary homeless health teams of medical practitioners were also identified: *“Specialised homelessness services and specialised collaborations between the health sector and homelessness sector, creating multidisciplinary teams”.*

Although these models had proven successful, their funding was often precarious.

Health funding models were discussed with a view to improving access to integrated healthcare responses, such as block funding through PHNs and funding for nurse-led models of care and for GPs. The current Medicare Benefits Schedule (MBS) was reportedly inadequate in terms of the items available to eligible health professionals and insufficient rebates to sustain ongoing services. Other challenges included the integration of new models of care with mainstream health services and access to health records.

Also discussed was the need to optimise health professionals’ scope of practice, particularly nurses, to improve access to care for people experiencing homelessness. *“Optimising the health workforce for improved access: knowledge sharing, integration across a range of health services, cultural services…”.*

What do we know about the scale of the health problem?

As one of the social determinants of health, access to stable accommodation has a profound impact on health and wellbeing.[6] The evidence linking homelessness and unstable accommodation with health outcomes is compelling. A 15-year retrospective longitudinal cohort study in Australia reported that at least one episode of any level of homelessness was associated with premature mortality.[7] Homeless individuals had a younger median age of death (66.60 vs. 78.19 years) and significantly increased mortality risk ratios compared to the non-homeless individuals.[7]

Living on the streets or in unstable accommodation places people at greater risk of accidental injury and violence, musculoskeletal, skin and respiratory problems, poor oral health, drug and alcohol use and exacerbates mental health issues.[2] A 16-year longitudinal cohort study in Australia reported that people at risk of homelessness in marginal housing situations also have an increased risk of mortality.[8] Another longitudinal (2011-2014) Australian study identified that episodes of depression increase the likelihood of a person experiencing homelessness.[9]

A consolidated report of Registry Week homelessness data in Australian cities identified extremely high rates of mental health conditions.[10] Registry Week seeks to develop a register of people who are homeless in areas in which homelessness services operate. Almost half of Registry Week respondents reported speaking with a mental health professional in the past 6 months, 29.8% had been taken to hospital against their will for mental health conditions, and 36.9% had attended emergency departments because they did not feel emotionally well. [10]

Between 2020-21, services to alleviate and/or reduce the health and social effects of homelessness were provided to at least 91,300 people per month across the country, representing an increase of 8% on the previous four years – according to available data.[11] The fastest growing groups of service users are First Nations people (+23%), people with mental ill-health (+20%), and women aged over 50 years (+19%).[11] Many available services are overwhelmed by the demand placed on them. In 2021-22, for example, on any given day across Australia, 290 requests for mental health, accommodation, and other supports simply could not be met.[12] Unless urgent action is taken to improve the accessibility of health services, some of our most vulnerable Australians will continue to suffer poor health outcomes, leading to premature death.

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[6] Rolfe S, Garnham L, Godwin J, Anderson I, Seaman P, and Donaldson C 2020. Housing as a social determinant of health and wellbeing: developing an empirically-informed realist theoretical framework'. *BMC Public Health* vol. 20, no. 1, 1138. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-09224-0

[7] Seastres RJ, Hutton J, Zordan R, Moore, G, Mackelprang J, Kiburg KV, Sundararajan V 2020. Long-Term effects of homelessness on mortality: a 15-year Australian cohort study. *Aust N Z J Public Health* vol. 44, no. 6, pp. 76–81. https://pubmed.ncbi.nlm.nih.gov/32955766/

[8] Zordan R, Mackelprang JL, Hutton J, Moore G, and Sundararajan V 2023. Premature mortality 16 years after emergency department presentation among homeless and at risk of homelessness adults: a retrospective longitudinal cohort study. International Journal of Epidemiology vol. 52, no. 2, pp. 501-511. doi: 10.1093/ije/dyad006.

[9] Moschion, J, and van Ours, JC 2021. Do transitions in and out of homelessness relate to mental health episodes? A longitudinal analysis in an extremely disadvantaged population. *Social Science & Medicine* vol. 279. https://doi.rg/10.1016/j.socsimed.2020.113667

[10] Flatau P, Tyson K, Callis Z, Seivwright A, Box E, Rouhani L, Ng SW, Lester N, and Firth D 2018. *The State of Homelessness in Australia's Cities: A Health and Social Cost Too High*. University Western Australia, Perth. https://research-repository.uwa.edu.au/en/publications/the-state-of-homelessness-in-australias-cities-a-health-and-socia

[11] Pawson H, Clarke A, Parsell C, and Hartley C 2022. Australian Homelessness Monitor 2022. *Launch Housing*, Collingwood. https://espace.library.uq.edu.au/view/UQ:b1aa39b

[12] Australian Institute of Health and Welfare 2022. *Specialist Homelessness Services Annual Report 2021-22.* https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/about

Despite the impact of homelessness on health and wellbeing, homelessness is seldom cited in health policy.

