# Homelessness Health Implementation Framework

2023 - 2026

South Eastern Sydney Local Health District

NSW GOVERNMENT

# SESLHD Homelessness Health Implementation Framework 2023-2026

## Contents

# Introduction

South Eastern Sydney Local Health District (SESLHD) is committed to providing compassionate and respectful person-centred care and working in partnership to improve health and wellbeing outcomes.

The purpose of the Homelessness Health Implementation Framework is to describe the priorities for SESLHD in improving access to care, patient experience and health outcomes among people experiencing homelessness; and the activities we will undertake to address these priorities.

There is an unacceptable gap between the health outcomes of people experiencing homelessness and other residents of South Eastern Sydney Local Health District. This reflects the convergence of the higher prevalence of many health conditions among people experiencing homelessness and the ways in which homelessness exacerbates or amplifies the burden of illness. This framework builds upon the achievements of the SESLHD Homelessness Health Strategy 2018-2021 (Appendix 1) and aligns to and is informed by the following strategic documents:

- Intersectoral Homelessness Health Strategy 2020-2025
- SESLHD Exceptional Care, Healthier Lives Strategy 2022-2025
- NSW Homelessness Strategy 2018-2023

The implementation framework provides the foundation upon which SESLHD services can plan and deliver integrated, trauma informed, culturally safe and person-centred care to improve the delivery of health services for people experiencing and at risk of homelessness. It focuses on sustaining momentum around our intersectoral work, leveraging relationships established through the COVID-19 pandemic, working together to build capability of staff and addressing social determinants of health.

The SESLHD Homelessness Health Committee is responsible for monitoring the implementation of the framework. The Committee comprises senior clinicians and managers from across SESLHD services and facilities and has been meeting quarterly since its formation in late 2018. From 2019-2022, the Committee led, supported and monitored a range of successful initiatives to improve the health and wellbeing of people experiencing or at risk of homelessness in our district (Appendix 2).

# Homelessness in South Eastern Sydney Local Health District

| **Definitions of Homelessness** [1] | | | |
|---|---|---|---|
| Primary homelessness | Secondary homelessness | Tertiary homelessness | At risk of homelessness |
| Is experienced by people without conventional accommodation (e.g. sleeping rough or in improvised dwellings | Is experienced by people who frequently moved from one temporary shelter to another (e.g. emergency accommodation, youth refuges, couch surfing) | Is experienced by people staying in accommodation which falls below minimum community standards (e.g. boarding houses and caravan parks | Is experienced by a person when they are at risk of losing their accommodation, often triggered by one or more of a range of factors that contribute to homelessness more broadly |

**Homelessness in SESLHD**[2]

- There are 7,500 people experiencing homelessness in SESLHD
- SESLHD has 20% of the total NSW population of people experiencing homelessness and has the single highest proportion of people experiencing homelessness in any LHD in NSW

2016 Census homeless persons data indicates:

- 58% men, 42% women and 20% ATSI
- Children and young people (0-24 yrs) account for 35% of those experiencing homelessness
- People aged 55+ make up 16% of the total; this has been increasing since 2006

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

# Health Needs of People Experiencing Homelessness

People experiencing homelessness have a higher prevalence of chronic conditions and often experience a higher burden of illness because of those conditions[3]. More prevalent health issues include:

- Mental health problems
- Problematic substance use, including intravenous drug use
- Metabolic syndrome
- Cardiovascular disease
- Oral health issues
- Chronic Obstructive Pulmonary Disease
- Liver disease, including chronic viral hepatitis and advanced liver disease
- Blood borne viruses including hepatitis C and HIV

[1] Mackenzie and Chamberlain (1992) cited in Homelessness Australia, 2022

[2] Australian Bureau of Statistics (2018), 'Estimating Homelessness' Census 2016

[3] South Eastern Sydney Local Health District (2015), Equity Strategy

There are many factors which make it difficult for people experiencing homelessness to access the right care at the right time. These include[4]:

- The complexity of the health system
- Complicated referral processes and strict eligibility criteria of many health services and programs
- Poorer access to GPs
- Increased likelihood of engaging with health services in a crisis or acute need
- Experiencing mental health problems, substance use and/or other co-morbidities
- Healthcare may not be the most pressing priority, given the urgent need for shelter and food
- Lack of Medicare cards and difficulty replacing documentation for people with No Fixed Address
- Violence, abuse and neglect

It should be noted that issues for sub-populations are complex and overlapping and many people experiencing homelessness are members of more than one sub-population. These sub-populations include:

