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ST VINCENT'S HOSPITAL MELBOURNE HOMELESSNESS PROGRAMS EVALUATION REPORT

An evaluation of ALERT, CHOPS, The Cottage and Prague House

September 2017

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ST VINCENT'S HOSPITAL MELBOURNE HOMELESSNESS PROGRAMS EVALUATION

The evaluation of four of SVHM Homelessness Programs was undertaken by the University of Western Australia (UWA) Centre for Social Impact (CSI) and was led by Associate Professor Lisa Wood.

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LIST OF ACRONYMS

ABI	Acquired Brain Injury
ACAS	Aged Care Assessment Services
ALERT	Assessment, Liaison, & Early Referral Team
AoD	Alcohol and other Drugs
APATT	Aged Psychiatry Assessment and Treatment Team
CATT/CATS	Crisis Assessment and Treatment Service
CBD	Central Business District
CBDATS	Community Brain Disorders Assessment & Treatment Service
CCS	Complex Care Services
CHOPS	Clarendon Homeless Outreach Psychiatric Service
CL Psych	Consultation and Liaison Psychiatry
CMHC	Community Mental Health Clinic
CMI	Client Management Interface (database)
CSI	Centre for Social Impact
DNA	Did Not Attend
DOAM	Department of Addiction Medicine
DSP	Disability Support Pension
EDCC	Emergency Department Care Coordination
ED	Emergency Department
FTE	Full Time Equivalent
GP	General Practitioner
HARP	Hospital Admission Risk Program
HASI	Homelessness and Accommodation Support Initiative
HHHAHS	Homelessness to Home Healthcare After Hours Service
HIP	Health Independence Program
HITH	Hospital in the Home

HRQoL	Health Related Quality of Life
ICU	Intensive Care Unit
ICD-10-CM	International Classification of Disease, Tenth Edition
KPI	Key Performance Indicator
LGA	Local Government Area
LOS	Length of Stay
MDT	Multidisciplinary Team
MRO	Medical Records Online
NDIS	National Disability Insurance Scheme
NFA	No Fixed Address
NGO	Non-Government Organisation
NPAH	National Partnership Agreement on Homelessness
NRCH	North Richmond Community Health
PAC	Post-Acute Care
PAS	Patient Administration System
QoL	Quality of Life
RDNS	Royal District Nursing Service
RDNS HPP	RDNS Homeless Persons Program
SHS	Specialist Homelessness Service
SRS	Supported Residential Service
SVHA	St Vincent's Health Australia
SVHM	St Vincent's Hospital Melbourne
SVHS	St Vincent's Hospital Sydney
TCM	The Care Manager (Database)
UK	United Kingdom
UWA	University of Western Australia
WA	Western Australia

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OVERVIEW

There is a growing number of Australians experiencing, or at risk of homelessness, impacting on around 22,000 people in Victoria on any given day. Homelessness is often concentrated in inner city areas, and in the 2016 homelessness Registry Week survey undertaken in Melbourne[a] there were 161 people sleeping rough. Homeless services in Melbourne and around the country are increasingly struggling to meet demand, compounded by the shortage of accommodation and affordable housing options for people who are homeless. This has significant repercussions for inner city public hospitals such as St Vincent's Hospital Melbourne (SVHM); people experiencing homelessness are more likely to have complex, compounding health needs and comorbidities, and greater usage of acute health services.

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. Thus this challenges traditional clinical boundaries and health system responses. At the aggregated level, there is a costly revolving door between homelessness and the health system, and the over-representation of homeless people in hospital statistics has resource as well as equity implications.

SVHM is founded on core principles of social justice, human dignity and health care for vulnerable populations hence people who are homeless have always aligned with its core mission and values. Its dedicated and innovative work to meet the health needs of homeless people is widely recognised and highly regarded in Victoria and nationally. Its breadth of contact with, and services for, people experiencing homelessness has evolved over time, and whilst there have been some evaluations of individual programs and services, this is the first evaluation to look at the suite of four key services for people who are homeless.

This report presents results of an evaluation of four SVHM homeless services; (i) Assessment, Liaison, & Early Referral Team (ALERT), (ii) Clarendon Homeless Outreach Psychiatric Service (CHOPS), (iii) The Sister Francesca Healy Cottage (The Cottage) and, (iv) Prague House. There were eight specific objectives guiding the evaluation, the essence being to measure, analyse, and document the impact of the services on client outcomes and to make recommendations for how these services may collaboratively strengthen future service delivery.

[a] Micah Projects Inc. (2017) *De-Identified Vulnerability Index-Service Prioritisation Decision Assistance Tool data for Melbourne, 2010-2016*, Micah Projects Inc.: Brisbane.

METHODS

A mixed methods approach was used in this evaluation, comprising analysis of quantitative hospital records data; qualitative data gathered from clients, staff and stakeholders within SVHM and externally; client case studies; and an economic analysis. The qualitative data was collected via in-depth interviews and focus groups from: staff and managers at the four services; clients from each of the four services; key internal SVHM stakeholders working with, and/or referring clients to the four services, and; key external stakeholders working with and/or referring clients to the four services. In addition, a series of client pathway case studies were generated based on interviews and a review of hospital records and notes.

De-identified hospital records data for homeless clients engaged with the four services during 2015 was provided to the research team by SVHM. SVHM hospital usage and client demographic data for clients who had contact with at least one of the four services during the 2015 calendar year was analysed to indicate; profiles of clients using the four services, client flow between services, service impact, changes in health service utilisation (e.g. emergency department (ED) presentations, average lengths of stay (LOS) in an inpatient unit) and, the economic impact of the homeless services. Hospital usage six months pre and post the start of an episode of support (for those who received support in 2015, and commenced their episode of care after the 1st of January 2011) was used to calculate changes in health service usage as a result of an episode of care with one of the four services. It is pertinent to note that the "post" period includes the actual period of service intervention.

The economic analysis was undertaken to determine the cost of providing the four services for the 2015-16 financial year. To compute a partial measure of cost effectiveness, SVHM administrative data on estimated annual operating costs as well as other costs incurred in the management and delivery of these services, and data on average costs for hospital bed-days, ED presentations and key clinical services utilised was sourced.

KEY FINDINGS

CLIENT PROFILE

The demographic and health profile of clients being seen by the four services was compiled through analysis of hospital records data, with contextual understanding of the empirical profile complemented by insights from the qualitative interviews with clients and staff. Of the 359 clients deemed homeless or at risk of homelessness that accessed any of the four services in 2015, 74% were male with a mean age 50 years. Nearly three quarters (73%) were born in Australia, and nearly all reported English as their preferred language (95%). Overall, 6% of clients identified as being of Aboriginal or Torres Strait Islander origin, with a higher proportion of Aboriginal or Torres Strait participants using ALERT compared to other services.

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 rarely encapsulates the complex needs of many people experiencing homelessness, and interviews with clients and staff illustrated the range and intricate web of psychosocial issues SVHM homeless clients are contending 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, whilst lack of housing often inflames or precipitates complex health needs.

CLIENT ENGAGEMENT WITH THE FOUR SERVICES

In 2015, 359 clients accessing one or more of the four services were identified as homeless or at risk of homelessness, with 431episodes of care provided across the four services. Of the 359 clients, 39% were supported by ALERT, 39% The Cottage, 23% CHOPS and the remaining 11% resided at Prague House. Due to the differing nature of each of the four services, the average length of an episode care is quite different; ALERT (95 days), The Cottage (9 days), CHOPS (997 days; approximately 2 years and 9 months) and Prague House (2,505 days; approximately 6 years and 10 months).

Whilst client referrals or joint-care approaches between services were quite often mentioned in staff and client interviews, and were evident in several of the case studies, the number of clients receiving care by more than one of the four services during 2015 was relatively small. With the exception of ALERT and The Cottage (36 shared clients), there were only a handful of shared clients identified between CHOPS, ALERT and/or Prague House. The Cottage had no shared clients with CHOPS or Prague House in the 2015 calendar year. Discussions with staff provided a number of explanations as to why there may not have been as many shared clients as expected: given the diversity of clients seen across the four services and the differing roles of the services, it was noted that cross-referral may often not be appropriate or relevant, either because of the nature of client needs, or if it falls outside of service scope or capacity. Variability in staff awareness of the suitability of other services for different client situations was also observed. There was however keen willingness among staff across the four services to optimise scope for cross-referral and integrated pathways of care.

HOSPITAL UTILISATION

The evaluation looked at changes in hospital usage for the cohort of clients who had accessed one of the four services in 2015 and who had commenced their episode of care after the 1st of January 2011. For this cohort (n=339), 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. Attendance (or non-attendance) at outpatient appointments was also examined.

Overall, across the four services, there was a 28% reduction in the number of clients who accessed the ED (from 232 to 168 people) in the six month period following episode commencement and a 13% reduction in the total number of ED presentations (from 667 to 581). The decrease in ED presentations primarily relates to ALERT and CHOPS clients. This observed

reduction in ED presentations within six months of commencing an episode of ALERT or CHOPS support is noteworthy, as a number of other studies have found that a longer window of time is required before significant reductions are detected. There was a significant decrease in the average ED presentations per person (from 2.0 to 1.7, $p<0.01$) and an observed decrease in LOS per ED presentation (from 5.8 to 5.0 hours).

Unplanned inpatient admissions (admissions as a result of an ED presentation) reduced by 34% from a total of 320 to 210 admissions in the six month period following episode commencement. The number of total days spent in unplanned inpatient admissions across this cohort also reduced, from 2,316 to 1,612 days in total, representing a decrease of 30%. As unplanned admissions can place substantial resource demands on hospitals such as SVHM, this observed reduction within six months is significant.

There was a significant increase in the average number of outpatient appointments per person between the six months pre and post episode commencement (from 2.2 to 2.5, $p<0.01$). The fact that overall outpatient appointments increased is not unexpected, as many of the staff interviews indicated that use of some health services can increase during the initial period of housing and support provision, particularly if previously unmet needs are now being addressed. Indeed some outpatient appointments can substantially increase, as was observed for a number of clients now accessing alcohol and drug counselling through the SVHM Department of Addiction Medicine.

COST BENEFITS ASSOCIATED WITH CHANGES IN HEALTH SERVICE UTILISATION

Caring for the health of people who are experiencing homelessness speaks to the heart of SVHM and its ethos, and there is often a discomfort in discussing the benefits of such services in purely economic terms. Nevertheless, there is growing evidence that targeted interventions for people who are homeless can reduce their use of more acute hospital services, with associated fiscal benefits. Such arguments are of policy and pragmatic importance in an era of strained health and social service budgets.

The change in use of SVHM services, comparing the six months pre episode commencement with the six months post, provides an average cost decrease across the four services of $4,203/person/six months. For the sub-sample of 339 people who had contact with one of the four services in 2015 and commenced their episode of care after the 1st of January 2011, this equates to the total cost decrease (relating to this group of people) of $1.425m in the six month period. This frees up resources to be applied elsewhere. It is pertinent to note that this figure is only based on a six month window following episode commencement and associated contact with one of the four SVHM services evaluated; this is noteworthy as a number of studies internationally and in Australia have reported initial increases in hospital use following service commencement (as health conditions became detected or better managed), with net cost savings not accruing until after the first year.

The largest per person cost decrease relates to Prague House, with a cost decrease of $22,025/person/six months, and CHOPS at $12,989/person/six months. Due in part to the high cost of mental health inpatient admissions, cost decreases associated with CHOPS represents 70% of the overall cost decrease observed. Smaller cost decreases are associated with those accessing both ALERT and The Cottage, and just ALERT, being $3,529 and

$1,302/person/six months, respectively. The cost of SVHM services used by Cottage clients increased by $2,980/person/six months, predominantly due to an increase in planned inpatient admission days. Decreases in ED presentations provide a small average savings of $208/person/six months (for the sub-sample of 339 people).

For clients supported by The Cottage, and 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. Case study and interview data in this SVHM evaluation supports this as a likely explanation. 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. Overall, changes in planned and unplanned inpatient days are the major contributing factors determining whether the change in SVHM costs represents an overall savings or cost increase.

The observed change in use of ED and other hospital services also has cost implications for the wider health system beyond SVHM. For example, reduced use of ED also results in a reduction in use of ambulance and a small decrease in police incidents associated with transportation to ED. The impact on ambulance arrivals to ED is not a cost borne by SVHM itself, but has been examined here as an example of the wider health system benefits that may potentially accrue from the homelessness services at SVHM and their impact.

SUCCESSES, CHALLENGES AND BARRIERS

Facilitators and critical success factors enabling the four services and SVHM to make a difference in the lives of homeless people were grouped into four domains (with 12 themes across this) based on the analysis of empirical, case study and interview data:

i) **underlying philosophy**- including the positive underlying philosophy and culture, the alignment of staff qualities with the broader SVHM philosophy, and innovations in striving for excellence in service provision;
ii) **service factors**- including the physical location and design of the four services, the responsive and flexible nature and the comprehensive and multifaceted staff roles;
iii) **collaboration**- including strong communication, relationships and knowledge sharing internally within SVHM and externally in the broader homelessness sector in Melbourne;
iv) **client focus**- including trust in staff, dignity and respect shown to clients, the ongoing and individually-specific support, and engagement between services and clients; were identified as positive outcomes for clients experiencing homelessness.

Whilst the overall tenor of the evaluation findings point to the many successes and strengths of the four services, there are also challenges. Some of the observed challenges are inherent in the complex health and psychosocial needs of many people who are homeless, and the underlying social determinants of health that lie beyond SVHM's direct sphere of influence. These include wider systemic issues such as the increasing demand on already strained homelessness and social services in Melbourne, and the lack of affordable and suitable accommodation options. Funding

constraints and efficiency targets set for hospitals were also noted as particularly challenging for services working with homeless people with complex and recurring needs. Other impediments to optimal client and organisational outcomes are however more internal to SVHM and can be addressed, and these have been incorporated into the report's recommendations. Barriers to optimal client and/or organisational outcomes that were identified included some lack of clarity about the relative functions, eligibility criteria and referral processes among the different services; a tendency to rely on informal or ad-hoc processes for collaboration; and scope to streamline client information sharing, data collection and client referral pathway mapping across SVHM services.

RECOMMENDATIONS

There are clear strengths underlying the culture, processes and outcomes of the four services. Whilst implications for SVHM within the body of an evaluation report of this magnitude are numerous, a number of key recommendations and areas for attention have also been distilled, grouped around four major themes.

Improve Collaboration and Integration

- develop an overarching integrated SVHM framework for health and homelessness;
- strengthen integrated pathways of care for clients experiencing homelessness;
- implement strategies and mechanisms to facilitate collaboration and integrated care, and;
- increase reciprocal awareness of services and their roles.

Build Upon Successes

- increase sharing of information and knowledge between services;
- expand capacity of existing SVHM services;
- increase resourcing and opportunities for professional development;
- increase sharing of SVHM expertise and service awareness, and;
- explore scope for more co-located services.

Addressing Gaps in Service Delivery Models and Homelessness Sector

- incorporate consumer/lived experiences into service planning and delivery;
- expand suite of services provided to homeless SVHM clients;
- increase partnerships within the Melbourne homelessness sector, and;
- provide greater support for clients with mental health needs.

Measuring Outcomes and Collective Impact

- articulate shared aims, outcomes and measures;
- measure service impact on homelessness and housing outcomes;
- improve and standardise data collection across SVHM services;
- build on SVHM contributions to evidence generation, and;
- strengthen collaboration and synergies with other St Vincent's Health Australia services.

CONCLUSION

Although the physical delivery of healthcare is the entry point, SVHM recognises that the causes of both homelessness and associated poor health are multifactorial, and that more tailored and multi-pronged solutions are necessary. As this evaluation has brought to light, the intentionality of SVHM's work with people who are homeless, and the compassion and dignity infused in their ethos and service delivery, has become highly regarded both within the SVHM network and beyond into the wider homelessness sector. Through the four key services central to the heart of the SVHM homelessness response, ALERT, The Cottage, Prague House and CHOPS have been shown in this evaluation to have had significant impacts at the client, service and organisational level, and have contributed to new innovations in tackling the revolving door between homelessness and health. Through their efforts, they have provided numerous lessons, points for development, and a persevering encouragement for other hospitals and services to model and lend from in their own contributions to this difficult issue.

More broadly, as reflected in an editorial in the British Journal of Hospital Medicine, the care of people experiencing homelessness in hospital is in effect an 'acid test' for the whole system[5]. Homeless patients often have multiple health problems that challenge clinical boundaries, and almost by definition they will bring a whole collection of social problems with them to hospital. It is this understanding that infuses the approach taken by SVHM, and we hope that the findings and recommendations of this evaluation enable SVHM to further amplify the difference it is making.