"Illness makes you sick. It shouldn't make you homeless, but too often it does."

Definition of homelessness

The Australian Bureau of Statistics' (ABS) definition of homelessness describes a person as homeless if they do not have suitable accommodation and live in an inadequate dwelling, have no or limited/non-extendable tenure, and have no control of/no access to (or space) for social relations.[13] In addition, the Australian Institute of Health and Welfare defines a person as homeless if they are living in either non-conventional accommodation, sleeping rough, or living in short-term or emergency accommodation due to a lack of other options, such as living temporarily with friends and relatives.[14]

Homelessness is also defined as an umbrella term used to describe four broad population groups: 1) Rough sleeping; 2) Supported accommodations (e.g. refuges and crisis accommodation); 3) Short-term accommodation without tenure (e.g. boarding houses, hostel, caravan, couch surfing); and 4) Accommodation in institutional settings (e.g. hospitals, drug and alcohol rehabilitation centres, jail). Of those experiencing homelessness, 7% are rough sleeping, which means 93% experience less visible forms of homelessness, such as couch surfing (sleeping on a sofa at a friend/relative's), living in overcrowded dwellings, or a hostel.[10]

Identifying these less obvious forms of homelessness requires proactive data collection through screening for homelessness. Given the impact of housing on a person's health and wellbeing, it is critical that mandatory screening for homelessness is established when people access health services.

Homelessness deaths

Homelessness has profound and lasting consequences. In Australia, an estimated 424 people who have experienced at least one episode of homelessness die each year.[4] The invisibility of homelessness in existing data means that we can only estimate the number of people who die each year in Australia who have experienced homelessness. A Perth-based project has documented deaths amongst those experiencing homelessness since 2017.[4] In 2020, there were 56 deaths among individuals who experienced homelessness in Perth; the average age of death was 47 years, over 30 years lower than the current life expectancy of 83 years.[4]

Mandatory screening for homelessness when attending health services would greatly improve the visibility of homelessness in data. To ensure the full impact of homelessness on health is identified, the A3HN recommends that a national homelessness deaths and life expectancy gap reporting framework be developed. The intent of such a framework would be to improve the accuracy of the data capture of deaths while homeless to inform models of care that improve access to healthcare and health outcomes for this vulnerable population.

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[13] Australian Bureau of Statistics 2012. *Information Paper – A Statistical Definition of Homelessness.* https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4922.0Main%20Features22012?opendocument&tabname=Summary&prodno=4922.0&issue=2012&num=&view=

[14] Australian Institute of Health and Welfare 2021. *Homelessness and homelessness services Glossary.* https://www.aihw.gov.au/reports-data/australias-welfare/australias-welfare-snapshots/glossary

Access to healthcare

Despite experiencing substantial health issues, people experiencing homelessness are less likely to access preventive or primary health services, compared to those living in stable accommodation. People experiencing homelessness avoid mainstream health care, particularly GP and primary care, due to previous negative experiences, shame, anticipated stigma, competing priorities for basic needs, and issues relating to affordability/accessibility (e.g., cost of transport to attend appointments, no means of appointment reminders due to lost phones etc.).[14] Instead, this vulnerable population is more likely to seek healthcare from a hospital emergency department, often at a later stage of ill health.[15] People who are rough sleeping are more likely to use ambulance and emergency department services compared to other forms of homelessness.[10] When attending an emergency department, they often wait longer to receive care,[16] are more likely to discharge against medical advice or leave before being seen by a health professional, and are more likely to re-present at a later time, often more unwell.[17,18] A recent study undertaken in Melbourne reported that 43% of people experiencing homelessness re-presented to the same emergency department within 28 days of their initial assessment.[16]

If admitted to hospital, people experiencing homelessness are likely to have a longer length of stay compared to those in stable housing.[13] This limited access to primary healthcare can result in costly hospital admissions and the development of chronic illness.[12,13] Optimising health service response to people experiencing homelessness is critical in improving their health outcomes and maximising the use of the health dollar.