- Aboriginal people
- Women
- Young people
- People with a disability
- People from culturally and linguistically diverse backgrounds including non-residents
- People leaving institutional settings including hospitals, rehabilitation, Juvenile Justice, and Department of Corrective Services facilities
- Older people
- People in under-served geographic areas
- LGBTQI+ people

Data from the 2020-2021 Australian Institute of Health and Welfare (AIHW) Specialist Homelessness Service (SHS) annual report indicates that some sub-populations have a higher utilisation of homelessness services across Australia, and that some health issues are more prevalent. For example, of the 278,300 people assisted by SHS agencies between 2020-2021[5]:

- 39% reported experiencing family and domestic violence
- 12% reported having a drug and alcohol issue
- 28% were under 18
- 38% reported experiencing a mental health issue
- 28% identified as Aboriginal and/or Torres Strait Islander
- 9% were aged over 55

The COVID-19 pandemic has highlighted access and equity issues for people experiencing homelessness including the challenges of isolating ‘at home’ when you don’t have anywhere to live; difficulty accessing testing; difficulty managing outbreaks in residential and rough sleeping settings and access to vaccinations.

[4] Australian Institute of Health and Welfare (2021), Health of people experiencing homelessness. Accessed at: https://www.aihw.gov.au/reports/australias-health/health-of-people-experiencing-homelessness#_Toc31631717

[5] Australian Institute of Health and Welfare (2022), Specialist homelessness services annual report 2020-2021. Accessed at: https://www.aihw.gov.au/reports/homelessness-services/shs-annual-report-2020-21/contents/clients-services-and-outcomes

# Homelessness Health Implementation Framework 2023-2026

| Domains of Action | Link to Exceptional Care, Healthier Lives Strategic Plan 2022-2025 | Link to Intersectoral Homelessness Health Strategy 2020-2025 | Key Current/planned initiatives | Potential Future Initiatives |
|---|---|---|---|---|
| 1. Identification of and responses to homelessness<br><br>○ Use validated tools to enhance identification of and responses to homelessness in acute and community settings across SESLHD<br>○ Ensure flexible service delivery through the development of new pathways and models of care that address barriers to care<br>○ Contribute to the growing body of evidence in homelessness health | Providing person centred care<br>○ Safe, high quality healthcare co-designed with consumers<br>○ Integrated, easy to navigate services across the district<br><br>Partnering for healthier communities<br>○ Partnership with communities and other agencies to address social determinants of health<br>○ Commitment to health equity and Closing the Gap | Improving access to the right care at the right time<br>○ Develop and pilot an assessment tool to maximise early identification of people experiencing homelessness in health care settings and support the development of locally appropriate tools in SVHN, SESLHD and SLHD (led by St Vincent's Health Network) | Pilot Homeless Health Access to Care Tool (in development, led by St Vincent's Health network)<br><br>Submit for publication to peer-reviewed journal; Intersectoral Approaches to Homelessness during COVID-19 manuscript<br><br>Deliver targeted models of care through dedicated and mainstream positions within KRC.<br><br>Deliver Special Needs Dental Service in partnership with Mission Australia Centre (MAC)<br><br>Continue the Homelessness Opportunities for Presentations to ED (HOPE) project, Sydney/Sydney Eye Hospital<br><br>Deliver outreach clinical care to MAC clients via the St George Department of Homeless Medicine<br><br>Annual homelessness/ risk of homelessness data collection project - Mental Health Service | Partnering with SESLHD Aboriginal Health Unit for the inpatient scoping project identifying social support needs for Aboriginal People presenting to hospital.<br><br>Incorporate or duplicate annual Mental Health Service data collection project in Drug & Alcohol setting |