1 BACKGROUND TO THE EVALUATION

1.1 INTRODUCTION

1.1.1 PURPOSE

This report has been produced in response to St Vincent's Hospital Melbourne's (SVHM) request to evaluate four of its homelessness programs. Specifically, to measure, analyse, and document the impact of SVHM homelessness services on client outcomes and to make recommendations for how these services may collaboratively strengthen their future service delivery. The specific objectives of the evaluation were to:

1. Document the demographic profile, health needs and service delivery provided to individuals experiencing homelessness who use four key SVHM homelessness services:
    - *(i)* Assessment, Liaison, & Early Referral Team (ALERT);
    - *(ii)* Clarendon Homeless Outreach Psychiatric Service (CHOPS);
    - *(iii)* The Sister Francesca Healy Cottage (The Cottage); and,
    - *(iv)* Prague House.
2. Measure the impacts of SVHM's homelessness services on clients' health/healthcare utilisation and homelessness/housing outcomes;
3. Understand and map the client flow and patterns of utilisation between the services;
4. Establish how well the health needs of homeless individuals serviced by SVHM homelessness services are being met;
5. Identify the successes, barriers and gaps in homelessness service provision at SVHM;
6. Determine how SVHM homelessness services can be improved to provide more targeted and outcome focused delivery;
7. Identify key opportunities for improved collaboration and integration between SVHM's homelessness services to support sustainability and service effectiveness;
8. Examine the cost-effectiveness of the relevant SVHM services in terms of reduction in health care utilisation costs relative to service provision costs.

1.1.2 BACKGROUND

Homelessness is a significant problem facing approximately 1 in every 204 Australians[6], with over 22,000 people in Victoria currently experiencing homelessness[7]. Whilst homelessness has always been an issue of social concern in Melbourne, there is evidence to suggest that there has been an increase in recent years, with many homelessness services struggling to meet demand, and the lack of affordable and crisis housing as compounding factors. Currently, the Melbourne metropolitan region has a homelessness rate of 4.3 per 1,000 people; the fifth highest of Australian cities[7].

SVHM is located in the City of Yarra which has the third highest rate of homelessness of Victorian Local Government Areas (LGAs); a rate of 10 per 1000 people. The catchment area for SVHM also includes the LGA areas of Moreland, with a rate of 4.9 per 1,000 people, Boroondara

(2.2 per 1,000 people), and Darebin (6.8 per 1,000 people)[8]. The Darebin and Moreland LGAs have the 7th and 11th highest rates of homelessness in Victoria[8].

Homelessness and Health are Intertwined

People experiencing homelessness are over-represented in a myriad of health statistics, including high morbidity[9] premature mortality[10], psychiatric illness[11], chronic disease[12] and greater usage of acute services[13]. Explanatory factors include a high prevalence of mental and chronic physical health conditions[14], delays in help-seeking[15], cost and access barriers[16] and living environments not conducive to good health. Individuals experiencing homelessness are less likely to access primary and preventive health services[17] resulting in increased risk for later-stage diagnosis of disease[18], poor control of manageable conditions (e.g. hypertension, diabetes), and hospitalisation for preventable conditions (e.g. skin or respiratory conditions).

As seen at SVHM itself, comorbidities are common in homeless populations[19], with substance dependence and mental illness often co-occurring[19-21]. As a consequence there is high demand on health system resources[22-25]. The homelessness support sector is also put under considerable strain by the proportion of clients needing intense support due to underlying health issues[26]. Moreover, there is a bi-directional relationship between homelessness and health[26,27]; for example, while mental illness and chronic diseases can precipitate homelessness, rough sleeping and precarious and unstable housing can also deteriorate mental health and exacerbate health conditions[26]. Thus addressing health issues among the homeless in isolation has diminished effectiveness, and a social determinants of health paradigm is needed.

Implications for the Health Sector and Public Hospitals

It is not only the high prevalence of those experiencing homelessness among hospital statistics that renders their healthcare a priority, but also the vulnerability of this population group, the complex nature of their health issues and the underlying determinants of these health issues. The impediment to health service access and continuity of care are also more problematic for people who are homeless, as articulated succinctly by the National Healthcare for the Homeless Council in Nashville:

> *As a consequence of homelessness, health care is frequently interrupted and uncoordinated. Mobility, lack of health insurance, fragmented health services, and a mainstream health care system that often is not prepared to deal with the complex psychosocial problems presented by homeless patients partially explain their discontinuity of care. Transience makes comprehensive medical care, referrals and follow-up difficult*[28].

People experiencing homelessness are more likely to engage with the acute end of the health system, which bears a higher price tag than earlier intervention and primary care or health service provision outside of hospital settings[14,19]. Indeed economic analysis internationally and within Australia indicates that the health sector bears much of the cost and consequences of recurrent homelessness[22-25,29-35]. On the flip side, there is also an expanding body of research documenting the cost and resource savings that can accrue for the health system when homelessness is reduced through effective interventions. Most studies to date have evaluated the cost effectiveness of interventions instigated in the homelessness sector. Australian studies have predominantly found homelessness support to be associated with reduced use of high cost health

services[23-25,32,33,35-37]. For example, in the Mission Australia MISHA project a 'Housing First' model was coupled with strong post-housing support, and health costs were found to decrease by an average 47% ($6,657/year) in the two years after support commenced, predominantly relating to stays in hospital and psychiatric facilities[25].

Fewer studies have examined the cost effectiveness of homelessness-focused programs and services driven within the health sector such as the homelessness services provided by SVHM. The recently completed evaluation of two homelessness services delivered by St Vincent's Hospital Sydney (SVHS) is, of course, an important exception to this, and showed that providing high quality care and engaging homeless clients led to an increase in the appropriateness of healthcare utilisation and, for the accommodation–based service, significant cost savings[38].

Homelessness in Melbourne and Hospital Implications

As SVHM finds on a daily basis, people experiencing homelessness are a common face in the public health system, particularly in inner city areas. International[13,21,39,40] and Australian data[15,21] indicates that people experiencing homelessness are over-represented in emergency presentations, with a 2016 survey of rough sleepers in the Melbourne central business district (CBD) finding that 48% had visited the emergency department (ED) in the last three months[41], with nearly a quarter (23%) of respondents listing SVHM as their healthcare provider (Figure 1); more than twice as many people than listed The Alfred (11%) or Royal Melbourne Hospital (10%) as their primary health care provider[41]. Homelessness has also been associated with recurrent hospitalisations[17], longer length of stay (LOS) and psychiatric care[42].

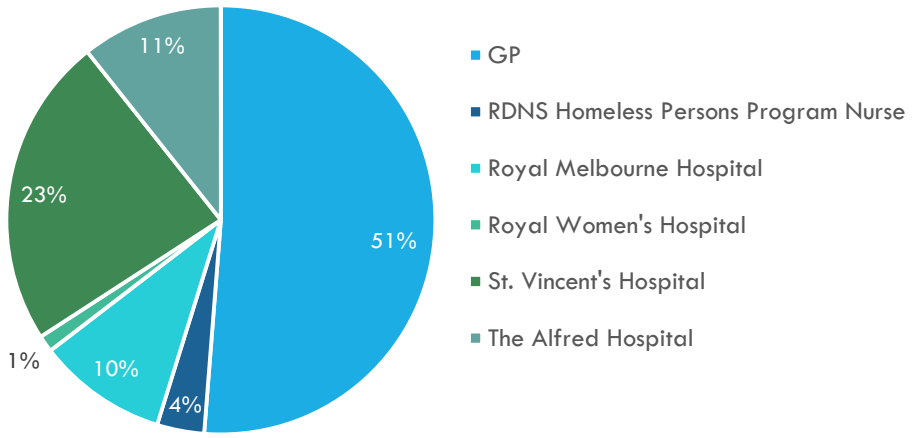

Figure 1: Primary Health Care Provider for Melbourne Rough Sleepers
Source: Micah Projects Inc. [41].

Registry Week data has been collected since 2010 in Melbourne using the Vulnerability Index tool[43] which assesses the key mortality risk indicators that are prevalent in people who are long term homeless (particularly rough sleepers). It provides an objective source of data on the prevalence and risk profiles of those who respond. The Vulnerability Index has been used across Australia, spanning nine cities in five states[41].

Over the past six years, VI-SPDAT data collected regularly in Melbourne shows an upward trend in the number of rough sleepers with tri-morbid health conditions (average 49%) and those with a serious health issue (average 73%) (Table 1). Those who attended an ED, had an

average of 3.3 visits in the previous 3 months (Table 2). The most common health issues amongst rough sleepers in Melbourne in 2016 were Asthma (30%), Hepatitis C (25%), Heat Stroke (23%) and Heart Disease (18%) (Figure 2).

Table 1: Demographics and Health Statistics of Melbourne Registry Week Responders 2010 -2016 (%)

	2010 (n=164)	2011 (n=151)	2012 (n=57)	2013 (n=140)	2014 (n=35)	2015 (n=149)	2016 (n=161)	Average (n=857)
Female	11.6	15.2	7.0	12.1	20.0	15.4	22.4	14.8
Aboriginal and Torre Strait Islander	13.4	15.2	21.1	13.6	17.1	15.4	11.2	15.3
Tri-morbid health condition	32.3	45.0	42.1	52.1	57.1	57.7	53.4	48.5
Mental health issue	52.4	68.9	66.7	68.6	80.0	73.2	71.4	68.7
Daily alcohol consumption (past month)	24.4	21.2	24.6	22.9	37.1	34.9	20.5	26.5
Serious health issue	62.2	72.2	73.7	75.0	77.1	72.5	75.2	72.6
Attended ED in last 3 months	34.8	45.0	52.6	73.6	57.1	43.0	48.4	50.6
Hospital inpatient in past year	48.8	54.3	56.1	77.1	65.7	55.7	59.0	59.5

Source: Micah Projects Inc. [41].

Table 2: Mean number of ED and Inpatient Contacts for Melbourne Registry Week Responders 2010-2016

	2010	2011	2012	2013	2014	2015	2016	Average
Ave number of visits to ED in last 3 months	3.8	4.5	3.7	2.8	2.8	2.6	3.1	3.3
Ave times as inpatient in hospital in past year	4.8	3.6	3.7	3.0	3.7	3.4	3.4	3.7

Please note that the averages are based on only those who attended ED in the time period. Source: Micah Projects Inc. [41].

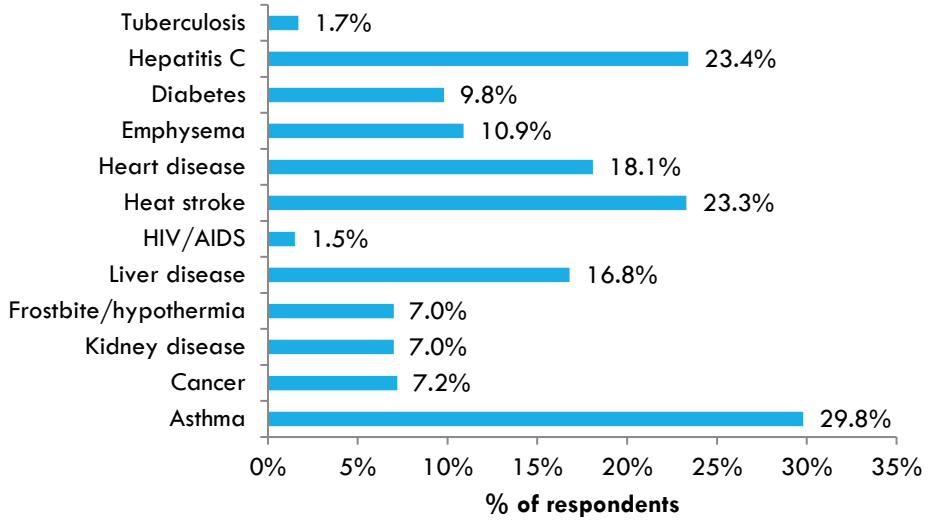

Figure 2: Overall Prevalence of Health Conditions of Melbourne Registry Week Responders in 2016
Source: Micah Projects Inc. [41].

Timeliness of This Evaluation

St Vincent's has been one of the Australian forerunners in prioritising the health care of people who find themselves homeless or at risk of homelessness, and this evaluation is timely given growing interest nationally and internationally in countering the revolving door between homelessness and poor health. An accumulating body of evidence confirms the significant

presence of people experiencing homelessness in health morbidity, mortality and health service data, but evidence based assessments of what works to redress this are far more sparse. Most of the Australian exceptions tend to pertain to initiatives within the homelessness sector or housing-related initiatives, and few have specifically evaluated programs or interventions instigated in a public hospital context. Table 3 presents a selection of relevant studies.

Table 3: Selected Australian Evaluation Studies and Hospital Outcomes

Intervention or program evaluated	Location	Year	Health and hospital outcomes
Common Ground initiative (in partnership with Mater Hospital Brisbane and Micah projects)	Brisbane	2016	24% decrease in admission rates to hospital ED for those using Common Ground homelessness services freeing up $6 mil per year of resources[44].
Evaluation of changes in health service use among formerly homeless people provided with public housing and support via an National Partnership Agreement on Homelessness (NPAH) program	Western Australia (WA)	2016	Of 983 NPAH clients, there was significant reductions in health service use (e.g. length of hospital stay, ED admissions, days in psychiatric care) when health records were compared before and after entry into public housing. This equated to a potential cost saving of $13,745 per person in a single year[45].
St Vincent's Homeless Health Service Evaluation	Sydney	2016	Initial increase in ED presentations and hospital admissions on contact with both Tierney House and COMET services. Significant reduction in use of acute health services by Tierney House clients generated a cost saving (-$3,827 per person) in the first year after contact and these were even greater in the second year ($11,621) [38].
Michael Project	Sydney	2007-2010	Significant reductions in use of crisis health services and increased utilisation of community based services. At 12 months a reduction in health expenditure of $8,222 per Michael Project client had been achieved over the year[46]
J2SI Pilot- Changes in health service usage of intervention group with intensive case management	Melbourne	2014	Decline of 80% in use of emergency hospital services in intervention group after housing and support[47].

This evaluation of SVHM homelessness services is also timely in the light of several trends within the health sector policy and service delivery landscape in Australia, Victoria and SVHM itself. This includes the growing shift towards models of client-centred care; greater attention to patients with complex needs and comorbidities; and calls for more integrated service responses, both across the primary, secondary and tertiary levels of the health system. More widely, with sectors and organisations outside of health that can significantly influence health and wellbeing outcomes (the homelessness sector being prominent among these)[48].

1.2 SVHM AND ITS RESPONSE TO HOMELESSNESS

1.2.1 CONGRUENCE WITH THE SVHM MISSION AND VALUES

SVHM is named after St Vincent de Paul, renowned as a champion of the poor, and as such has a long established philosophy of delivering health care based on the principles of social justice and human dignity, and service to some of the most vulnerable people within the community. Its original values are mirrored in the four core values of St Vincent Health Australia (SVHA); compassion, justice, integrity and excellence[2]. In addition to the infusion of these values in the culture and service ethos of health services that form part of SVHA, St Vincent's services have a focus on addressing the social and structural causes of disadvantage and marginalisation[2].

Box 1: Social Justice through Health

St Vincent's Health Australia

Through the provision of care, we seek to change the structures and systems that lead to some people experiencing poorer health outcomes than others as a consequence of poverty, marginalisation or vulnerability. Our focus is on addressing the health care needs of Aboriginal and Torres Strait Islander people, people experiencing chronic homelessness and people living in the community seeking asylum[2].

Whilst people who are homeless have always aligned with the core mission and values of SVHM, several decades ago the hospital began to consolidate its leadership and focus around homelessness in health. One of the early documented examples of this was in 1991, when SVHM and the Royal District Nursing Service Homeless Person's Program (RDNS HPP) participated in a seminal project to examine the health care needs of Melbourne's homeless[49]. A void in services for people experiencing homelessness who had received hospital care, but were not well enough to return to hostel or unstable housing environments, was identified, and the concept of The Cottage was born. Since then, The Cottage (described below) has become one of the hallmarks of SVHM's work with people experiencing homelessness; with other SVHM initiatives around homelessness since evolving.

Over time, SVHM has developed a multidisciplinary approach to healthcare delivery for people experiencing homelessness[50], which has been recognised within Melbourne, Victoria and wider Australia for its dedicated work to improve the health and wellbeing of those experiencing homelessness. An example of this is recent discussions surrounding SVHM's work in this space at a WA clinical senate meeting.

1.2.2 SERVICES FOR PEOPLE EXPERIENCING HOMELESSNESS AT SVHM

The terms of reference for this evaluation specified the review of four differing services that have a primary focus on homelessness at SVHM; ALERT (ED outreach/care co-ordination), The Cottage (short term convalescence), CHOPS (mental health outreach) and Prague House (residential aged care facility). An overview of each of these is provided below. At the commencement of this research, ALERT and The Cottage were under the umbrella of the "Hospital Admission Risk Program (HARP)", a group of programs targeting vulnerable patients at high risk of hospital presentation. Over the course of the project, HARP has evolved and is now known as "Complex Care Services", to which ALERT and The Cottage are now aligned.