Access to the MBS is an ongoing challenge for health professionals who provide care to people experiencing homelessness in the community, such as in clinics, refuges, or on the street. Many homeless health services are nurse-led.[19] Nurse practitioners and registered nurses have extremely limited access to the MBS, which impedes their capacity to work to the full scope of their practice, and therefore reduces their impact on improving access to care and health outcomes.[20] For example, nurse practitioners are eligible to provide a very limited number of MBS-subsidised investigative items, which often increases their referrals to medical practitioners to complete the episodes of care. Nurses' broader access to MBS-subsidised services would greatly enhance their capacity to improve access to care for people experiencing homelessness, who rely on universal healthcare.

Similarly, the level of MBS rebate for care provided by health professionals, particularly psychologists, counsellors, and GPs, is regularly cited as an impediment to providing bulk-billed care. The 2021-22 Patient Experiences Survey outlined an increase in the proportion of people who reported that cost was a reason for delaying or not using a dental or medical specialist.[21] A recent narrative review stated that the current fee-for-service model of the MBS makes the integration and coordination of multidisciplinary care difficult, and is

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[15] Davies A and Wood LJ 2018. Homeless health care: meeting the challenges of providing primary care. *Medical Journal of Australia* vol. 209, no. 5, pp. 230–4. doi: 10.5694/mja17.01264

[16] Ayala A, Tegtmeyer K, Atassi G, and Powell E 2021. The effect of homelessness on patient wait times in the emergency department. *Journal of Emergency Medicine* vol. 60, no. 5 , pp. 661–8. doi: 10.1016/j.jemermed.2020.12.031

[17] Lee S, Thomas P, Newnham H, Freidin JM, Smith C, Lowthian J, Borghmans F, Gocentas RA, De Silva D, and Stafrace S 2019. Homeless status documentation at a metropolitan hospital emergency department. *Emergency Medicine Australasia* vol. 31, no. 4, pp. 639-45. doi: 10.1111/1742-6723.13256

[18] Moore G, Gerdtz MF, Hepworth G, and Manias E 2011. Homelessness: patterns of emergency department use and risk factors for re-presentation. *Emergency Medicine Journal* vol. 28, no. 5, pp. 422-7. doi: 10.1136/emj.2009.087239

[19] McWilliams L, Paisi M, Middleton S, Shawe J, Thornton A, Larkin M, Taylor J, and Currie J 2022. Scoping review: Scope of practice of nurse-led services and access to care for people experiencing homelessness. *Journal of Advanced Nursing* vol. 78, no. 11, pp. 3587-3606. https://pubmed.ncbi.nlm.nih.gov/35894221/

[20] Currie J, Chiarella M and Buckley T 2019. Privately practising nurse practitioners' provision of care subsidised through the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme in Australia: Results from a national survey. *Australian Health Review* vol. 43, no. 1, pp. 55-61. doi: 10.1071/AH17130

[21] Australian Bureau of Statistics 2022. *Patient Experiences.* https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release

therefore problematic for those with complex chronic illness.[22] The authors propose that fee-for-service be replaced by funding systems that reduce fragmentation and improve whole system integration, such as block funding and outcomes-based funding.[22] The A3HN supports the review and revision of existing MBS items to ensure the sustainability of homeless health models of care that improve access and health outcomes.

There are additional concerns for the health of people experiencing homelessness who are non-residents, given their ineligibility for Medicare-funded healthcare. It is estimated around 20% of people sleeping rough every night in inner-city Sydney are not permanent residents as per Sydney Non-Resident Case Coordination Group data. Ensuring they have access to equitable healthcare – as well as other crisis support services – is a critical issue to address.

How many people are experiencing homelessness in Australia?

The number of people using homelessness services to access health and housing support has increased by 8% in the past four years.[4] The most recent 2021 national Census statistics reported that 122,494 people were experiencing homelessness in Australia.[23] Homelessness appears most prevalently in our larger cities. For example, the bi-annual City of Sydney street count (2021) reported 272 people sleeping on the streets in the Sydney Local Government Area and 288 people sleeping in crisis and temporary accommodation.[24] Aboriginal and Torres Strait Islander peoples are 3.8% of Australia's population, yet are grossly overrepresented in the number of people considered homeless in Australia at 20.4% of all persons who were homeless on Census night in 2021.[25]

Current methods of data collection are inadequate in detailing the scale of the problem around homelessness and access to healthcare because they are not designed to maximise touchpoints with those experiencing homelessness in real-time. Subsequently, available data leads us to believe the breadth and depth of the problem is significantly unrealised. While we know homelessness is prevalent across all states and territories, the full impact of the problem is unclear. One of the most reliable sources of data is the 5-yearly census – a lag indicator that cannot inform responsive and proactive support. What is required is contemporaneous data that enables identification of the presence of homelessness. This data can then be used to inform the response to the health needs associated with homelessness.