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| | | | Drug and Alcohol Services to continue to provide the following support for clients experiencing and at risk of homelessness:<br>• Priority access to treatment<br>• Key workers to address homelessness whilst engaged with service<br>• Dedicated specialist team to address psychosocial barriers to treatment, including homelessness (Assertive Community Management) | |
| 2. Health service coordination<br><br>○ Strengthen integrated care and shared planning among key internal service providers<br>○ Enhance communication and coordination among the range of homelessness health service providers across inner Sydney<br>○ Work with Specialist Homelessness Services (SHS) and other homelessness service providers to support public health initiatives | Partnering for healthier communities<br>○ Partnership with communities and other agencies to address the social determinants of health<br>○ Whole of Sydney, multi-sectoral approaches to proactively promote health and well-being<br>Providing person-centred care<br>○ Integrated, easy to navigate services across the continuum of care | Strengthening prevention and public health<br>○ Develop a coordinated response to disease prevention among people experiencing homelessness (led by St Vincent's health network)<br><br>Increasing access to primary care<br>○ Explore feasibility of trialling new models of primary care in key locations, including novel models to improve service integration for people experiencing homelessness (led by | Continue regular communication with SHS through SHS bulletin and forums/sessions<br><br>Continue to provide access to COVID-19 and flu vaccination clinics with partners.<br><br>Continue to provide outreach and inreach health and psychosocial support services to people experiencing homelessness in the inner city<br><br>Continue to provide an accessible primary and specialist health service for people experiencing homelessness (KRC)<br><br>Continue to provide joint outreach and intersectoral case coordination | Facilitate the Homelessness Health Service Coordination Group and other regular interagency forums to review and plan initiatives to support coordination, planning of service delivery and continuity of care for clients across services<br><br>Scale up model of service the MAC and SVH Dental provide to include SLHD – Sydney Dental Hospital.<br><br>Develop priority housing pathway within SESLHD to facilitate eligibility to |

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| | | Central and Eastern Sydney PHN) | for rough sleepers (HART and HOST patrols and care coordination)<br>Review and expand Mental Health & Housing coordination groups<br>Continue to provide the Special Needs Dental Service co-located at the Mission Australia Centre in liaison with SVH Dental Service, NGOs and Homelessness Services.<br><br>Provide integrated counselling and case management responses to victims of domestic violence and sexual assault.<br><br>Implement Specialist Integrated Service for Adult Survivors of sexual assault in partnership with mental health, drug and alcohol and Aboriginal Health.<br><br>Continue to coordinate the Safer Pathway health responses to victims at serious threat from domestic and family violence at 4 Safety Action Meeting sites.<br><br>Continue to review opportunities to improve management of co-morbid mental health and drug and alcohol presentation to enable greater integration of treatment across multiple systems, including building stronger partnerships between relevant services (e.g. DAS and MH) | Adult Drug Court program for people experiencing homelessness |

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| 3. No Exits to Homelessness<br><br>○ Strengthen intersectoral partnerships to reduce exits to homelessness<br>○ Strengthen discharge planning that considers the housing, social and health needs of people experiencing homelessness<br>○ Increase access to case management services for people experiencing homelessness | Partnering for healthier communities<br>○ Partnership with communities and other agencies to address determinants of health<br>○ Commitment to health equity and Closing the Gap<br><br>Providing person centred care<br>○ Compassionate, personalised care that empowers consumers, families, and carers | Improving access to the right care at the right time<br>○ Strengthen partnerships between health, housing and other organisations working with people experiencing homelessness (led by Department of Communities and Justice (DCJ))<br>○ Enhance existing and build new case coordination mechanisms that provide early intervention and strengthen care coordination with a focus on secondary and tertiary homelessness (led by DCJ) | Wesley Mission funded to provide in-reach across SESLHD Mental Health Units (2 year project); funding provided by DCJ<br><br>Three year funding of SESLHD Housing and Mental Health Liaison Coordinator role<br><br>Pathways Plus Program Mental Health Service collaboration with ICLA transitional accommodation model to provide improved access and wrap around supports for homeless consumers | Map discharge planning across SESLHD facilities for people experiencing homelessness, with an emphasis on holistic care planning<br><br>Advocate through the Senior Collaborative Alliance for co-designed projects that reduce exits to homelessness<br><br>Develop pathways from SESLHD facilities to community services such as KRC for people experiencing homelessness<br><br>Explore options for funding Housing and Drug & Alcohol Liaison Coordinator role<br><br>Explore expanding or duplicating Pathways Plus Program for drug & alcohol clients<br><br>Support Managed Alcohol Program (MAP) development for clients with severe drug & |