Complex Care Services (CCS) is one pillar of the Victorian State Government's transition to "Health Independence Programs (HIP)", which encompasses ambulatory care, outreach and community based services across SVHM. It is pertinent to note from the outset, however, that these are by no means the only services and areas within SVHM that are providing care and health services to people experiencing homelessness, and as noted in subsequent sections of this report, there was widespread recognition across the spectrum of staff and stakeholders interviewed, that people experiencing homelessness are an integral part of the SVHM remit across the organisation to work with the '*poorest of the poor and those who are most vulnerable*'.

Photo 1: ALERT is based in SVHM ED

ALERT is a CCS that was established in 2000 as part of the Victorian Government's Hospital Demand Strategy to improve health outcomes and reduce demand on ED. ALERT provides 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.

Photo 2: Rough sleeper in Melbourne CBD

CHOPS is a specialist homelessness outreach service of SVHM's Mental Health. It is specifically designed to work with people with mental illness who are homeless or in tenuous housing and has been running for over 10 years. The CHOPS team consists of 6 workers making up 5 full time equivalent (FTE) positions, with a total case load of 40 clients at any given time. The CHOPS team has a strong multidisciplinary focus and is made up of nurses, occupational therapists and social workers. The team provides assertive and flexible outreach including opportunistic "check ins" with clients if they are seen on the street, and extends to locating clients who have temporarily moved out of the CHOPS catchment area.

CHOPS also assists in the implementation of Community Treatment Orders, supports community-based care and sustains an ongoing engagement strategy with clients.

Photo 3: The Cottage

The Cottage is a supportive, home like environment where CCS and Hospital in the Home (HITH) services are provided to people who are homeless or at risk of homelessness. The aim is to provide holistic, recuperative care to clients with a nursing need, as an alternative to staying in hospital. The Cottage is a small terrace house with 6 beds located on the SVHM 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 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.

Prague House is a 45 bed, low level care residential aged care facility operating under the auspices of SVHA since 1976. Prague House is a specialised aged care facility that supports residents living with a mental health diagnosis and or an acquired brain injury to live life to their fullest potential. Many residents have a history of homelessness or have been at high risk of becoming homeless. The average age of residents at Prague House is 65, which is younger than most other aged care facilities due to the background of the residents.

Photo 4: Prague House

The staff at Prague House consists of nurses, activity staff, pastoral care, personal carers, housekeepers, cooks and administrative staff. Staff often take on the role of family by shopping for residents, with many residents having no family contact and few, if any, friends. Prague House is 'home' to the residents where their individuality is respected, however it is a dry house and there is the expectation of no swearing, fighting, bullying or bartering.

1.2.3 PREVIOUS EVALUATIONS OF THE FOUR SERVICES

Several evaluations of SVHM's individual homelessness services have been undertaken previously. However, these evaluations were largely internal and limited to individual services. In 2011, HARP was evaluated via a descriptive analysis of client demographics and diagnosis information[51]. The Cottage has been evaluated on a number of occasions; a retrospective chart analysis of consecutive admissions from 1996 was undertaken in 1999[49]; a small (24 patient) evaluation was undertaken in 2003[52] assessing patient demographics, histories and admission details, and a qualitative and quantitative assessment of patient experiences in 2013/14[53]. An evaluation of the effectiveness and challenges facing the ALERT service was undertaken in 2014 by ALERT management[50]. This current report presents a holistic evaluation of four of SVHM's homelessness services examining how they operate individually, with each other, within SVHM more broadly and in the homelessness sector in Melbourne.

2 METHODOLOGY

A mixed methods approach was undertaken to address the evaluation objectives over four different domains (Figure 3).

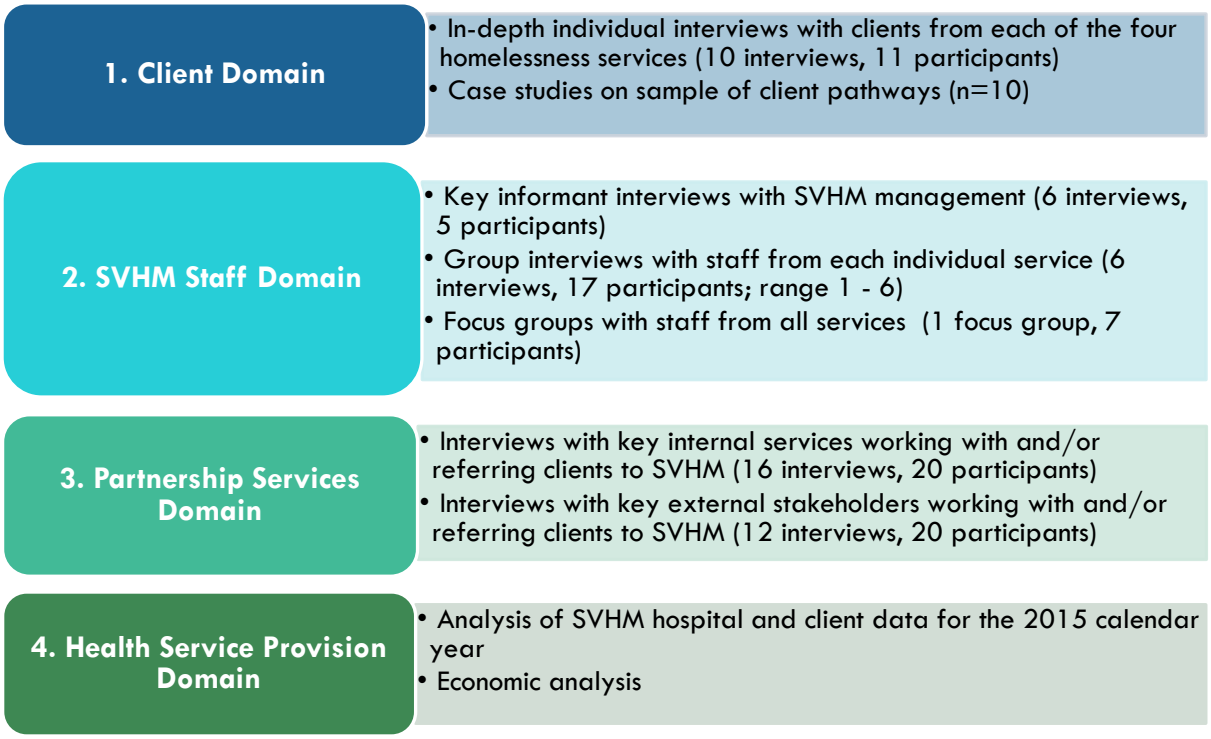

Figure 3: Summary of Domains and Data Collection Sources and Strategies

2.1 CLIENT DOMAIN

2.1.1 IN-DEPTH CLIENT INTERVIEWS

In-depth interviews[b] were held with a sub-sample of 11 clients who had accessed at least one of the four services (ALERT n=2; The Cottage n=5; CHOPS n=2; Prague House n=2). The purpose of the interviews was to capture how they first came in contact with the SVHM service(s); their experience of the service (i.e. staff helpfulness and understanding); how the service made a difference (both in terms of meeting their needs or improving their outcomes); any issues they may have experienced with the service(s); suggestions and feedback on how services could be improved; and their knowledge of the other services.

A purposive sampling method was used to guide recruitment of clients, reflective of the breadth of homeless people who come into contact with SVHM from varied demographic backgrounds

[b] One interview was completed in pairs for a total of 10 interviews, with 11 participants. Consent was sought from both participants before commencing the interview.

and with varying health, psychosocial and welfare needs. SVHM staff from each of the four services played an integral role in identifying and inviting clients to be interviewed, tapping into the staffs' established relationships of trust with clients, and their wisdom regarding the amenability and accessibility of clients for interview. Staff were advised to stress that participation in interviews was entirely voluntary and would in no way impact on their relationship with SVHM services. The involvement of staff in the recruitment of interviews was invaluable; illustratively, one staff member walked clients to the interview room to ensure they made it, whilst another followed up with a client who was unable to attend the original time, and arranged a revised venue and time to accommodate the client's circumstances.

Client interviews, on average, lasted for 45 minutes, with the interviews ranging between 27 and 60 minutes. All clients were provided with the client information sheet and consent form prior to interview commencement, with opportunity to ask the research team any questions relating to this. Permission to audio record interviews for the purpose of accurate transcripts was requested prior to the commencement of each interview, and all interviewees consented to this. Upon conclusion of the interview, clients were provided with their choice of a $20 Target or Kmart voucher as reimbursement for their travel and/or time. The type of voucher was determined in consultation with staff from the four SVHM services. As one service had particular concerns about vouchers that could be used for the purchase of alcohol or cigarettes, vouchers for Kmart or Target were chosen, with the research team checking the proximity of these stores to the SVHM catchment prior to their purchase. It is pertinent to note that the majority of clients were pleasantly surprised about the voucher provided to them at the conclusion of interviews, with many indicating that they would have happily contributed without this. Encouragingly, several clients overtly noted their eagerness to contribute to evaluation and research to demonstrate the benefits of SVHM work with people who are homeless.

2.1.2 CASE STUDIES

Case studies are a powerful yet underutilised complement to program or service evaluation[54], and are able to complement empirical and qualitative data with a triangulated narrative through the eyes of the client journey in relation to program experience and outcomes. Ten case studies were developed to provide deeper insight into the pathways into, between and from SVHM homelessness services, and the trajectory of client experiences. The majority of case studies were developed around clients that the research team had the opportunity to interview, with several case studies being developed from the information elicited from staff and client interviews in addition to hospital administrative data. Case studies were created to illustrate the breadth of SVHM homelessness work. The compilation of these case studies drew on a range of data including information elicited from both client and staff interviews; service provider summaries of client history; documentation of referrals between SVHM services and/or external service providers; changes observed/documented in client wellbeing; and hospital administrative data.

Data was triangulated in the analysis and an iterative process was used to describe the trajectory of client and service pathways to identify factors driving or impeding the health outcomes achieved.

These case studies are interspersed throughout the report to illustrate key points that they exemplify. For the purposes of this report, case studies and client vignettes are presented in shaded blue boxes.

2.2 SVHM STAFF DOMAIN

2.2.1 KEY INFORMANT INTERVIEWS WITH MANAGEMENT OF THE FOUR SERVICES

Six semi-structured interviews with a total of five managers/senior staff from each of the four services were undertaken[c]. Interviews explored perceptions of the purpose of the homeless services, and the roles they play within SVHM; the main types of care/service offered to clients; usual referral pathways; unique attributes of the services; how well the needs of individuals experiencing homelessness are being met by; a) the specific service, and b) by SVHM more broadly; the barriers and gaps in homelessness service provision at SVHM and/or in the network of other services they work with; possible scope to provide more targeted and outcome focused delivery via SVHM homelessness services; and, opportunities for improved collaboration and integration between SVHM services to support sustainability.

Participants were also asked to visually depict (by drawing) how they perceived relationships between the four homelessness services (for example, which ones cross-refer or collaborate), and to identify other services with SVHM that they work with or see as having a role to play in relation to people who are homeless. Additionally, participants were asked to indicate for their own service, key external services they work with. A visual representation of these relationships and perceptions is included in Chapter 5.

Interviews lasted an average of 80 minutes, ranging between 61 and 109 minutes and were arranged at a time and venue of convenience to participants. Upon the conclusion of the interview, participants were asked to assist in identifying other SVHM staff members from the service team that should be interviewed and for suggestions for key services (external and internal) to be interviewed. Where possible, participants also provided specific contact information for internal and external services.

2.2.2 INTERVIEWS WITH STAFF FROM EACH OF THE FOUR SERVICES

Six semi-structured group/individual interviews were undertaken with 17 staff members from each of the four homeless services. Interviews ranged in participant numbers, with between one and six participants per session. Each service manager assisted in recruiting staff from their respective service for these interviews; the manager arranged a time suitable to the majority of the staff and either notified staff via calendar invite or in person. Some additional interviews were undertaken to capture the perspectives of staff not able to attend a group session. Interviews were conducted at a location convenient to the staff (e.g. lunch room or meeting room

[c] two people were spoken with on two occasions and one interview had two participants

at their service). On average, these discussions lasted for 47 minutes, ranging between 22 and 66 minutes.

These interviews canvassed staff views on service delivery for clients; observed changes in clients following service delivery; extent to which the service meets the need of clients; feedback on how SVHM homelessness services can be improved to provide more outcome focused delivery; successes, barriers and gaps in service provision, and; strategies for increasing collaboration and integration between services. Current ways of working with other SVHM services and external services were also discussed in these interviews.

2.2.3 COMBINED FOCUS GROUP WITH MANAGEMENT FROM ALL FOUR SERVICES

Following the collation of initial data that emerged from staff and client interviews, a focus group bringing seven senior staff/managers from all four services was held (two staff from ALERT; one from The Cottage; one from CHOPS; two from Prague House and the evaluation co-ordinator). The evaluation co-ordinator was responsible for booking the meeting room and inviting participants along, and attended as an observer.

This semi-structured session was intentionally scheduled after the interviews with the managers and staff of the four services had been conducted and transcribed; some of the preliminary themes that had emerged relating to service collaboration and integration were raised as part of the discussion as a discussion prompt. The focus group lasted approximately 90 minutes and focused on the impacts of the individual services and as a part of SVHM more broadly; the referral pathways between services; the successors, barriers and enablers for collaborative partnerships between services, and; potential strategies for increasing collaboration and integration between services. Understandings of each other's services were also explored as part of this focus group, and the program logic models for each service were used as a discussion prompt to elicit areas of commonality in relation to service ethos, clientele and desired outcomes (see Appendix 1 for program logics for each service).

2.3 PARTNERSHIP SERVICES DOMAIN

For the purposes of this project, the partnership domain was defined as encompassing both internal SVHM stakeholders, such as other teams and services within the hospital or wider SVHM family, and external services, comprising services in the community and broader health or homelessness sectors that one or more of the four SVHM homelessness services identified as a key organisation they engage with. A full list of identified and interviewed internal and external services can be found in Appendix 2.

2.3.1 INTERVIEWS WITH KEY INTERNAL STAKEHOLDERS WORKING WITH AND/OR REFERRING CLIENTS TO SVHM HOMELESSNESS SERVICES

Sixteen semi-structured interviews were conducted with 20 internal [SVHM] staff members. Firstly to facilitate an understanding of the service they provided and how they work with homeless clients and then; to describe the referral processes and client flow/patterns between the four services; to identify barriers, successes and gaps of service provision; to determine how

homelessness services can be improved to provide more outcome focused service delivery, and; to elicit insight into perceived critical success factors of SVHM's homelessness programs.

Key internal stakeholders were identified by service managers and initial contact was made by the evaluation co-ordinator to inform them that they had been identified as a key stakeholder for this evaluation. Once initial contact had been made, a member from the research team made contact via phone or email to book in a time to meet. Participants had the option of meeting at the Library Room (which had been pre-booked for these sessions) or at a location convenient to them. Whilst not all identified staff responded to our request to meet (or a mutual meeting time could not be arranged) (n=6), only one person declined to be involved. Additionally, one interview was conducted over the phone as they wished to participate but a suitable time to meet could not be arranged face to face.

On average interviews were 53 minutes long, ranging between 28 and 86 minutes.

2.3.2 INTERVIEWS WITH KEY EXTERNAL SERVICES WORKING WITH AND/OR REFERRING CLIENTS TO SVHM HOMELESSNESS SERVICES

Interviews were undertaken with 12 key external services, with 20 staff members from these agencies participating. The purpose of the interviews were to determine which services at SVHM they worked with/were aware of; the perceived role of SVHM services; the type and extent of contact they had with different services at SVHM; what they perceived to work well or not so well in terms of service provision; perceived differences/similarities between SVHM and other hospitals; how SVHM fits into the broader homelessness field in Melbourne; opportunities for collaboration; examples of outcome measurement, and; suggestions for the future ways of working together.

Key external services were identified by service managers and available details were passed onto the research team to make contact. Where possible, initial contact was made via email to introduce the project and a subsequent telephone call made to confirm a meeting time. All interviews were undertaken at a location convenient to the participant. Service managers initially identified 30 external organisations that they deemed to be key stakeholders for their services; of these services, no one refused to be involved, but the remaining either did not respond, were unavailable to meet during our visit, or specific contacts were not provided. The original evaluation proposal and budget proposed ten interviews with external services, but a far greater number of external services were subsequently suggested by service managers and SVHM staff. The evaluation team approached over 20 external services for interview, and of these 12 made themselves available for interview within the review timeframe. The evaluation team interviewed a wide breadth of stakeholder types, ranging from organisations with a housing and homelessness focus, through to other health services that work with similar clientele, and a mix of agencies that may refer to or receive referrals from the four services.