Community-based non-government organisations and charities have attempted to address the absence of contemporaneous data by undertaking their own street counts, and by establishing databases that seek to monitor levels of homelessness in real time. One example is the By-Name List, a database used by the AAEH AtoZ Campaign and the End Street Sleeping Collaboration in New South Wales. The By-Name List is populated by screening people experiencing homelessness through the Vulnerability Index-Service Prioritisation Decision Assistance Tool (VI-SPDAT). Other attempts to enumerate the scale of the problem are national reports using data gathered through face-to-face surveys with people experiencing homelessness during street count Registry Weeks across Australia. Professor Paul Flatau produced a national report entitled *'The State of Homelessness in Australia's Cities: A Health and Social Cost Too High'*, commissioned by the AAEH, which comprised interviews with over 8,000 people sleeping rough or otherwise homeless, collected across Australia between 2010-2017.[10]

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[22] Angeles, MR, Crosland P and Hensher, M 2023. Challenges for Medicare and universal health care in Australia since 2000. *Medical Journal Australia* vol. 218, no. 7, pp. 322-329. https://doi.org/10.5694/mja2.51844
[23] Australian Bureau of Statistics 2023. *Census Population and Housing: Estimating Homelessness*. (Cat. no. 2049.0). https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release#data-downloads
[24] NSW Government Department of Communities & Justice 2021. *NSW Statewide Street Count 2021 Technical Paper*. https://www.facs.nsw.gov.au/__data/assets/pdf_file/0003/808428/Technical-paper-NSW-Statewide-Street-Count-2021.pdf
[25] Pawson H, Parsell C, Liu E, Hartley C, and Thompson S 2020. *Australian Homelessness Monitor 2020*. Launch Housing. https://apo.org.au/node/308929

Impact of COVID-19 on homelessness

Establishing social distancing and isolation for people experiencing homelessness during the COVID-19 pandemic was challenging and highlighted the pressing need to prioritise accessible and available options to address homelessness. Australian jurisdictions responded proactively during the pandemic and housed up to 33,000 rough sleepers in hotels and other forms of temporary accommodation.[25] This response involved rapid and effective collaboration between governments, agencies, and others to fund and support accommodation and wrap-around services in our major cities, with positive impacts on health and often pathways to long-term and supported accommodation.

Now that pandemic measures have eased, and the economic impacts of the pandemic are being realised, a rise in homelessness is predicted. There is an opportunity to reinvigorate and build on the approach taken during the COVID-19 pandemic for sustainable impact on the health and lives of people experiencing homelessness.

An example of service innovation following COVID-19 responses is the COVID Isolation and Recovery Facility (CIRF) established at Sumner House during the COVID-19 pandemic by St Vincent's Hospital Melbourne, Launch Housing and The Brotherhood of St Laurence. The service initially provided a safe and secure place for people experiencing homelessness to isolate while they had COVID-19. This model has now been extended to become the *Better Health and Housing Program*, with support from an additional partner, Homes Victoria. This ground-breaking model is a residential-based integrated health and homelessness service for people who are experiencing chronic homelessness and poor health. Participants are supported over a period of three to six months, with staff working closely with them to address resident-identified goals related to their health, housing and broader life domains.

In Australia, women experiencing domestic and family violence are a leading cause of homelessness. There was concern that the social isolation, social distancing and recurrent lockdowns associated with the pandemic would intensify domestic and family violence. Many women reported that violence had increased during COVID-19.[26] The Australian Institute of Health and Welfare reported that one in ten women had experienced physical violence from their partner since the beginning of the pandemic, and one in four who had experienced physical or sexual violence in the 12 months since the start of the pandemic reported being unable to seek assistance on at least one occasion due to safety concerns.[26] Of those accessing homelessness services between 2021-22, 27% had experienced domestic and family violence. [12]

With the growing number of people experiencing homelessness in Australia, the urgency to address health outcomes associated with homelessness has never been greater.