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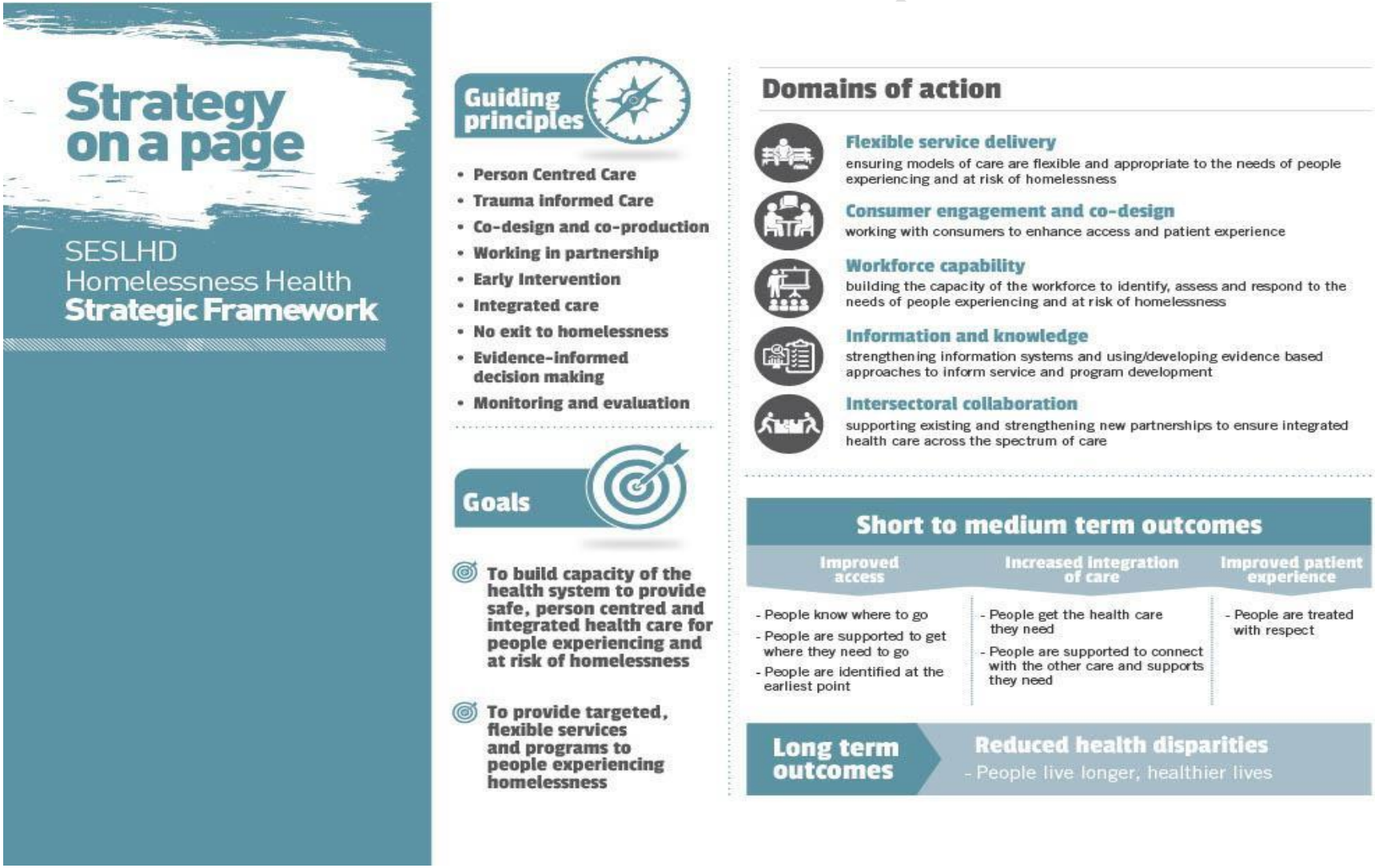
|---|---|---|---|---|
| | | | | alcohol issues and homelessness |
| 4. Workforce Capability<br><br>○ Build capability of SESLHD workforce through professional development opportunities and education and training initiatives<br>○ Contribute to the implementation of the Intersectoral Homelessness Health Strategy Workforce Development Plan | Supporting teams to thrive<br>○ Development opportunities for staff to excel | Building workforce capacity<br>○ Development targeted training to address key gaps in workforce development across the region (led by SESLHD)<br><br>Increasing access to primary care<br>○ Enable and support GP registrars to work in homelessness health clinics during training (led by Central Eastern Sydney Primary Health Network) | Intersectoral Homelessness Health Workforce Development Plan<br><br>SESLHD Homelessness Health Training<br><br>CESPHN Continuing Professional Development (CPD) training for primary health providers including GPs<br><br>Education to DCJ Housing and within SESLHD Mental Health to improve partnerships and prevent tenancy failure in the context of mental health.<br><br>Allied Health Cross Boundary Grant<br><br>Build capability of SESLHD drug and alcohol workers to support DAS clients to secure and maintain social housing (e.g., completion of key forms and support letters) | Pilot GP and SRMO placement at KRC<br><br>Annual program of events to raise awareness about homelessness health: Homelessness Week activities, Grand rounds Research 2 Practice forums and other showcase initiatives)<br><br>Develop occupational therapy role within drug and alcohol to assist in maintaining tenancies |
| Ways of Working:<br>1. Leveraging and strengthening intersectoral partnerships<br>2. Prioritising consumer engagement and co-design<br>3. Being flexible and responsive to emerging changes in the service system and emerging health needs across people experiencing homelessness | | | | |