On average interviews were 49 minutes long, ranging between 24 and 68 minutes, with between one and three participants present per interview.

2.4 HEALTH SERVICES DOMAIN

2.4.1 SVHM HOSPITAL AND CLIENT DATA

The research team worked with the HIP data manager to identify the requisite hospital data to support this evaluation project. Data on measures such as number and frequency of ED presentations, hospital admissions and LOS were sought to enable a comparison of health service use prior to and following contact with one of the four services. The process of identifying the cohort took longer than expected as it was assumed that all service users would be homeless, however ALERT also provides service to non-homeless clients with other service eligibility (i.e. target cohorts such as those with a disability, experiencing domestic or family violence or those with substance misuse). Following consultation between SVHM management and the research team it was deemed inappropriate to use only the no fixed address (NFA) marker to identify the clients that were homeless. The rationale was that using this marker would capture those known to be, or identifying as, experiencing primary homelessness (such as someone who is sleeping rough, e.g., in a park or under bridges), but would not capture those experiencing secondary homelessness (an accommodation arrangement that has no formal tenure, e.g., staying in crisis accommodation or temporarily with friend/family) or tertiary homelessness (insecure accommodation arrangement, e.g., boarding house or caravan park)[55]. See Figure 4 below for an overview of the process undertaken to collect data.

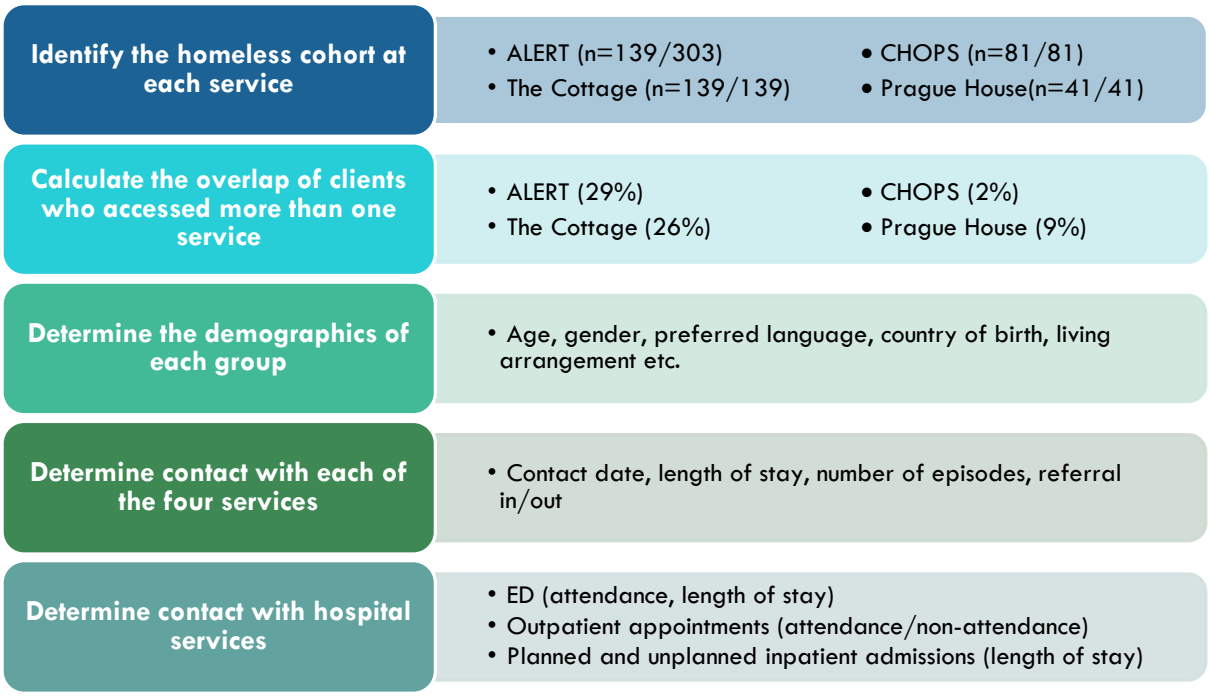

Figure 4: Method of Identifying SVHM Clients for Data Analysis

Once the study population was identified (359 out of 523 clients seen were identified as homeless), we were able to calculate the number of clients seen by more than one of the four services during the 2015 calendar year. This was done to provide an empirical assessment of the extent to which there is shared clients and referrals between the four services.

Data extraction was required from different software used for data collection at each homeless service e.g. ALERT/Cottage from The Care Manager (TCM) database, CHOPS from the Client Management Interface (CMI) and Prague House from an internally held excel spreadsheet. Homelessness service variables are also different and collected in different formats necessitating mapping data to common values where possible to create a homogenous dataset for analysis. Hospital data from Patient Administration System (PAS) was linked using the client's ID number and provided to researchers at the University of Western Australia (UWA) for analysis in a de-identified format.

2.4.2 ECONOMIC ANALYSIS

The economic analysis provides a partial assessment of the cost-effectiveness of the four SVHM homelessness services being evaluated. The cost of providing the services for the 2015-16 financial year is estimated, along with the cost of providing non-homelessness general SVHM health services (i.e. ED, inpatient admissions). The impact of homelessness support on the use of other SVHM health services and the associated cost is estimated for the sub-set of homeless clients who received support from one of the four services during 2015 (and that support episode commenced after the 1st of January 2011). Health service use and associated cost (e.g. ED presentations, bed days) in the six months prior to commencing support from one of the four services is compared to health service use and cost in the six months following commencement of support.

It is hypothesised that where support is provided by one of the four services it will result in reduced use of general health services (including reduced re-admissions), and that there will be a potential for an associated SVHM cost decrease. Potential cost decreases also accrue when people transition to a less costly form of treatment (e.g. outpatient or community based care versus hospitalisation). The cost effectiveness component of this study will compare, where available, data on health service use (type, frequency and duration) at baseline or prior to the client commencing support with one of the four services, with post-support health service use data. The economic analysis will examine changes in ED presentations, days in hospital (including psychiatric care) and outpatient attendances as these have been identified in previous literature as having the largest health care cost impact. Although not a direct cost to SVHM, the cost of arrivals at ED by ambulance does represent a cost to the broader health system and has also been estimated and reported.

To compute a partial measure of cost effectiveness, two types of cost measures were used:

(i) SVHM administrative data on the 2015-16 annual operating cost of the four services, as well as other costs incurred in the management and delivery of the four services. This was obtained for both personnel and non-personnel costs and used in calculating the net costs of service provision, and;

(ii) Data on 2015-16 average costs for hospital bed-days, ED presentations and key clinical services utilised by the client group (e.g. psychiatric care or mental health outpatient services) was sourced from SVHM. The cost of outpatient services and ambulance are based on publicly available Victorian health system cost data.

It should be noted that data limitations mean the economic analysis provides a preliminary assessment only and cannot be used to make definitive conclusions surrounding the cost-

effectiveness of the four homelessness services. Data limitations include the difficulty of estimating support service cost; including disentangling funding streams and attributing cost where services support both homelessness and non-homelessness clients. The data window of six months pre- and post-commencement of support is very short, and, as a consequence, no assessment can be made of the medium to long-term impact of support on health service use. This is of particular importance when people have complex issues and the period immediately after support commences is spent assessing the extent of these issues before further action can be implemented. Also, where there are previously unaddressed health issues and in addressing these issues health service use increases in the short term, but may decrease in the medium to longer term. It is not possible to directly attribute observed changes in health service use to one of the four services, as it is not possible to determine whether clients are accessing other homelessness support and health services, including other hospitals. These issues are discussed in further detail in Chapter 7.

2.5 DATA ANALYSIS

2.5.1 QUANTITATIVE DATA ANALYSIS

Statistical Package for the Social Sciences (SPSS) v 22 was used for the descriptive analysis. Due to the non-normality of the data, Chi-square analysis has been used to determine differences between pre and post categorical data, whereas, Wilcoxon non-parametric tests have been used to determine differences between pre and post continuous data.

The following datasets have been provided:

- **Demographics** of 359 clients accessing ALERT, The Cottage, CHOPS and Prague House;
- **Episodes** data for the 2015 calendar year (linked to demographics through client ID);
- **Hospital** usage of 339 clients six months pre and post start of episode of support for those who received support in 2015 and their episode of support commenced after the 1st of January 2011 (linked to demographics through client ID);
- **ED presentations** (linked to demographics through client ID, pre and post determined through linkage with Hospital data pre and post usage); and,
- **ED diagnoses** (linked to demographics through client ID, pre and post determined through linkage with Hospital data pre and post usage).

Please note that the sum of individual services may not add to table totals as clients may have accessed more than one service. The table total columns represent unique clients.

Data Analysis Definitions

Average ED presentations and admissions: calculated over the whole sample, including those who did not have a presentation/admission (i.e. inclusion of those with zero, n=339).

Average LOS: calculated over total presentations/admissions and do not include those who did not present/were not admitted (i.e. inclusion of >1 only).

Inpatient days: inpatient days were converted from hours and have been rounded up (i.e. 3 hours = 1 day, 25 hours = 2 days).

Data window: 182+/- days was used to define the six month period pre/post first episode start date.

Outliers: those greater than the mean plus three standard deviations.

2.5.2 QUALITATIVE DATA ANALYSIS

Data was transcribed verbatim by Pacific Transcription and coded using QSR NViVo, a qualitative data analysis computer software package[56] following each interview or focus group. Thematic analysis using inductive category development and constant comparison coding[57] was undertaken with cross checking between team members to enhance validity. The coding schema was not static and was revised to include emergent codes as data analysis progresses[58]. To ensure that all conclusions in the study are dependent upon the subjects and not the researcher, key findings were presented to the research team for discussion.

3 CLIENT DEMOGRAPHICS, HEALTH PROFILE, AND ENGAGEMENT WITH SVHM HOMELESSNESS SERVICES

People experiencing homelessness often have multiple and complex health issues, are less likely to access preventative or primary health services[15,21] and have an increased prevalence of chronic health conditions such as hypertension, cardiovascular disease and diabetes mellitus[14,17,18]. A lack of access and utilisation of primary care services often results in later-stage diagnosis of disease, development of severe complications and poorer health outcomes[14,21,59]. Rough sleepers often develop or exacerbate their physical and mental health issues as a result of their poor living environment and social isolation, including skin, podiatry and respiratory problems[17], hyper-awareness due to their unsafe environment, injuries from physical violence, poor sleep patterns, trauma, and psychological distress. As a result, the prevalence of a broad range of mental and physical health issues is significantly higher for people who are homeless than the general population[60].

This chapter will explore client demographics, engagement with SVHM services (i.e. contacts, episodes and LOS) and the overall health profiles of homeless clients at SVHM.

3.1 CLIENT DEMOGRAPHICS

3.1.1 NUMBER OF CLIENTS EXPERIENCING HOMELESSNESS

Throughout 2015, 359 patients accessing at least one of the four homeless services were identified as homeless or at risk of homelessness, with a total of 431 episodes of care provided by the services. Identifying this cohort for the purposes of the evaluation was not however straightforward. This is partly due a lack of standardised definition of homelessness across SVHM, and no 'demographic flag' that is routinely and consistently collected in hospital records. Whilst the International Classification of Disease, tenth addition (ICD-10-CM) diagnosis code Z59~[61,d] is recorded on some SVHM patient records, it may not be recorded for patients who do not appear 'homeless' or who state that they have a residential address (when in fact they may be couch surfing, or stating an address but only use it for purposes of a mailing address). Thus clients who fall within the primary, secondary and tertiary classifications of homelessness as defined by the Australian Bureau of Statistics and Specialist Homelessness Services (SHS) collections collated by the Australian Institute of Health and Welfare[55,62,63], may be under-identified. Moreover, it was unclear how consistently the ICD code Z59 is recorded at SVHM, and it was not mentioned by any of the four services as a key metric they rely upon.

[d] Defined as: Persons lacking permanent or reliable shelter, variously due to poverty, lack of affordable housing, mental illness, substance abuse, juvenile alienation, or other factors

In computing the number of people who are homeless or at risk of homelessness seen by one or more of the four services in 2015, the following approach was taken by the HIP Data Manager to collate the data provided to the evaluation team:

(i) All clients seen by CHOPS are homeless, by definition of being able to access this service;
(ii) All residents of Prague House were deemed to have been homeless or at risk of homelessness prior to moving into Prague House; Prague House staff confirmed that homelessness or high risk thereof is a primary risk factor for the vast majority of clients;
(iii) As ALERT sees some clients who have complex psychosocial needs other than homelessness, a manual process had to be undertaken to ascertain the homelessness status of ALERT clients during 2015;
(iv) All Cottage clients were deemed to be homeless or at risk of homelessness. Whilst 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 (e.g. 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.

3.1.2 SVHM SERVICES ACCESSED BY CLIENTS EXPERIENCING HOMELESSNESS IN 2015

Of the 359 homeless clients accessing the four services in 2015, 39% were supported by ALERT, 39% accessed The Cottage, 23% were supported by CHOPS and the remaining 11% resided at Prague House. Of these 359 clients, 41 accessed two services, with 36 accessing both ALERT and The Cottage; one both ALERT and CHOPS; three both ALERT and Prague House, and; one both CHOPS and Prague House. However, there was some divergence between SVHM staff perceptions of client overlap and the empirical data which is discussed in detail in Chapter 5.

3.1.3 DEMOGRAPHICS

Of the clients who accessed any of the four homeless services, 74% were male, and their average age 50 years. As expected, clients who accessed Prague House were older than those who accessed other services. The majority of clients were born in Australia (73%), with English as their preferred language (95%).

Overall, 6% of clients identified as being of Aboriginal or Torres Strait Islander origin, with a higher proportion of Aboriginal or Torres Strait Islander clients using ALERT compared to other services.

Almost half (48%) of clients reported living alone, 24% with others, 7% with family, and 21% did not state their living arrangements.

Forty-six percent of clients' usual accommodation was independent living, 26% homeless/public place, 10% aged care residence, 10% short term accommodation and 8% other (supported community/residential, institutions, other).

Overall, 4% of clients reported having a carer, with a greater proportion of CHOPS clients having a carer than those accessing other services (Table 4).

Table 4: Client Demographics in Each of the Four Services

n(%)	ALERT	The Cottage	CHOPS	Prague House	Total^
Clients (n)	139	139	81	41	359
Male	104(75)	102(75)	62(76)	26(63)	265(74)
Female	35(25)	37(25)	19(24)	15(37)	94(26)
Mean Age	46	54	41	65	50
Country of Birth					
Australia	108(78)	96(69)	58(72)	34(83)	263(73)
Other countries	31(22)	43(31)	23(28)	7(17)	96(27)
Aboriginal and Torres Strait Islander	12(9)	8(6)	2(3)	1(2)	23(6)
Preferred Language English	136(98)	127(91)	76(95)	41(100)	341(95)
Living Arrangements					
Lives alone	58(42)	90(65)	45(56)	2(5)	172(48)
Lives with family	9(6)	11(8)	12(15)	0(0)	26(7)
Lives with others	16(12)	16(12)	22(27)	38(93)	87(24)
Not state/inadequately described	56(40)	22(16)	2(3)	1(2)	74(21)
Usual Accommodation					
Aged care residence	0(0)	0(0)	0(0)	37(90)	37(10)
Homeless/public place	67(48)	32(23)	7(9)	2(5)	92(26)
Short term	9(7)	3(2)	24(30)	0(0)	35(10)
Independent living	50(36)	94(68)	43(53)	1(2)	166(46)
Other	13(9)	10(7)	6(8)	1(2)	29(8)
Carer	3(2)	3(2)	8(10)	1(2)	14(4)

^41 clients accessed more than one of the four services

3.1.4 ALERT CLIENT DEMOGRAPHICS

During 2015, 139 clients were supported by ALERT, of these, 99 were supported by ALERT only, with the other 40 supported by ALERT and at least one other service (36 The Cottage; 3 Prague House; 1 CHOPS).

Three quarters (75%) of clients supported by ALERT were male, with an average age of 46 years (range: 19-90 years), over half (59%) were aged between 35 and 54 years (Figure 5).

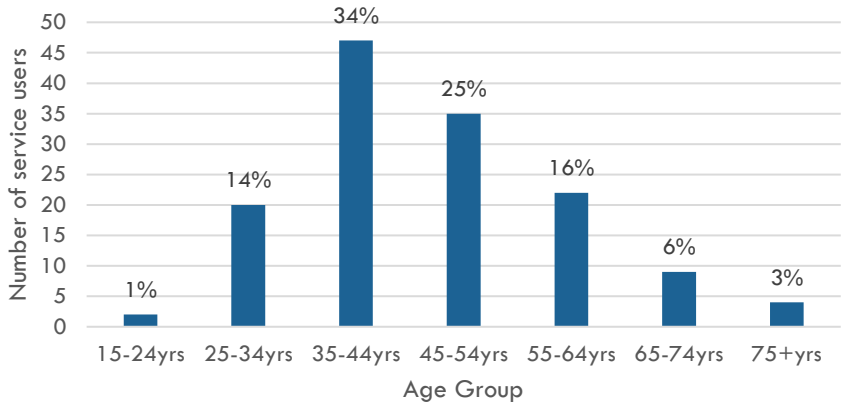

Figure 5: Age Distribution of ALERT Clients (Number and Proportion)

More than three quarters (78%) of ALERT clients were born in Australia, with 12% being born in Europe, 4% in Southeast Asia and 3% in Sub-Saharan Africa (Figure 6).