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[26] Australian Institute of Health and Welfare 2021. *Family, domestic and sexual violence service responses in the time of COVID-19.*
https://www.aihw.gov.au/reports/domestic-violence/family-domestic-and-sexual-violence-service-respon/summary

What we know works: Examples of best practice health-led responses to homelessness throughout the A3HN

The A3HN have summarised examples of best practices to highlight successful strategies to improve access to healthcare and health outcomes for people experiencing homelessness.

Due to the varying and complex needs of individuals experiencing homelessness, a comprehensive health response to homelessness across a variety of settings, underpinned by integration and collaboration, is critical. Siloed health services and models of care do not work well for this population group, because:

- ➔ The health needs of people experiencing homelessness are often multiple and complex;
- ➔ Contacting and navigating health services is often overwhelming or impeded by practical barriers (such as access to and cost of transport or not having a phone or address to be reminded of appointments);
- ➔ There may be a low level of trust of health services (and government agencies) because of past negative experiences (or people are excluded from services due to criteria or after having multiple missed attendances);
- ➔ Trauma is pervasive, both from experiences prior to homelessness and while experiencing homelessness; and
- ➔ The transient nature of homelessness makes comprehensive medical care difficult. Services need to be available in a multitude of settings and provide numerous touchpoints for people to feel safe and supported in accessing care wherever they are.

Advance to Zero (AtoZ) Campaign

The AtoZ Campaign is a ground-breaking national initiative of the AAEH that supports local collaborative community efforts to end homelessness, starting with rough sleeping – one community at a time. The AAEH supports communities participating in the Campaign through a series of six-monthly improvement cycles, where communities work together, build capacity and share knowledge, tools and lessons.

Nurse-led Outreach Health Care

Homeless to Home Healthcare After-Hours Service is a nurse-led outreach and healthcare service in Brisbane. An economic model of this service estimated the annual net social benefit was between $12.61m to $13.06m in terms of improvements in health-related quality of life.[27]

Wound care treatment accounts for a substantial proportion of hospital admissions and presentations to emergency departments for people experiencing homelessness. During the COVID-19 pandemic, a nurse-led outreach community wound care service for people experiencing homelessness was established in Brisbane.[28] A cost-benefit analysis reported the 726 nurse interactions cost $50,273. Based on the cost of a non-admitted patient, the

[27] Connelly L 2013. *An economic evaluation of the homeless to home healthcare after-hours service*. Micah Projects, Brisbane.
https://micahprojects.org.au/assets/docs/Publications/IR_130_An-Economic-Evaluation-of-the-Homeless-to-Home-Healthcare-After-Hours-Service.pdf

[28] Downes M 2021. *Wound Care Services: Report to Micah Projects on the cost of providing wound care services to people who are homeless*. Micah Projects, Brisbane.
https://d2yuko1qrktt9v.cloudfront.net/live/docs/202108-Wound-Care-Report.pdf

expected cost of providing this care through a hospital system (emergency or outpatient departments) was reported as $284,592. Therefore, this nurse-led service achieved a cost saving of approximately $234,000.[28]

Specialist Homelessness Primary Care and Multidisciplinary Services

Australia has a growing number of specialist health services working with people experiencing homelessness. While they vary in the settings they work in, common elements include a trauma-informed ethos, reducing barriers to accessibility and multidisciplinary care.

Australia's largest specialist homelessness primary care provider for people experiencing homelessness is Homeless Healthcare (HHC), a not-for-profit organisation established in 2008 to improve the health of people experiencing homelessness and marginalisation in Perth, Western Australia. The HHC ethos and model of care is based on the premise that safe, secure housing is fundamental for health, and that the social determinants of health need to be addressed concurrently with healthcare. In 2021/22, HHC provided over 33,000 consultations in the community at a variety of locations including mobile clinics, drop-in centres, transitional accommodation facilities, and street outreach.[29] In a 2022 evaluation of HHC, among a cohort of patients with three years follow up hospital data, there was a 48% reduction in hospital costs, equating to a cost reduction associated with fewer emergency department and inpatient admissions of almost $11,000 per patient.[30] The annual operating cost per patient of HHC's Hub services is by contrast only $831 per patient for an entire year, which is 3.3 times cheaper than a single bed day in a WA public hospital. A Productivity Commission report on innovations in care for chronic health conditions refers to HHC as an effective example improving access to primary care via street outreach and clinics embedded in homelessness services.[31]