## Appendix 1: “Strategy on a Page” SESLHD Homelessness Health Strategy 2018-2021



## Appendix 2: Key Achievements SESLHD Homelessness Health Strategy 2019-2022

**2019**

***Sydney Hospital and Sydney Eye Hospital (SSEH) Homelessness Opportunities for Presentation to Emergency HOPE Project***

The HOPE Project was funded through a SESLHD 'The Inspiring Ideas Challenge' (TIIC) grant, with the aim of improving the response to homelessness in the SSEH Emergency Department (ED). The project used an eMR alert to build a profile of those experiencing homelessness accessing SSEH ED. This enabled better understanding of presenting issues and patterns, and facilitated intersectoral collaboration with local homelessness health and housing services. Additionally, the introduction of a clinical template to assess social risk, and the delivery of in-service education and trauma informed care training enabled culture change across the ED. The provision of a 'HOPE package' (including information regarding local supports and services and an Opal card) increased access to essential health, housing and social services.

***National Homelessness Week 2019 Activities***

To acknowledge National Homelessness Week the SESLHD Homelessness Health Program partnered with Rough Edges to offer the opportunity for staff across the district to participate in an 'Urban Exposure Walk'. Each walk was guided by a person with lived experience of homelessness and offered a unique and intimate insight into the experience of homelessness in the Kings Cross and Darlinghurst areas. Around 65 SESLHD staff participated. In addition, a range of other initiatives occurred across the district, including a donation drive to The Sutherland Hospital (TSH) Samaritans Fund, the delivery of a lunch and learn session for TSH staff and an interagency forum on homelessness led by KRC.

***Mental Health, Housing & Homelessness Pathways Project***

Jointly led between SESLHD Mental Health Services and the Homelessness Health Program, the Mental Health, Housing and Homelessness Health Pathways Project aimed to strengthen pathways to housing and other support services with the aims of reducing: (1) risks to tenancies; (2) tenancy loss; and (3) discharges from hospital into homelessness. The project was supported by the Department of Communities and Justice and resulted in the establishment of a range of communication and escalation mechanisms between mental health and housing services.

***Home and Healthy***

Home and Healthy was a social impact investment funded program, delivered by Mission Australia. Launched in July 2019, the Home and Healthy Program aimed to reduce exits to homelessness from health services through the provision of up to two years of assertive case management to support clients to access stable housing. The program also aimed to achieve goals related to employment, education and training. The program was delivered over two years between July 2019 and July 2021 and supported 73 participants referred by SESLHD services/facilities.

**2020**

***Department of Homeless Medicine established at St George Hospital***

St George Hospital (SGH) Division of Medicine has a well-established relationship with Mission Australia Centre (MAC) to deliver primary and specialist health services to men experiencing homelessness accessing the Centre. The clinic is led by Prof Mark Brown and supported by nursing staff. In 2020 the clinic was added as a new department within the Division of Medicine at SGH to ensure a sustainable workforce within this department into the future.

***Kirketon Road Centre Mobile COVID-19 testing clinic***

The Kirketon Road Centre (KRC) mobile COVID-19 testing initiative provided a rolling series of pop-up clinics commencing in April 2020. The clinic was delivered during the day and evening in a range of Inner Sydney City locations where people experiencing and at risk of homelessness are known to frequent, as well as in high density social housing blocks.

***Co-Authoring Collective Document, Sydney/Sydney Eye Hospital***

Re-authoring documentation practices thesis completed Dec 2020. This project was led by Sarah Joy, Social Work Manager Sydney/Sydney Eye Hospital and focused on building a co-designed Collective Document that captured the knowledge/skills of people with lived experience of homelessness and was presented at a range of forums.

***Intersectoral Homelessness Health Strategy 2020-2025 Launch***

The Intersectoral Homelessness Health Strategy (IHHS) 2020-2025 was formally launched during National Homelessness Week 2020. The IHHS formalises the approach to the planning, delivery and evaluation of homelessness health services across the Sydney and South Eastern Sydney Local Health District geographical areas. The Strategy identifies five priority action areas to be progressed collaboratively between the partners and other relevant stakeholders over the lifetime of the Strategy. The Priority Action Areas are: 1) Improving access to the right care at the right time; 2) Strengthening prevention and public health; 3) Increasing access to primary care; 4) Building workforce capability; 5) Establishing collaborative governance and shared planning.