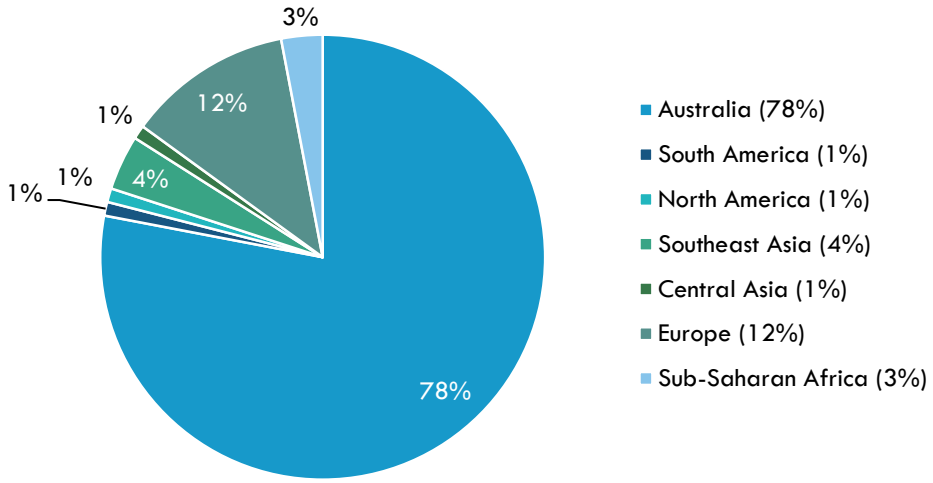

Figure 6: Country of Birth of ALERT Clients (%)

Nearly all (98%) ALERT clients stated that English was their preferred language, with one person requiring an interpreter. Of the four services, ALERT had the highest proportion of Aboriginal and Torre Strait Islander clients (9%), of these, 92% were males.

When asked about their usual accommodation, 48% of the ALERT clients were recorded as homeless or usually accommodated in a public place, whilst 36% indicated that they were in independent living. It cannot be ascertained from the dataset what constitutes independent living in a homelessness context, and this is likely to have a different meaning for many than mainstream community notions of 'independent living' accommodation.

The vignette in Box 2 gives a sense of the fluid and frequently changing living circumstances of a client from ALERT.

Box 2: Vignette on Fluidity of Housing Circumstances

I've been homeless on and off for years and in different states, not just Victoria, but also South Australia, Qld and WA. … I've slept under stairwells around Melbourne, stayed in boarding houses, emergency accommodation, and had my own flat for a while. When I first came into contact with St Vincent's I went to stay at emergency accommodation for men, then I went to detox then I went to stay at another hostel. There was an organisation that was meant to be helping me find housing but they lost my file. My case worker at ALERT helped me get into transitional housing; I've been there a year but my ultimate goal is to get more permanent housing and somewhere I can have a dog. ***- Client***

3.1.5 THE COTTAGE CLIENT DEMOGRAPHICS

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 7).

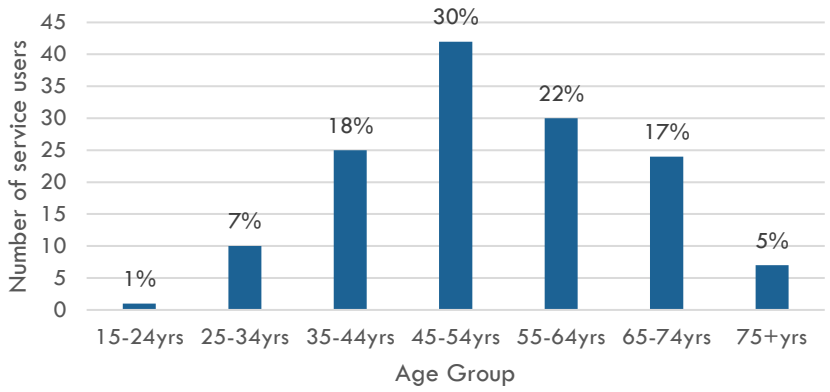

Figure 7: Age Distribution of The Cottage Clients (Number and Proportion)

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 8).

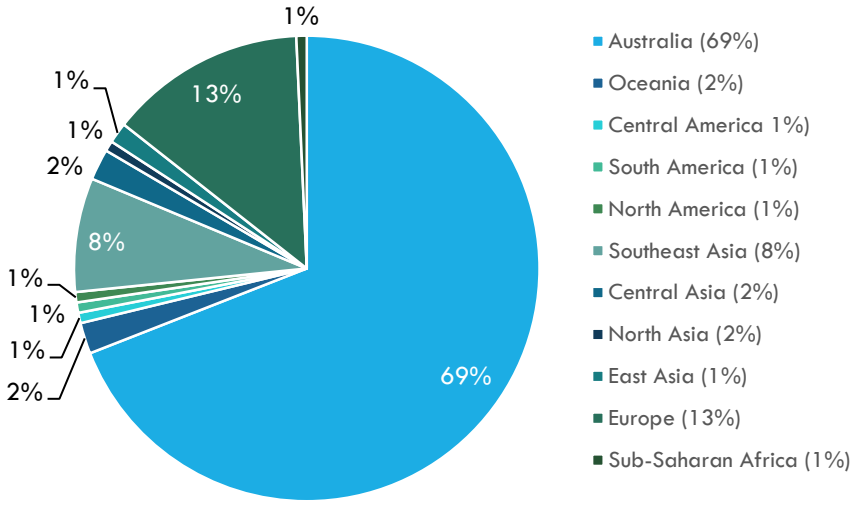

Figure 8: Country of Birth of The Cottage Clients (%)

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.

3.1.6 CHOPS CLIENT DEMOGRAPHICS

During 2015, 81 clients were supported by CHOPS, of these, 79 were supported by CHOPS only, with two other clients supported by ALERT (n=1) and Prague House (n=1).

Just over three-quarters (76%) of CHOPS clients were male with an average age of 41 years old (range: 21 – 66 years). Nearly a third (31%) of clients were aged between 35 and 44 years (Figure 9).

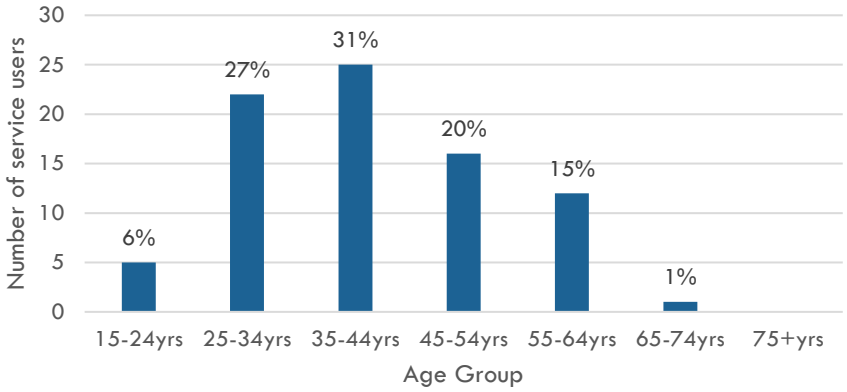

Figure 9: Age Distribution of CHOPS Clients (number and proportion)

Almost three quarters (72%) of CHOPS clients were born in Australia, with the next most common regions of birth being Southeast Asia (11%), Europe (6%) and Sub-Saharan Africa (5%) (Figure 10).

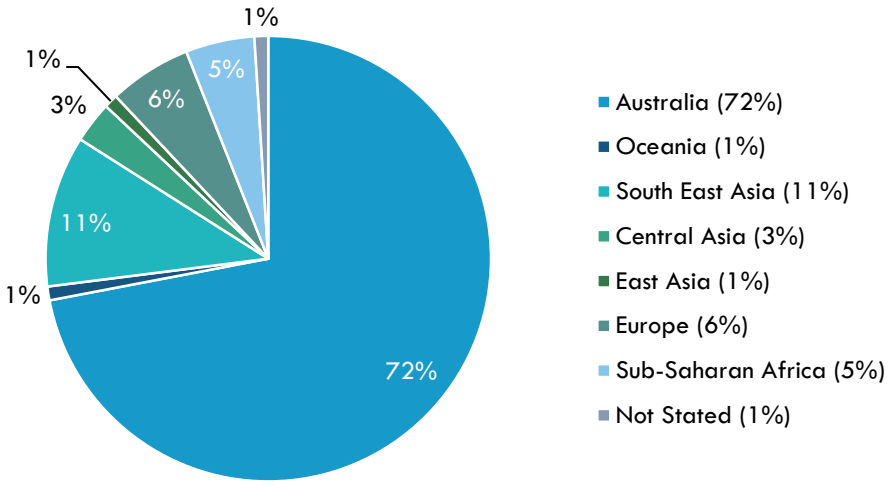

Figure 10: Country of Birth of CHOPS Clients (%)

The majority (95%) of CHOPS clients preferred language is English, with two clients requiring the use of a translator.

Only 3% (n=2) of CHOPS clients identify as Aboriginal or Torres Strait Islander, both of which were female.

More than half (56%) of CHOPS clients are recorded on the system as living alone, 27% living with others, 15% living with family and 3% not having adequate details about their living arrangements recorded. Interestingly only 9% of the CHOPS clients recorded their usual accommodation status as homeless or a public place, whilst 30% described it as short term, and 53% as living independently.

3.1.7 PRAGUE HOUSE RESIDENT DEMOGRAPHICS

During 2015, 41 residents were supported by Prague House, of these, 37 were supported by Prague House only, with three residents receiving additional support from ALERT and one from CHOPS.

The majority of Prague House residents were male (63%), with an average age of 65 years (range: 50-82 years). While Prague residents had a much older average age than the other three services, an average age of 65 is about 20 years younger than a typical aged care facility [64]. The majority (39%) of residents were aged between 65-74 years old (Figure 11).

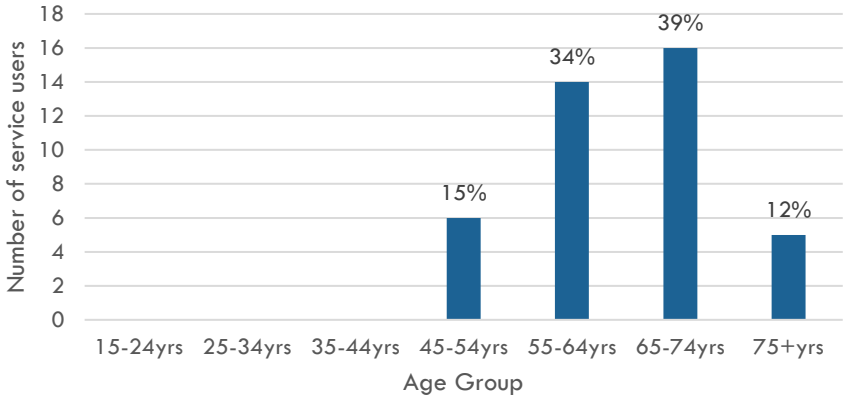

Figure 11: Age Distribution of Prague House Residents (Number and Proportion)

Of the four services, Prague House had the highest proportion of clients that were born in Australia (83%), the next most common region of birth was Europe (10%) with the remaining residents born in East and Southeast Asia and North America (Figure 12).

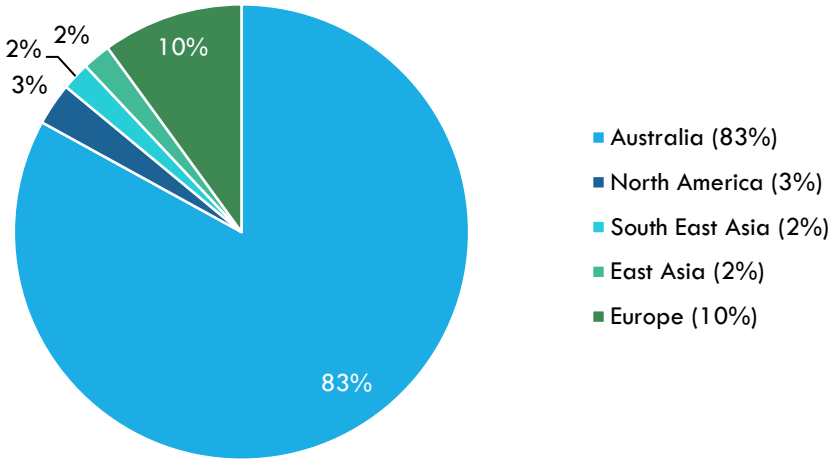

Figure 12: Country of Birth of Prague House Residents (%)

All Prague House residents (i.e. 100%) indicated that their preferred language is English and only one client identified as Aboriginal or Torres Strait Islander (2%).

While all 41 residents were living at Prague House at the conclusion of 2015, it is pertinent to note that only 90% of them were flagged in the system as living in an aged care residence, with 5% recorded as homeless or in a public place. Similarly 93% of clients were described as living with others, but 5% were described as living on their own. These inconsistencies could be due to different reporting of living situation by the residents themselves, details in the system not being updated or residents changing living situations between 2015 and the data extraction period.

Many of the Prague House residents have had long histories of homelessness and unstable housing which came through in both the staff and client interviews.

3.2 HEALTH PROFILE OF CLIENTS

At the commencement of each episode with any of the four services, the client's main diagnosis was recorded. The most prevalent diagnoses for episodes were substance 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%) (Table 5).

Table 5: Primary Diagnosis on Commencement of Episode

	ALERT n=142 (%)	The Cottage n=167 (%)	CHOPS n=81 (%)	Prague House n=41 (%)	Total n=431(%)
Cancer	2(1.4)	8(4.8)	0(0.0)	1(2.4)	11(2.6)
Cardiac related	4(2.8)	11(6.6)	0(0.0)	0(0.0)	15(3.5)
Dermatological	4(2.8)	8(4.8)	0(0.0)	0(0.0)	12(2.8)
Diabetes	3(2.1)	9(5.4)	0(0.0)	0(0.0)	12(2.8)
Digestive system	2(1.4)	9(5.4)	0(0.0)	0(0.0)	11(2.6)
Substance use causing mental and behavioural disorders	61(43.0)	32(19.2)	0(0.0)	0(0.0)	93(21.6)
Infectious diseases	4(2.8)	5(3.0)	0(0.0)	0(0.0)	9(2.1)
Injuries and Fractures (incl. wounds and falls)	26(18.3)	15(9.0)	0(0.0)	0(0.0)	41(9.5)
Kidney and urinary system disorders	2(1.4)	8(4.8)	0(0.0)	0(0.0)	10(2.3)
Liver disease	4(2.8)	9(5.4)	0(0.0)	1(2.4)	14(3.2)
Mental health disorders	14(9.9)	5(3.0)	12(14.8)	4(9.8)	35(8.1)
Neurological (incl. seizures, stroke, intellectual disability)	5(3.5)	1(0.6)	0(0.0)	11(26.8)	17(3.9)
Post-operative (non-orthopaedic)	2(1.4)	38(22.8)	0(0.0)	0(0.0)	40(9.3)
Schizophrenia / Schizoaffective disorder	4(2.8)	1(0.6)	63(77.8)	23(56.1)	91(21.1)
Other^	5(3.5)	7(4.2)	0(0.0)	1(2.4)	13(3.0)
No diagnosis specified	0(0.0)	1(0.6)	6(7.4)	0(0.0)	7(1.6)

^ Other health conditions include diseases of the nervous system; diseases of the gallbladder, biliary tract and pancreas; gastroenteritis; other endocrine, nutritional and metabolic disorders; pulmonary diseases; anaemia, and; blood diseases.

3.2.1 HEALTH PROFILE OF ALERT CLIENTS

Of the 142 ALERT episodes of care, the most common diagnosis clients had upon service contact was substance use causing mental and behavioural disorders (43%), injuries and fractures (18%) and mental health disorders (10%) (Figure 13).