Toward Home Wellbeing, part of the Toward Home Alliance in Adelaide, is a multidisciplinary team of care coordinators, mental health practitioners, peer practitioners with lived experience, and a registered nurse. Toward Home Wellbeing improves health and wellbeing outcomes for people experiencing homelessness by providing mental health and nursing care, and facilitating access and engagement to mainstream and specialist health services. Once housed, the Toward Home Wellbeing team continues to support people to maintain their housing, and health and wellbeing.[32]

Melbourne-based cohealth aims to improve the health and wellbeing of communities by addressing health and social inequity. The community health team provides support to individuals and families, offering a broad range of wrap-around services to address health and social needs that may start with providing access to material aid, luggage storage, a shower or laundry. Services include both primary care and specialist services, such as homeless outreach mental health services, outreach alcohol and other drug support, mobile clinical services (e.g. GP, Hep C vaccinations, COVID-19 testing), access to dental care, medical practitioners, nurses and allied health professionals such as counsellors, social workers, dietitians, podiatrists and physiotherapists, and homelessness support services. Partnering provides ready access to other supports such as housing, legal, financial, and family violence counselling in a hub-style service in the CBD. cohealth works in the social model of health and also provides social inclusion activities, including recreational sport and arts activities, and

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[29] Homeless Healthcare 2022. *Homeless Healthcare.* www.homelesshealthcare.org.au.

[30] Tuson M, Wood L, Wood I, Vallesi S 2022. *The Homeless Healthcare Hub: Evaluation Snapshot, August 2022*. Institute for Health Research, UNDA.
https://api.research-repository.uwa.edu.au/ws/portalfiles/portal/193666269/Hub_evaluation_report_final.pdf

[31] Productivity Commission 2021. *Innovations in Care for Chronic Health Conditions*.
https://www.pc.gov.au/research/completed/chronic-care-innovations/chronic-care-innovations.pdf

[32] Sonder Better Care Better Health 2022. *Strategic Plan (2022-2027).*
https://sonder.net.au/app/uploads/2023/05/Sonder-Strategic-Plan-2022-2027.pdf

education sessions on life skills and wellbeing topics, such as preparing healthy meals or pathways into employment.

Dedicated Hospital Homeless Team with Primary Care in-Reach

The Royal Perth Hospital (RPH) Homeless Team was established in 2016, and adapted from the UK Pathway approach, which is an evidence-based approach to supporting people experiencing homelessness in hospital settings by providing in-reach primary care alongside psychosocial support. The RPH Homeless Team was the first of its kind to be established outside of the UK, and is a collaboration between RPH, HHC and Ruah Community Services. The team improves outcomes for people experiencing homelessness by supporting them through admission to hospital, discharge planning and linking to community-based services, including accommodation providers. The RPH Homeless Team was featured as a case study in a 2021 Productivity Commission report entitled 'Implementing Innovation Across the Health System'.[33] The report recommended that *"Extending the Royal Perth Hospital Homeless Team model to all principal referral hospitals and large public acute hospitals would cost about $68 million and would predominantly benefit Australia's population of rough sleepers (comprising 746,000 people aged 15 years and over who have experienced rough sleeping at some point in their lives) who are frequent users of hospitals, and in particular emergency departments."* [33] The report also notes that hospital based teams that embed GPs and primary care, as is the case with the RPH Homeless Team, are associated with better health outcomes because it strengthens the focus on early intervention and prevention.[33]

Multi-disciplinary Outreach Healthcare

St Vincent's Hospital Sydney Homeless Health Service (HHS) is NSW's only specialist homeless health unit, a multidisciplinary team of Aboriginal health workers, peer support workers, nurses, doctors and allied health staff. The service provides outreach healthcare, support and care coordination to people experiencing homelessness where they sleep (streets or crisis accommodation), or where they spend time during the day (drop-in centres or mobile voluntary services). The HHS also provides specialist diabetes and podiatry services via the Integrated Care Mobile Clinic Vehicle. The HHS partners closely with the Department of Communities and Justice, the City of Sydney and other Specialist Homeless Services to ensure that people accessing healthcare also have access to accommodation and support.