***Oral Health and Homelessness Video Presented at the Senior Executive Forum***

The Oral Health and Homelessness video highlighted the value and unique features of the SESLHD Special Needs Dental Service (SDNS). It included an interview with a former client of the service who spoke about the trauma-informed and inclusive care he experienced during his treatment at the SNDS. The video was presented by the Chief Executive at the NSW Senior Executive Forum and the SESLHD Annual General Meeting.

**2021**

***Arncliffe Health Linkage Service***

The Arncliffe Health Linkage Service was established in partnership with Evolve Community Housing to facilitate linkages to local health and social services for tenants living at the Arncliffe site who were experiencing high levels of vulnerability and/or complex health needs. The service offered health linkage and health promotion activities from January to June 2021. During its operation a range of health education sessions were offered to Arncliffe tenants including Drug and Alcohol, Mental Health, Oral Health, Breastscreen and Women's Health.

***Swab Squad***

The Swab Squad was a collaborative model of care between South Eastern Sydney Local Health District services (Public Health Unit, KRC and Homelessness Health Program) and St Vincent's Homeless Health Service. The Swab Squad offered rapid PCR testing to residential specialist homelessness services, temporary accommodation and high risk social housing blocks that identified a positive case and were at risk of a larger COVID-19 outbreak. The Swab Squad operated during the peak of the delta outbreak and delivered approximately 638 tests between August and November 2021.

***COVID-19 Vaccine Access Program***

The SESLHD Vaccine Access Program delivered a range of outreach and pop-up clinics to increase access to the COVID-19 vaccine for vulnerable populations, including people experiencing and at risk of homelessness. Key initiatives of this program include:

- Establishment of the Ozanam Learning Centre (OLC) vaccine hub; this hub was targeted to people experiencing or at risk of homelessness in the Inner Sydney area. It commenced in May 2021 and was led by St Vincent's Health Network and supported by KRC, the SESLHD Homelessness Health Program, City of Sydney, Department of Communities and Justice (DCJ) and St Vincent de Paul. The model was the first of its kind in NSW and has since delivered over 6,000 vaccinations.
- KRC Mobile Vaccination Clinic; building on the success of the mobile testing clinic, the KRC vaccination clinic offered the COVID-19 vaccine at a number of locations frequented by people experiencing homelessness, such as Martin Place and Woolloomooloo as well as high density social housing settings such as Northcott, Lexington Hub and Eastlakes.
- The Boarding House Vaccination Program; this program was a small and very targeted initiative that offered on-site COVID-19 vaccinations to vulnerable people living in boarding houses across the inner city. The project was delivered by KRC, in partnership with the Wayside Chapel and funded by the Priority Populations Unit.

**2022**

***Extension of the Mental Health and Housing Liaison Coordinator Position***

The Mental Health and Housing Liaison Coordinator position was established in 2020 for a period of 12 months. The position guides coordination between mental health and housing services and builds capability across both agencies. Key achievements of this position include the completion of Mental Health and Homelessness Data Snapshots across the Mental Health Service and the establishment of a new transitional accommodation model for people exiting mental health inpatient units and at risk of homelessness. As a result of this success the position has been extended to 2025.

***COVID-19 Information Sessions for Homelessness Service Providers***

Throughout the COVID-19 pandemic, the Homelessness Health Program has supported local homelessness services to adapt and respond to the changing nature of the pandemic through the provision of the COVID-19 Bulletin for Specialist Homelessness Services and a range of online webinars and information sessions. In 2022 the Homelessness Health Program set up monthly forums to facilitate regular contact between health and homelessness services and to strengthen capability of these services to adapt service delivery as required.

***Intersectoral Homelessness Health Workforce Development Plan***

The Intersectoral Homelessness Health Workforce Development Plan project is being led by SESLHD on behalf of the Intersectoral Homelessness Health Senior Collaborative Alliance. The purpose is to review existing and identify future workforce development initiatives to support the formation of a workforce development plan. The plan will identify targeted training opportunities to build capability of staff and clinicians working across health services that support people experiencing homelessness, as well as intersectoral homelessness services that partner with health providers. The plan is currently in draft form with expected completion in late 2022 and implementation in 2023.