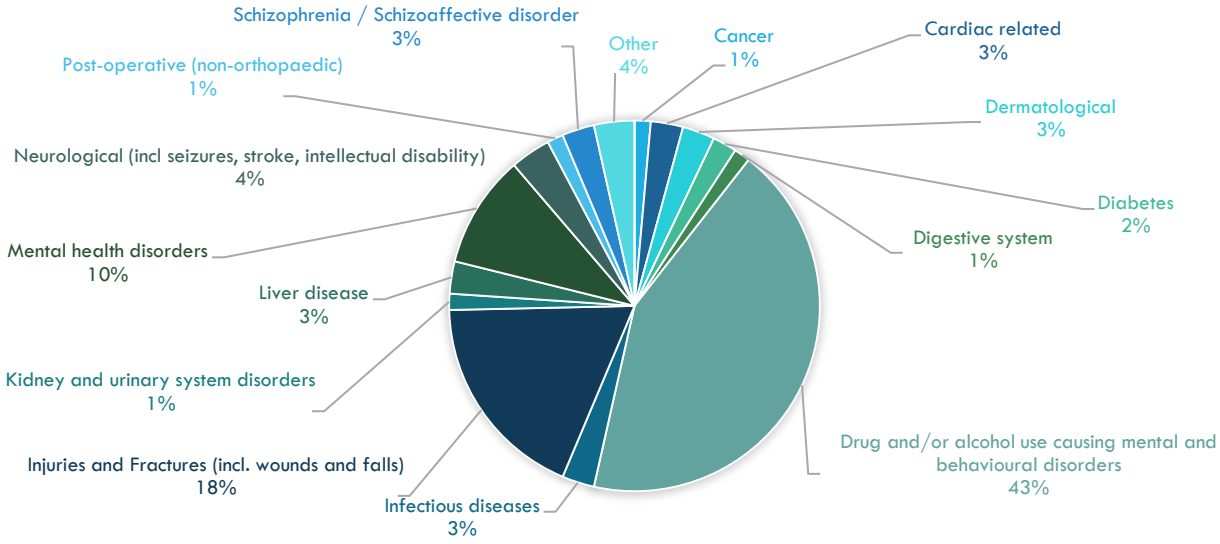

Figure 13: Primary ALERT Diagnosis Descriptions

In addition to the main health condition per episode, other factors affecting health are recorded for both ALERT and The Cottage clients (Table 6). ALERT clients had on average 8 factors affecting their health (min 1, max 22). The most common factors affecting their health included homelessness (63%); daily living issues (54%) and; family and relationship issues (47%). These factors affecting health and the complexity of SVHM clients are also reflected through the interviews and are discussed further in Section 3.3.

Table 6: Factors Affecting Health of ALERT and Cottage clients*

	ALERT (%)	The Cottage (%)
Carer issue	27.3	74.8
Concern about intervention / treatment	31.7	42.4
Daily living issue	54.0	84.9
Employment issue	28.8	39.6
Environmental issue	28.1	68.3
Eviction Issue	7.9	3.6
Family & other relationships issue	47.5	63.3
Financial issue	39.6	14.4
Homelessness	63.3	31.7
Isolation issue	46.0	74.1
Issues due to medication	27.3	56.8
Issues in self-management	2.2	3.6
Learning issue	13.7	37.4
Legal issue	5.0	0.7
Need for emergency accommodation	30.2	3.6
Need for sheltered accommodation	3.6	3.6
Need for supported accommodation	23.7	48.9
Other housing issue	21.6	10.8
Tenancy issues	6.5	10.8
Unsuitable accommodation	16.5	44.6

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

3.2.2 HEALTH PROFILE OF THE COTTAGE CLIENTS

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%) (Figure 14).

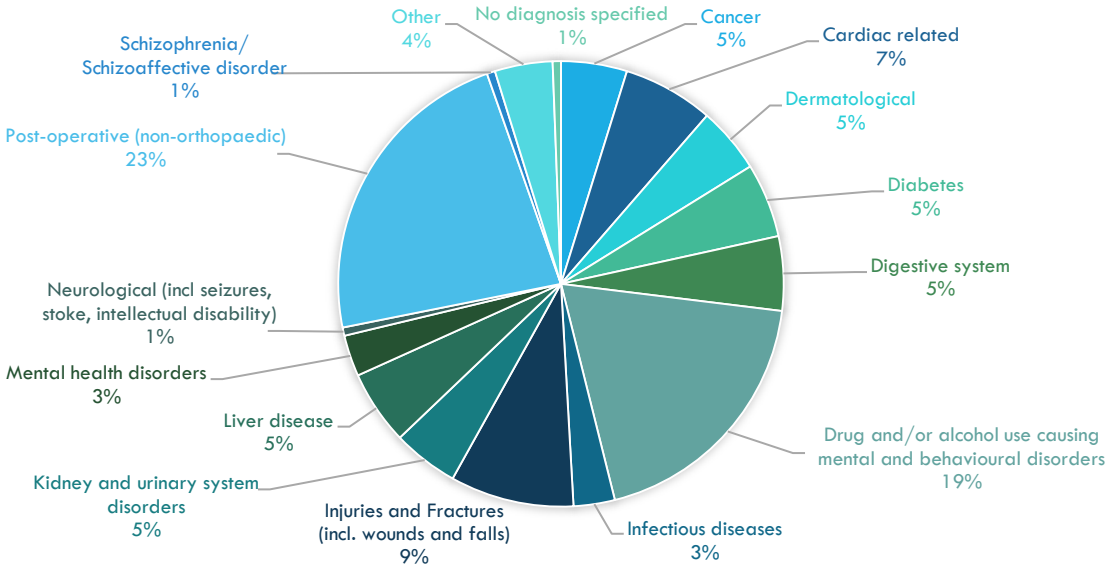

Figure 14: The Cottage Diagnosis Descriptions

In addition the main health condition per episode of care, other factors affecting health are recorded for Cottage clients (Table 6). 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%).

3.2.3 HEALTH PROFILE OF CHOPS CLIENTS

Of the 81 episodes of care provided by CHOPS, the most common diagnosis upon an episode of care commencing was schizophrenia/schizoaffective disorder which accounted for over three quarters (78%) of diagnoses and other mental health disorders (15%) which included diagnoses such and mental and behaviours disorders, nonorganic psychosis and bipolar disorder. The remaining 7% of clients did not have a primary diagnosis recorded for entry of episode, but given CHOPS is a mental health outreach service, it is assumed the primary diagnosis would be of a mental health nature (Figure 15).

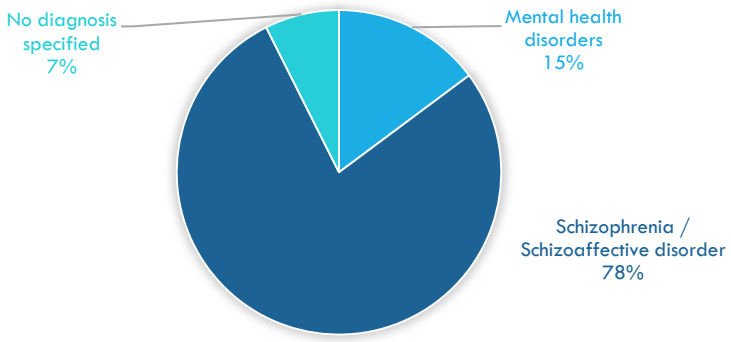

Figure 15: CHOPS Diagnosis Descriptions

In addition to their primary diagnosis, CHOPS also have records of all diagnoses for that particular client over the course of their involvement with Clarendon Community Mental Health Clinic (CMHC) (some dating back to 1998). This data is not presented in this report, but on average it shows that CHOPS clients had 17 diagnoses (min 1, max 69). However, it is pertinent to note that this often included multiple repeats of the same diagnosis at different time points (for example 3 episodes of schizophrenia during an 8 year window).

3.2.4 HEALTH PROFILE OF PRAGUE HOUSE RESIDENTS

Of the 41 episodes of care at Prague House, the most common diagnosis residents had upon service entry was schizophrenia/schizoaffective disorder (56%), neurological problems (27%) and other mental health disorders (10%) (Figure 16).

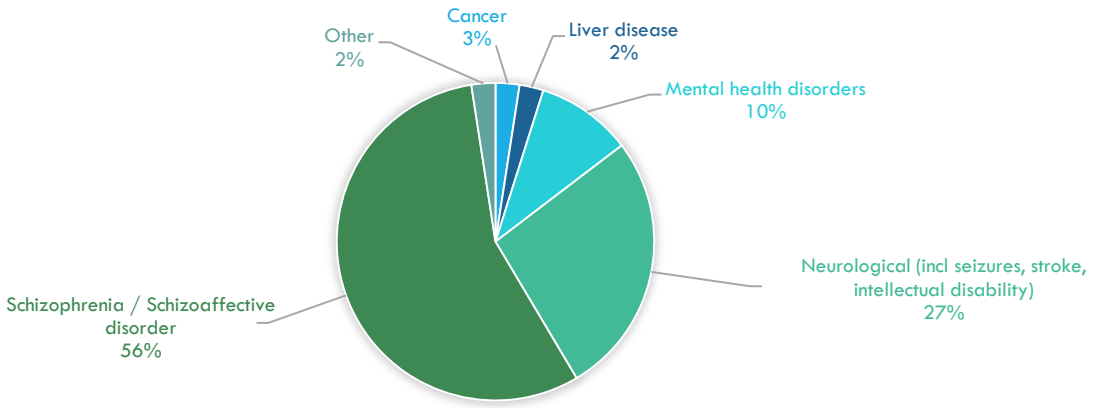

Figure 16: Prague House Diagnosis Description

The high prevalence of mental health issues among Prague House residents is not surprising, as this is one of the criteria for eligibility:

> *So they have to have either a mental health issue or an alcohol or substance related brain injury or an acquired brain injury either from a fall or - they also need to have an aged care assessment to be able to come here.. That's often where there's a bit of a lag because some of the people who are referred to us are quite young, so getting that aged care assessment for somebody who's 38 is not as easy as somebody who's 68.* ***– Service staff***

3.3 CLIENT NEEDS

3.3.1 CLIENT NEEDS EXTEND BEYOND HEALTH

While Section 3.2 describes clients' primary health diagnosis upon service entry; a primary health diagnosis often does not encapsulate the complex and multiple needs of a large number of clientele experiencing homelessness. The social determinants of health (Figure 17) is thus a particularly relevant lens through which to view the array of inter-related factors present in the lives of many of the clients seen by the four services.

Figure 17: Social Determinants of Health for People Experiencing Homelessness

The vignettes in Box 3 and Box 4 demonstrate how concurrent physical, mental and other psychosocial comorbidities are present and are further compounded by an individual's homelessness.

Box 3: Vignette on Complex Needs of an ALERT/Cottage Client

A male in his mid-sixties has a number of complex medical conditions including alcohol dependency, poorly controlled diabetes, depression and hypertension. He has been engaged with ALERT since 2012 and stayed at The Cottage on a number of occasions after being discharged from hospital or after detoxing at Depaul House.

He has had difficulties maintaining his housing due to his alcohol dependence and lack of social support network. After his first stay at The Cottage he was discharged back to his own accommodation but struggled without social contact or a strong support network:

> *"I still went back to live at home on my own and that was sort of a disastrous result, because I had a first class unit, but I was still on my own and I sort of don't connect with other people."*

He stated that he appreciated the space and calm atmosphere provided by The Cottage to address these issues:

> *"it's there to provide people with space when they're in difficult circumstances so they don't have to immediately have to address things; so that they are given space to either a lesser or a greater extent to work through those things."*

ALERT have assisted in addressing his alcohol dependency and management of chronic disease by facilitating referrals and accessing alternative accommodation.

Box 4: Vignette on Homelessness and Comorbidities of a CHOPS Client

A male CHOPS client in his mid-fifties has multiple compounding comorbidities including chronic paranoid schizophrenia, hepatitis C and cirrhosis of the liver. He has a past history of self-harm, suicidal ideation, heroin dependence and is currently on Methadone and his records also note a childhood characterised by abuse and neglect.

Over the past five years CHOPS have worked with him closely to help address his need, and have assisted with not only his medical needs (i.e. delivery of Webster packs), but also with other aspects of improving his mental wellbeing such as goal setting around smoking cessation, methadone reduction and making meaningful friendships.

These are only two of many patients who exemplify the inter-related and compounding impact of social and physical determinants of health of SVHM clientele, with examples being provided by numerous SVHM staff and external stakeholders.

> *there's a woman the other day that CHOPS are trying to work with and the homelessness nurse is trying to work with - her behaviours off the wall, she's got cancer, she's losing her housing, she disappears, that work takes time.* ***– External stakeholder***

The vignettes and various stories told through interviews demonstrate the multifaceted issues that some staff overcome and address in order to improve the health of their clients. Overall, the staff of these services recognised and were aware of these entwined and complex needs.

> *we are very aware that mental illness, although it might be a causative or a result of that - their current situation, is only one part of a much more complex situation for them individually.* ***– Service staff***

3.3.2 WHAT ARE SOME OF THE MAJOR SOCIAL DETERMINANTS OF HEALTH THAT ARE EVIDENT?

Lack of stable, affordable and appropriate accommodation is a major issue facing this client demographic, and is also recognised as a fundamental social determinant of health [65,66]. There is wide recognition within SVHM that, to optimally address health priorities housing needs cannot be ignored. Additionally, a myriad of psychosocial issues are present among this clientele, including unemployment, substance abuse, social isolation and interactions with the criminal justice system. In the section that follows, we draw on interviews with clients and staff to illustrate the range and complexity of housing and psychosocial needs of the client population, as this provides important context for the rest of this report. It is pertinent to note however, that although housing and psychosocial needs are discussed separately, in reality they are intertwined and overlapping for many homeless people seen at SVHM.

Housing Needs

A recurring theme in the client interview analysis was the inter-relationship between complex health needs and lack of housing (i.e. complexity of needs leading to homelessness and/or homelessness leading to complex needs). Such complex and inter-related health needs may lead to treatment complexities and the need for diverse and flexible service provision, with some clients requiring more intensive supervision, and often a stepped down approach to care. Substance detoxification in a rehabilitation centre was a first step for some clients, while other

clients needed improved housing conditions. One client even spoke about how the biggest difference in his treatment was being forced under a court order to stay in a detox facility.

> *Six months in a hospital environment without discharge, you're forced on an order to stay here until you've recovered and you're safe to leave and be independent again.* ***– Client***

Clients' housing needs may be complicated by their individual requirements, for example the need to avoid environments where there is frequent consumption of alcohol and other substances.

> *When your housemate is using Ice it can be quite a disturbing household, to the point where I had to get the police so I could get my stuff out of the house without being pulverised.* ***– Client***

> *I'm scared a little bit because I'm like can you fall into peer pressure or do you start doing it again. I end up in that rut of psychosis and stuff.* ***– Client***

> *I am now in a rooming house in Cheltenham. It's doing my head in, because it's the same sort of stuff that got me in trouble in the first place.* ***– Client***

> *… there's no way I would have made in a boarding house. That would have torn me apart in a boarding house… They're just drug dens. They don't try and stop it.* ***– Client***

Clients' housing arrangements are often vulnerable and can be jeopardised by a change in circumstances, as illustrated by the client quotes below.

> *Basically, I was homeless because I couldn't go back to the rehab because basically all the amenities are upstairs and I couldn't get upstairs...* ***– Client***

> *Well, the last time I came in, I had open heart surgery and they didn't want me going back to a place where it will be on my own…Also, that it give me a rest for a couple of weeks after a major operation.* ***– Client***

> *For me to go back, straight to there with this and no help or anything - I couldn't imagine what would've happened. I probably would've been slipping over, falling and hurting myself, and all that.* ***– Client***

Once a client moves into accommodation, the issues may not necessarily cease. Instead, there are often difficulties in readjusting to having accommodation after sleeping rough or spending time in homelessness, with both the costs and rules an issue for some.

> *He'd been living on the streets free and all of a sudden there's rules and it's quite expensive compared to what they've if they've been on the streets and not paying any rent. Then they're paying this huge amount.* ***– Service staff***

Overall, boarding houses and temporary accommodation were overwhelmingly indicated to be of sub-standard condition and contributing to health issues of clients including illicit substance use and mental health problems. Poor previous experiences in such housing presented as a barrier to many clients obtaining suitable and safe accommodation.

Psychosocial Needs

Interviews with clients also conveyed the entwining presence of multiple health issues and lack of appropriate housing with other psychosocial and environmental determinants of health.

Whilst for some clients, health issues are consequences of homelessness, for others their slide into homelessness has been precipitated or exacerbated by a pre-existing health issue. This is illustrated in the vignette below, which describes an array of psychosocial needs of a Cottage client.

Box 5: Vignette on Journey into Homelessness

One of the clients of The Cottage had incurred a significant brain injury following an accident as a young adult, this impeded his ability to work and he had to give up the flat he had initially purchased with his injury settlement. In the homeless years that followed, he began to use cannabis as a form of self-medication, and had been diagnosed with cannabis induced psychosis, although the client did not accept this diagnosis. He has continued to struggle with the social, emotional regulation and unemployment consequences of his brain injury, and a couple of the SVHM ED presentations have been attributed to injuries precipitated by outbursts of anger.