Medical Respite

The concept of providing post-hospital respite care for people experiencing homelessness began in Boston in the early 1990s, and has now expanded to over 145 programs across the US, with a growing number of iterations in other countries, including the UK, Denmark, and Australia.[34] The first Australian examples of respite facilities for homeless patients being discharged from hospital have been Tierney House, established by St Vincent's Hospital Sydney, which has 13 beds, and The Cottage at St Vincent's Hospital Melbourne, which has 6 beds.[35] Most recently, the Perth Medical Respite Centre (MRC) for people experiencing homelessness opened in October 2021, and comprises a 20 bed facility. It has medical nursing staff onsite around the clock and daily GP in-reach, as well as key workers who support residents with psychosocial needs, including housing and accommodation options to avert discharges back into homelessness. The Perth MRC is a collaboration between HHC and Uniting WA. The Cottage, Tierney House and MRC all include peer support workers, often with

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[33] Productivity Commission 2021. *Implementing innovation across the health system*. https://www.pc.gov.au/research/completed/chronic-care-innovations/health-implementation-priorities.pdf
[34] National Health Care for the Homeless Council 2023. *Medical Respite Program Directory: Descriptions of Medical Respite Programs in the United States*. https://nimrc.org/medical-respite-directory/
[35] Gazey A, Vallesi S, Martin K, Cumming C, and Wood, L 2019. The Cottage: providing medical respite care in a home-like environment for people experiencing homelessness. *Housing, Care and Support* vol. 20, no. 1, pp. 54-64. doi:10.1108/HCS-08-2018-0020

lived experience of homelessness. Previously, Baptist Care in SA also had a respite centre pilot, although this was discontinued due to COVID-19.

A key intent of medical respite care is to provide short-term supported discharge accommodation and post-hospital care for people experiencing homelessness to avert discharging them to the streets. This provides a safe space for people to recoup whilst also connecting them to support services, including community health, housing, homelessness, disability and social support services. Evaluations of Tierney House[36], The Cottage[36] and MRC[37] have all demonstrated reductions in hospital use and associated cost-savings to the health system.

Permanent supportive housing provides the opportunity for vulnerable adults to be permanently housed in an affordable and supported environment. Support can include onsite access to health and social support services, as well as therapeutic activities that promote wellbeing. One example is the Common Ground permanent supportive housing facility in Brisbane, established in 2012. Brisbane Common Ground is a 14-storey apartment building containing 146 units of accommodation in studio and one-bedroom apartments. Services available include onsite concierge service, art studio, rooftop garden, communal lounge, Wi-Fi and an onsite registered nurse. A cost-benefit analysis of Brisbane Common Ground reported a saving of $13,100 per person per year.[38]

Housing First: Doorway

The Doorway program delivered by Wellways is an integrated housing and recovery support program for people with severe and persistent mental illness and experiencing or at risk of homelessness. Doorway is modelled on Housing First and utilises the private rental market and rental subsidies to fully support people to gain immediate access to secure housing. Once a person has signed a lease, they continue to work alongside the Housing and Recovery Worker to build their tenancy skills and design their individualised recovery journey. The program works in partnership with clinical public mental health teams to provide an integrated healthcare team response.

The program commenced in 2010 and has undergone three evaluative projects, which identified a significant increase in mental health and wellbeing outcomes for participants and a decrease in participant use of bed-based mental health clinical services and general hospital admissions.[39,40,41]The evaluation also identified net savings of $13,096 per participant per annum in health service use, and $1,149 to $19,837 in savings for all service use, including housing.[41]

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[36] Conroy E, Bower M, Kadwell L, Reeve R, Flatau P, and Miscenko D 2016. *St Vincent's Hospital's Homeless Health Service: Bridging the Gap between the Homeless and Health Care*.
https://www.westernsydney.edu.au/__data/assets/pdf_file/0010/1346851/St_Vincents_Research_Bulletin_FINAL_FINAL.pdf

[37]Wood L, Vallesi S, Tuson M 2023. *Perth's First Medical Respite Centre: Evaluation of the First Year of Operation, Executive Summary*. Institute for Health Research, UNDA.
https://static1.squarespace.com/static/6071957fd38b343b68afe4d5/t/649a9375a8e2a313b45ba357/1687851896175/Year+1+MRC+Evaluation+-+Exec+Summary.pdf

[38] Parsell C, Petersen M, and Culhane D 2017. Cost Offsets of Supportive Housing: Evidence for Social Work. *British Journal of Social Work* vol. 47, no. 5, pp. 1534-1553. https://doi.org/10.1093/bjsw/bcw115

[39] Nous Group 2014. *Doorway – Summative Evaluation – November 2013; Mental Illness Fellowship*.
https://nousgroup.com/wp-content/uploads/2018/02/Doorway-Summative-Evaluation-Report.pdf