The link between social isolation and loneliness, and poorer physical and mental health outcomes is well documented[67]. Social isolation and loneliness were apparent for some clients, with a number of clients having infrequent or no contact with family and friends. This social exclusion precipitated many mental health issues and substance misuse, causing one client to be trapped in a cycle of substance use.

> *So when you have mental health issues and are homeless you can start to isolate yourself and then you start taking drugs to cope with that… to medicate for that isolation, to cope with that, the drugs become a coping strategy. But then you've just created more health issues for yourself and because humans are social animals and then you isolate yourself from there, you're creating more issues.* ***– Client***

> *Because I don't see my family, I've got my cousin and that's about it.* ***– Client***

Clients discussed the negative impact of alcohol and other substance use on their other health conditions.

> *…because ever increasingly the diabetes and the alcohol don't mix together. I have a tendency when I drink alcohol not to take my insulin as well and it becomes a very dangerous situation.* ***– Client***

Some clients did not intend to continue their cessation of alcohol and other substance consumption once discharged from detox, as they did not believe this was realistic for them. These clients instead reported their focus on controlling or cutting down their use.

> *I went in with - and openly said this and honestly said, that yes, I do have an issue with alcohol and homelessness and so forth like that. But I don't really have an intention to stop drinking. I will stop drinking whilst I'm here or I'm using the facilities and purpose built for that. But when I leave here, I - it's unrealistic for me to say that I'm going to stop drinking*

alcohol, because it's not going to happen. I can take Naltrexone, which I do. When I feel if it's getting too much and it's becoming too much of a habit, I'll go onto Naltrexone for a few weeks to break the habit and take away the craving for it. Then adjust my life to that. Then I'll start drinking again. But not - you know not always to excess. ***– Client***

In several staff interviews it was noted that whilst some homeless clients need quite a bit of support to help them 'get back on their feet', there was need to ensure that services are also allowing clients to be empowered and to take ownership of their situations.

People who are homeless with chronic needs require empowerment and they need resilience. Charitable services particularly can come in when everything [is going wrong] - and can rescue people. But then they just learn to be completely incompetent because there's always somebody there ***– Service staff***

It is also pertinent to note that direct health needs are not always necessarily the most important needs clients want addressed.

Often the clients that find their way to CHOPS are quite disengaged from their families and some of the work that the clinicians are doing with some of the clients we've got at the moment is actually trying to reunify people with their families and trying to even find their families - ***Service staff***

Box 6 demonstrates how ALERT works with a client and external services to; assist with his housing, source additional material needs and other psychosocial needs.

Box 6: Addressing Clients' Housing and Psychosocial Needs

A male patient was admitted through the ED to St V's Mental Health Unit after presenting with a history of depression and attempts at self-harm. After discharge he moved to temporary accommodation where he was contacted by his ALERT worker. ALERT referred him to Ozanam House and continued to link him with other services and provide support. Through ALERT, he was helped to source items such as a phone and glasses and was linked to an Alcohol and Drug (AoD) Counsellor and psychologist.

As reflected in Maslow's hierarchy of needs[68] and much of the homelessness and health literature, it is difficult to effectively improve health outcomes when people have unmet fundamental needs relating to shelter, food, clothing and transport. For many people who are homelessness, day to day survival takes practical precedence. SVHM is fortunate in that its ethos, organisational mission and endorsement of a social determinants framework of health enable it to look beyond the immediate clinical needs alone.

Each of the four services examined in this evaluation reflect this in their culture and practice. Additionally, there are other options within SVHM more widely that can facilitate the addressing of non-clinical needs for clients with complex or priority needs. ALERT and Cottage, for example are able to draw on brokerage funding as part of the SVHM Complex Care Services model (Box 7).

Box 7: Use of Brokerage Funds

Use of Brokerage funds to provide rapid support to homeless clients for basic needs that impact on health:

1. **Within SVHM**: via the complex care model, SVHM allocates some resourcing for brokerage, that can be used to assist vulnerable clients with resources such as meals, temporary accommodation, supermarket vouchers, travel, glasses.
2. **Through partners**: Clients experiencing homelessness from SVHM can be referred to services such as NRCH. Here eligible clients may access PAC funding after a public hospital presentation. For example, in 2015/2016 the NRCH Inner Melbourne PAC Program had 102 homelessness client referrals, with 63% of these referrals coming from SVHM (primarily from ED and ALERT). Accommodation, food vouchers, support worker visits and therapy/clinical intervention were among the supports provided by NRCH to homeless clients during this period.

SVHM services can also refer eligible clients to the Post-Acute Care (PAC) program run by North Richmond Community Health (NRCH). Another example cited was the care packs and clothing for people who present to ED homeless that were prepared and donated by a local school. It is likely that other examples of harnessing support for clients who are homeless are evident within SVHM. Such support is likely to reduce the likelihood of these clients re-presenting to hospital, and just as importantly, provide them with a more holistic package of care.

3.4 ENGAGEMENT WITH THE FOUR SERVICES

A total of 431 episodes of care, 5,872 contacts and 36,061 days of care were recorded for the 359 clients in our sample. This translates to an average of 1.2 episodes, 26 contacts and 84 days per episode of care per client across the four services (Table 7). Clinically significant interactions between a client (or carer) and health professional i.e. phone calls, home visit or ED interactions are recorded as contacts. As Prague House and The Cottage are residential services and they have daily contact with their residents, contacts are either not recorded (Prague) or recorded in a different way (one per day - Cottage), therefore, the average of 26 contacts per episode is for ALERT and CHOPS episodes only.

Table 7: Episodes and Contacts per Service

	ALERT	The Cottage	CHOPS	Prague House	Total
No. of episodes in 2015 mean (sd) range	142 1.0(0.1) 1-2	167 1.2(0.5) 1-4	81 1.0(0) 1-1	41 1.0(0) 1-1	431 1.2(0.5) 1-5
No. of contacts in 2015 mean (sd) range	2,021 14.2(19.1) 1-140	-	3,851 47.5(56.5) 1-276	-	5,872 26.3(40.5) 1-276
Days per episodes of care (total)^ mean (sd) range	13,477 94.9(139.7) 1->812	1,478 8.9(9.7) 1-70	43,940 997.2(758.3) 1-3,800	102,713 2,505.2(2,209.5) >393->9,558	161,608 375.0(1,034.8) 1->9,558

^ Total days per episode of care for those whose episode had care days in the 2015 calendar year. Days per episode of care show the average length of episodes as at January 2017. A number of these episodes for ALERT and Prague House were still ongoing at this point in time and have been indicated by a greater than (>) symbol where the range is likely to be larger than what is reported.

The majority (84%) of clients had a single episode of care in the 2015 calendar year, with 45 individuals (13%) having two episodes of care, and 3% with three or more episodes of care (Figure 18).

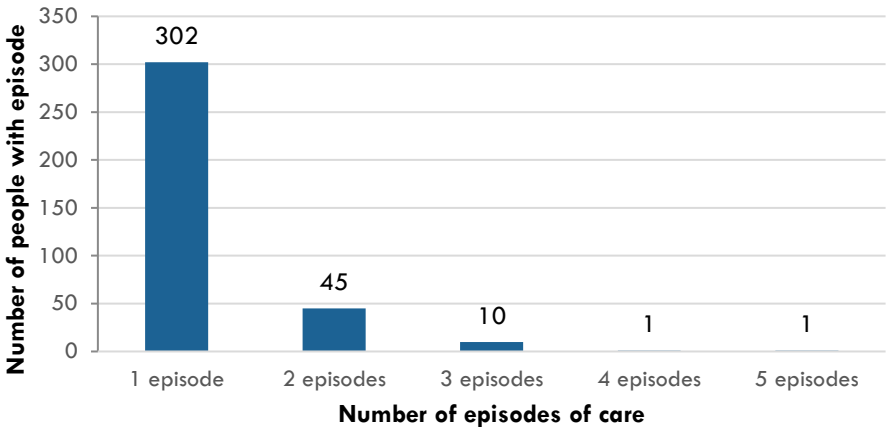

Figure 18: Number of Episodes of care per Person in the 2015 Calendar Year

3.4.1 ALERT SERVICE DELIVERY

A total of 142 episodes of care and 2,021 contacts were recorded for ALERT clients in the 2015 calendar year. Three clients had two separate episodes of care under the ALERT team (i.e. were discharged and readmitted back into care in 2015). On average, clients that had contact in 2015 were under the care of the ALERT team for a period of 95 days.

Thirty-one (22%) clients had episodes of care less than one week in length, with 10 episodes of care (7%) only one day in length. These short stays are assumed to be either lost to follow up or clients declining a support offer. Nearly half (48%) of episodes of care were longer than one month in duration (Figure 19).

Of the 142 episodes of care, 16 commenced in 2014 and continued into 2015, and 24 continued into 2016. Of the 24 episodes that continued past the 2015 calendar year, 3 remained active at the beginning of 2017.

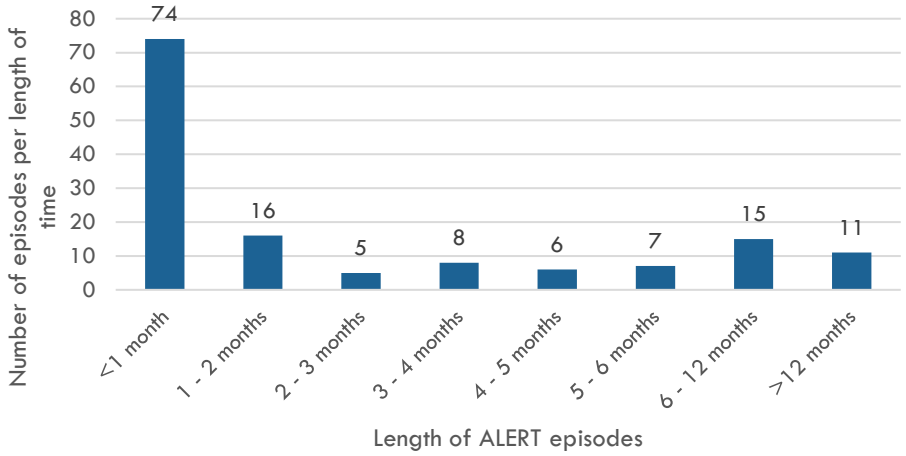

Figure 19: Number of ALERT Episodes per Length of Time
[Note: 30 days was used to define one month for the purpose of this figure]

3.4.2 THE COTTAGE SERVICE DELIVERY

There were a total of 167 episodes of care at The Cottage during 2015. Data on the number of contacts (i.e. 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 (i.e. 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 20).

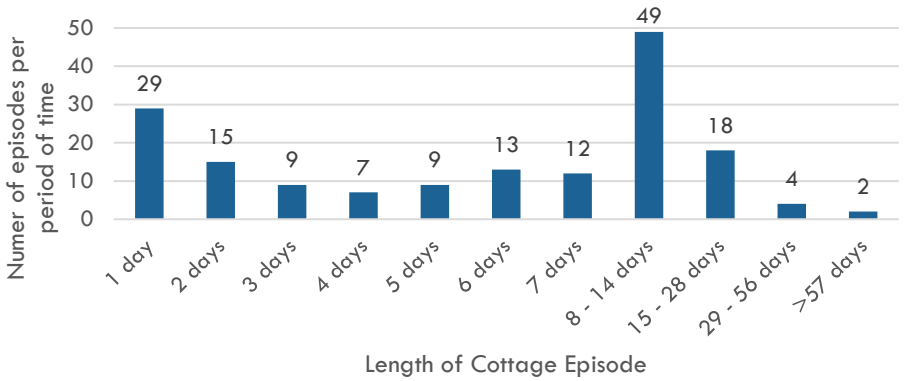

Figure 20: Number of Cottage Episodes per Length of Time

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:

> *Back when the idea of The Cottage was first conceived, it was noticed that there was a client group re-presenting frequently to SVHM with deteriorations that could have been prevented, for example they may have had a respiratory infection, been prescribed oral antibiotics, but then forget to take them. So they'd come back and would need admission with IV antibiotics. It was like a revolving door for that client group.* ***– Service staff***

3.4.3 CHOPS SERVICE DELIVERY

A total of 81 episodes and 3,851 contacts in 2015 were recorded for CHOPS clients. All clients had only one episode of care with CHOPS (i.e. if they were discharged from CHOPS they did not come back into contact with the team for the remainder of that year).

On average, clients who had an episode of care with contact in 2015 were under the care of the CHOPS team for 997 days (approximately 2 years and 9 months); the longest episode of

care (still active in 2015) commenced in 2005. Clients were most likely to have support from the CHOPS team for either less than one month (28%), or greater than one year (38%). There were 15 clients that had recorded episodes of care lasting only one day; it is likely that these clients were referred to CHOPS for care/assessment but they refused assistance (Figure 21).

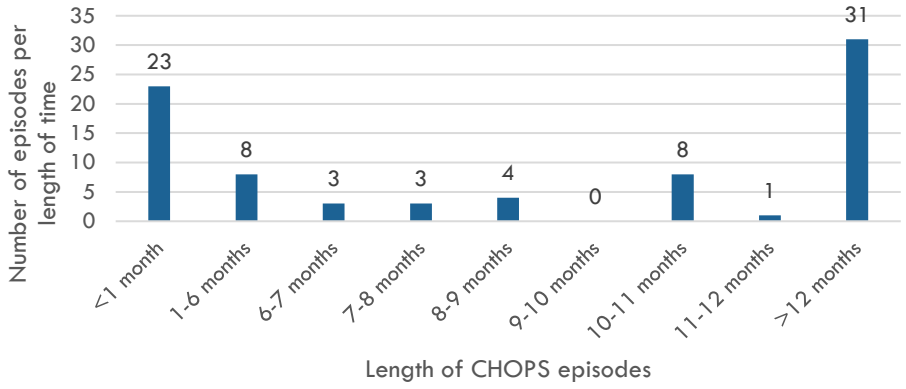

Figure 21: Number of CHOPS Episodes per Length of Time
[Note: 30 days was used to define one month for the purpose of this figure]

3.4.4 PRAGUE HOUSE SERVICE DELIVERY

A total of 41 episodes remained active at the end of the 2015 calendar year were recorded for Prague House residents. Contacts are not captured/recorded as residents have regular contact with staff and it would not be possible to accurately capture this information. During the 2015 calendar year 10 residents moved in, with the remaining 31 moving in prior to 2015. The average length of residency at Prague House as at the beginning of 2017 was 2,505 days (approximately 6 years and 10 months).

The longest residing resident has been at Prague House since 1990, with 12 residents (29%) residing there for greater than 10 years (Figure 22).

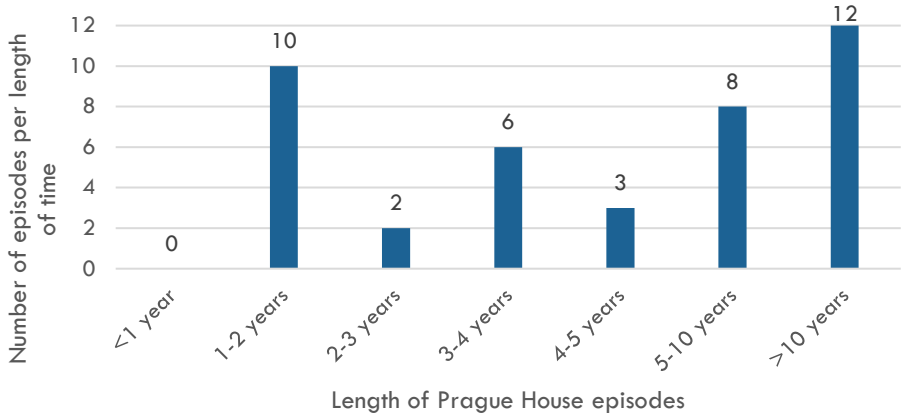

Figure 22: Number of Prague House Episodes per Length of Time
[Note: 365 days was used to define one year for the purpose of this figure. Data was valid as at January 2017.]

Unfortunately data on residents that exited during the 2015 calendar year was not available for the purposes of this evaluation.

4 IMPACTS OF SVHM SERVICES ON HOMELESS CLIENTS' HEALTH AND HEALTHCARE UTILISATION

People experiencing homelessness are significantly more likely than the general population to access tertiary level health services[13,17] and are frequently admitted to hospital for conditions that could have been more effectively managed in a primary care setting[17,69]. In a retrospective review of the most frequently presenting patients to SVHM ED between 1996 and 2002, 41% of patients who presented to ED for issues that could have been treated by a General Practitioner (GP) were identified as homeless. The over-representation of the homeless among frequent presenters to ED has been well documented internationally[20,39] and within Australia[17,70]. Hospital admissions and LOS are two other commonly used metrics that have been shown elsewhere to be greater among patients experiencing homelessness.