[40] Dunt DR, Day SE, Collister L, Fogerty B, Frankish R, Castle DJ, Hoppner C, Stafrace S, Sherwood S, Newton JR, and Redston S 2022. Evaluation of a Housing First programme for people from the public mental health sector with severe and persistent mental illnesses and precarious housing: Housing, health and service use outcomes, *Australian & New Zealand Journal of Psychiatry* vol. 56, no. 3, pp. 281-291. doi:10.1177/00048674211011702

[41] Dunt DR, Benoy AW, Phillipou A, Collister LL, Crowther EM, Freidin J, and Castle DJ 2017. Evaluation of an integrated housing and recovery model for people with severe and persistent mental illnesses: the Doorway program. *Australian Health Review* vol. 41, pp. 573-581. http://dx.doi.org/10.1071/AH16055

Gippsland Psychosocial Support Service

Gippsland Psychosocial Support Service (PSS), a PHN-funded program delivered by Wellways, has incorporated Housing First practice and principles into each wellbeing worker role. This practice provides an opportunity for early identification of housing need and risk. Fully recognising the link between mental health and the experience of homelessness, this practice is able to provide a more effective response to an individual's mental health recovery. Using the guiding principles of choice and self-determination, sustainability, and social connection, each Gippsland PSS staff member is trained in evidence-based and best practice Housing First and recovery frameworks, empowering mental health workers to engage in housing conversations and interventions with the people they work with.

By upskilling each PSS wellbeing worker with the skills and capacity to navigate housing conversations, each participant can receive a tailored response. Having one worker that can support people with recovery and housing-related issues reduces the impact on the individual of having to navigate across two complex service systems and the repeated stress this can have for people. The Gippsland PSS service is able to easily identify and support participants at risk or experiencing homelessness to achieve a home, build tenancy sustainability skills, and support their mental health recovery.

Organisational Partnerships

Housing for Health is an alliance of academics, GPs, nurses, allied health professionals, and housing and community services in Canberra, Australian Capital Territory. During the COVID-19 pandemic, Housing for Health facilitated vaccination for people experiencing or at risk of homelessness, which included opportunistic health clinics. Likewise, St Vincent's Health Melbourne partnered with the Burnet Institute, Salvation Army, and Bolton Clarke Homeless Persons Program (HPP) to roll out a mobile COVID-19 vaccination initiative from July 2020 to support people experiencing homelessness and people seeking asylum. The service also provided Hepatitis A, Hepatitis B, and influenza vaccinations, basic health referrals, and other harm reduction strategies prior to COVID-19 vaccinations being available.

The intersectoral Homelessness Health Alliance is a community-wide collaborative approach to improving access to healthcare and health outcomes for people experiencing or at risk of homelessness in Sydney, New South Wales. The Alliance comprises the City of Sydney, St Vincent's Health Network Sydney, South Eastern Sydney Local Health District, Sydney Local Health District, and the Central and Eastern Sydney Primary Health Network. The Alliance has key areas of focus including: improving access to the right care at the right time, strengthening prevention and public health, increasing access to primary care, building workforce capacity, and establishing collaborative governance and shared planning. Through these formalised partnerships, a number of initiatives were established during the COVID-19 Pandemic. Mobile testing was introduced, including pop-up clinics and testing in resident specialist homelessness services, temporary accommodation, and high risk social housing blocks. A total of 9,482 PCR tests were provided. Along with this, a COVID-19 Vaccination Hub for people experiencing or at risk of homelessness was established. More than 4,305 COVID-19 vaccinations were administered during its operation.[42]

[42] Currie J, Hollingdrake O, Grech E, McEnroe G, McWilliams L., and Le Lievre, D 2022. Optimising access to the COVID-19 vaccination for people experiencing homelessness. *International Journal of Environmental Research and Public Health* vol. 19, no. 23. https://doi.org/10.3390/ijerph192315686

Conclusion

To end homelessness by making it rare, brief and once-off, we need to see it as much a health issue as a housing issue. These issues are inseparable and need to be better addressed.

This paper puts forward two simple suggestions for the Commonwealth Department of Health to consider:

- ➔ Establish a dedicated and ongoing funding stream through PHNs to better address the urgent healthcare needs of people experiencing homelessness.
- ➔ Establish a working group to consider how to better meet the health needs of people experiencing homelessness within new and existing Commonwealth policy frameworks – including the National Housing and Homelessness Plan.

In addition to these recommendations, it is also encouraged that any organisation with an interest in supporting a health-led end to homelessness get involved with the A3HN.

Homelessness is a *health emergency* but it is also entirely *preventable*.