Whilst SVHM has long recognised that people who are homeless are prominent among their ED and hospital patient profile, this chapter provides a comprehensive empirical examination of the extent and patterns of hospital utilisation by people who are homeless during a defined period. Additionally, this chapter also investigates the extent to which hospital service use changes following client contact with one or more of the four homelessness services.

This chapter analyses hospital administrative data for the subset of ALERT, The Cottage, CHOPS and Prague House clients who made contact with the respective services within the 2015 calendar year AND commenced their episode of care after the 1st of January 2011. For example a Prague House resident who was still residing at Prague House in 2015, but commenced their stay in 2010 has been excluded and a Prague House resident still residing there in 2015 who commenced their stay in 2013 (i.e. after the cut-off date of 1st of January 2011) is included (Figure 23). Findings presented throughout this chapter look at hospital use in the six month period prior to a client's episode start date (referred to as pre) and six months post their episode start date (referred to as post).

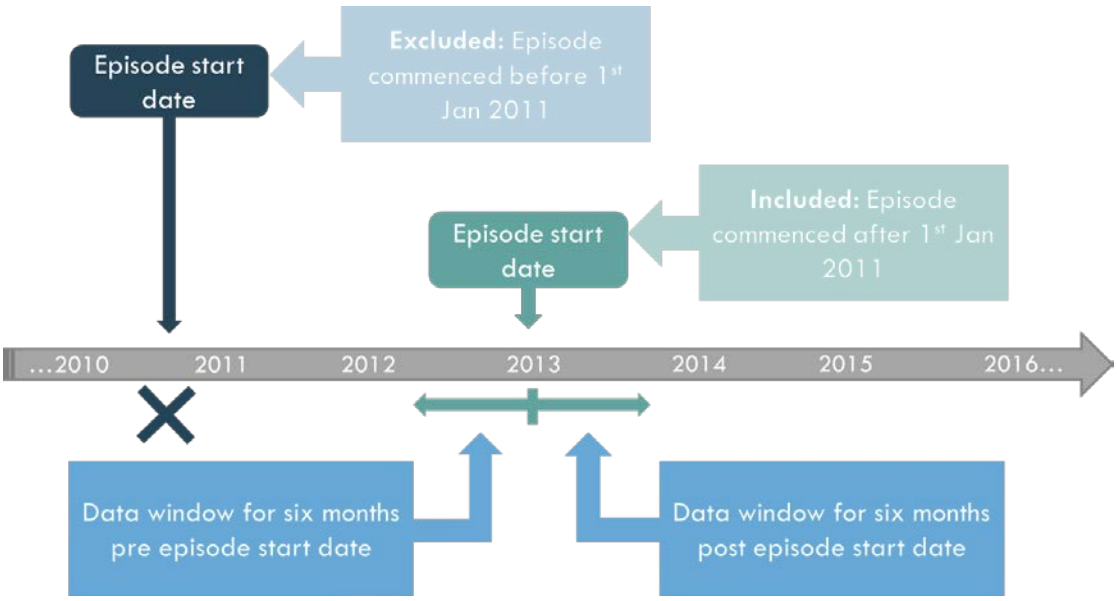

Figure 23: Sub-sample Criteria Six Months Pre/Post Data Window

It is important to emphasise that the 'post' period referred to in this chapter and throughout the report includes the actual period of time during which clients received support from one of the four services, as such, 'post' should be taken to indicate 'post commencement' only, rather than 'post intervention' per se. For homeless clients in this cohort, the episode of care and the nature of support subsequently instigated by the four services is rarely 'one-off'. For all four services, the type of support provided is tailored to the needs of the individual client and thus the duration of support may extend beyond the data window period, particularly for clients of CHOPS (more than one third had an episode of care extending beyond one year) and Prague House (who typically continue to live there for many years). For ALERT also, support can be of an intense and ongoing nature for a period of months (with nearly one fifth of this cohort having an episode of care period longer than six months). A much longer evaluation period would be required to look at changes in health service use following completion of episodes of care, and for longer term clients of Prague House in particular, a fully 'post-intervention' evaluation is not really feasible.

Box 8 illustrates the long history some clients have had with SVHM (both in terms of hospital presentations and contact with SVHM services); for clients such as this with multiple, complex presentations to SVHM over a long period of time and for varying medical issues, it is important to note that the 2015 data window for this evaluation reflects only partial insight into his history with SVHM, and highlights the enormous variability that can be masked by aggregated empirical data alone.

Box 8: Complexity of Inpatient Admissions

A male in his early forties with a history of alcohol dependence and depression had four separate stays at The Cottage in the 2015 calendar year, but prior has had multiple complex presentations to SVHM since first presenting in 2006. In April 2015 he was admitted for post-detox respite, and then engaged by the ALERT team for ongoing support and case management. He was a client of ALERT for a 13 month period (until May 2016). Since 2015 he has had at least fortnightly contact with SVHM (either through the ED or as an outpatient). These presentations are usually for intoxication, injuries sustained while intoxicated, overdose or self-harm related. Additionally, there have been multiple inpatient admissions for alcohol withdrawal and liver damage; between 2015 – April 2017 he had 38 inpatient admissions to various units including emergency short stay, psychiatry and general medicine.

While only inpatient admissions that occurred within the defined period are included in the number of admissions results presented in this chapter; it should be noted that length of inpatient admissions is defined as the number of unplanned inpatient days which occurred **during** the six months pre- and six months post commencement of an episode of care, irrespective of when the person was admitted and discharged. For example, if a person was an inpatient during the six months pre episode of care, but was admitted prior to that six month point, only the inpatient days which occurred within the six months prior to commencing support would be included (Figure 24).

Additionally, clients' whose admission commences in the pre episode of care period, but continues into post episode of care period will only be counted in the respective period (e.g. a client may be admitted into the inpatient psychiatric ward and one week into their admission

they engage with CHOPS; therefore any subsequent days of their inpatient admission are then counted in the post episode commencement period).

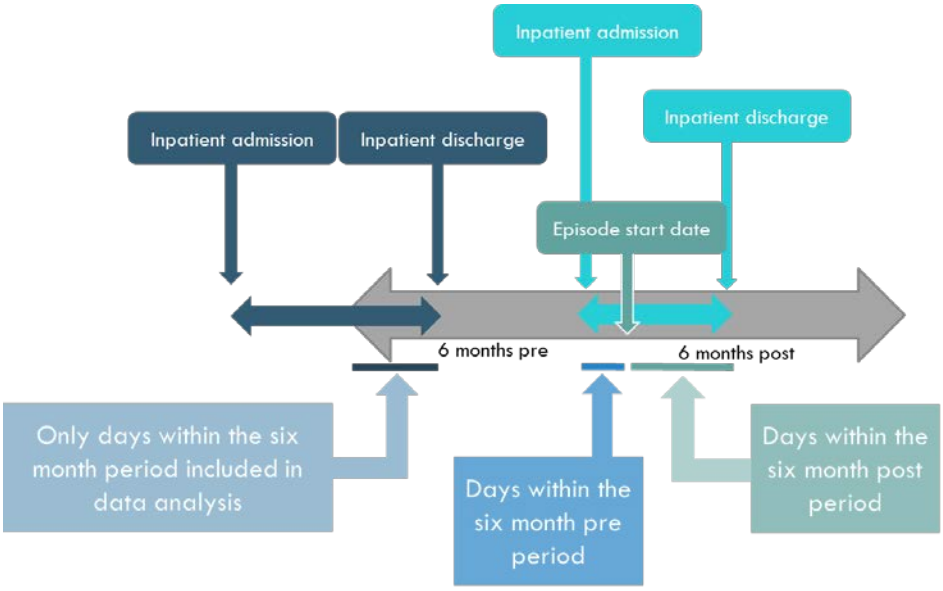

Figure 24: Inpatient Admission Days Included in Analysis

The findings reported in this chapter encompass a number of different measures of health service use; the majority relate to ED statistics; number of ED presentations, average length of stay in ED, ED attendances where client left without being seen, number of ED presentations resulting in an unplanned inpatient admission, ED arrivals via ambulance and discharge destinations. Other findings relate to outpatient appointments; number attended and not attended and the number of planned inpatient admissions. These findings will also form the inputs for the economic analysis (see Chapter 7).

It should be noted that the subset of clients who had episodes of care provided by both ALERT and The Cottage (n=36) have been analysed as a separate group, as often episodes of care were concurrent. Change in use of health services is associated with this integrated support, and this group is reported on separately and referred to as ALERT/The Cottage.

4.1 ED PRESENTATIONS

ED presentations result in three outcomes: clients seen; clients left unseen; and clients whose presentation resulted in an unplanned admission (Figure 25).

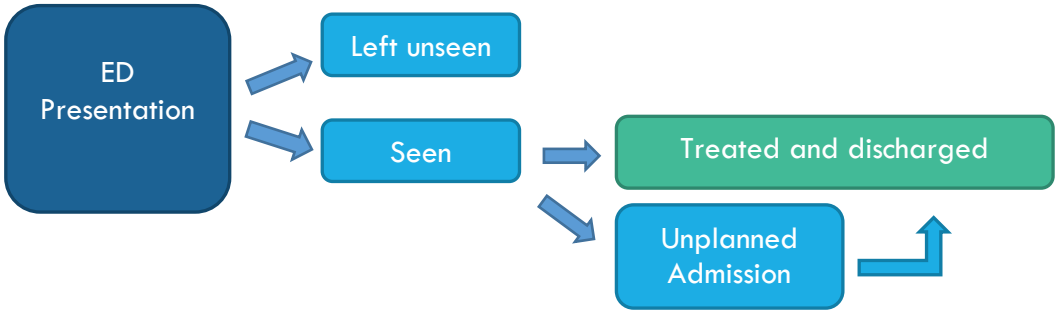

Figure 25: Outcome Pathways of ED Presentation of Service Clients

There was an overall reduction in the total number of ED presentations from 667 to 581 for the four services; with reductions in total presentations observed for ALERT (from 315 to 280), ALERT/Cottage (from 108 to 106) and CHOPS (from 132 to 74). In addition to an overall reduction in number of presentations, there was also a reduction in the total number of people presenting to the ED (from 232 people to 168 people); with reductions in people observed for all services (Figure 26 and Table 8). This may be indicative that the support provided could be successful in assisting clients to manage their health issues more effectively, decreasing demand for ED services, however we cannot fully ascertain the reason why they decreased their acute health service utilisation.

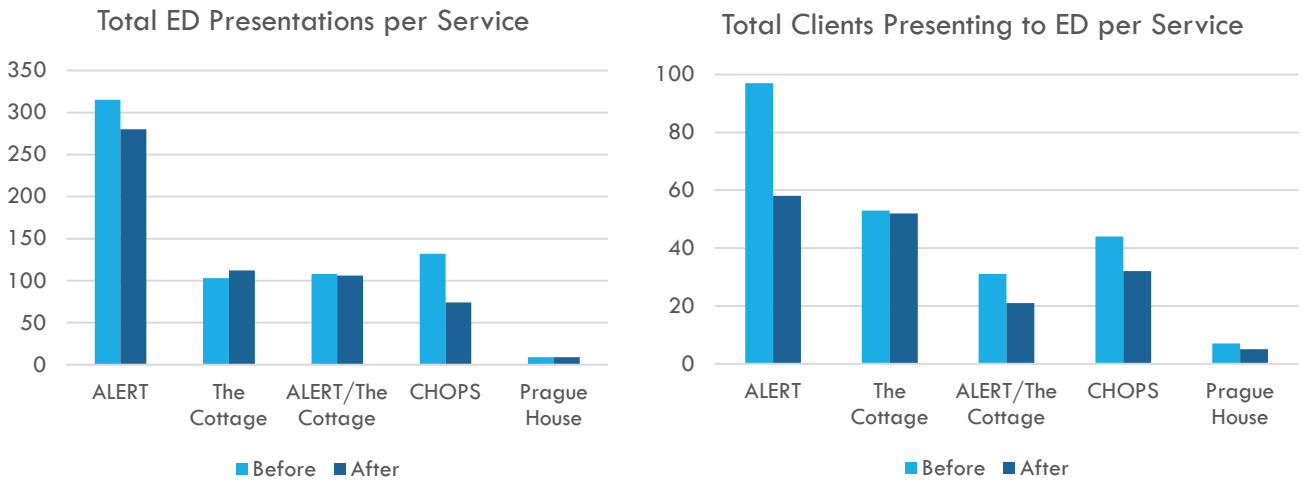

Figure 26: Number of Presentations and People Presenting to the ED 6 Months Pre/Post Episode Start Date

Table 8: ED Presentations Data 6 Months Pre/Post Episode Start Date

		ALERT (n=102)	The Cottage (n=103)	ALERT/The Cottage (n=36)	CHOPS (n=77)	Prague House (n=21)	Total (n=339)
Before	Total ED presentations	315	103	108	132	9	667
	Average number of ED presentations per person (sd)^	3.1(5.4)	1.0(1.4)	3.0(4.6)	1.7(2.7)	0.4(0.7)	2.0(3.7)
	Range in number of presentations per person	0-43	0-6	0-27	0-13	0-2	0-43
	Total people presenting to ED	97	53	31	44	7	232
After	Total ED presentations	280	112	106	74	9	581
	Average number of ED presentations per person (sd)^	2.7(7.6)**	1.1(1.9)	2.9(5.5)	1.0(1.8)**	0.4(1.0)	1.7(4.8)**
	Range in number of presentations per person	0-70	0-15	0-31	0-11	0-4	0-70
	Total people presenting to ED	58	52	21	32	5	168

*p<0.05, **p<0.01

^Average ED presentations calculated over whole sub-sample including those who did not present in the specified period

Note: When outliers (n=4) were removed the average number of ED presentations per person reduced from 2.0 to 1.7 in the six months pre episode commencement, and from 1.7 to 1.4 in the six months post episode commencement.

There was also a decreased need to access ED services noted by clients themselves, who discussed feeling proud that they no longer needed to frequently present at ED

> *I was like… a revolving door through the ED department, but whatever the circumstances since November 2015, I've never been back inside the doors of the ED department, sort of to me says something. -* ***Client***

Overall there was a significant decrease ($p<0.01$) in the average number of ED presentations per person (from 2.0 to 1.7 over the whole sample). Of those who presented to the ED in the specified period, nearly half only presented once in both the pre and post periods (pre, n=108 or 47%; post, n=73 or 43%) (Figure 27). People who are homeless are known to be over-represented in ED statistics on frequent attendees (both at SVHM and elsewhere[15,71]) and in this cohort of clients, the proportion presenting to ED five or more times in the six month pre or post period was 9% and 14% respectively, with one client presenting to the ED on 70 occasions in a six month period. Given that highly frequent ED attenders can skew the average ED presentations, the average number of ED presentations was recomputed with outliers[e] removed, and as a result the average number of ED presentations per person changes to 1.7 six months pre to 1.4 six months post which has potential significant cost implications. Overall the outliers (n=4) accounted for approximately a fifth of ED presentations (15.7% pre, 21.5% post).

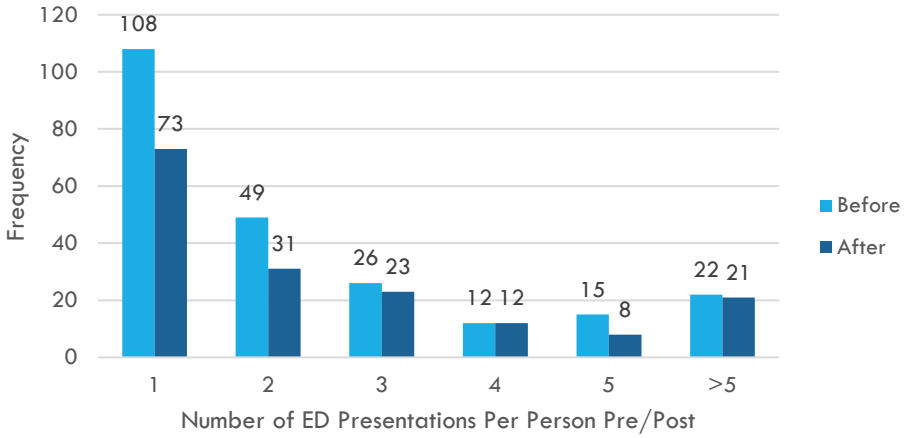

Figure 27: Frequency of People with Number of ED Presentations 6 Months Pre/Post Episode Start Date

The average length of an ED presentation decreased by nearly an hour from 5.8 hours to 5.0 hours (Figure 28 and Table 9). It should be noted that these changes in average ED this may be attributable to other initiatives that improve ED flow, or which there has been significant focus (e.g., NEAT targets) rather than attributable to the four services per se. However, the observed change may also be indicative of more efficient management of other health issues as a result of support clients are receiving i.e. with issues being less complex when people do present at ED. The large decrease for Prague House may also reflect the benefit of its residential model, with more timely discharge possible when a person has accommodation to be discharged to.

[e] Outliers are defines as those greater than the mean plus three standard deviations.

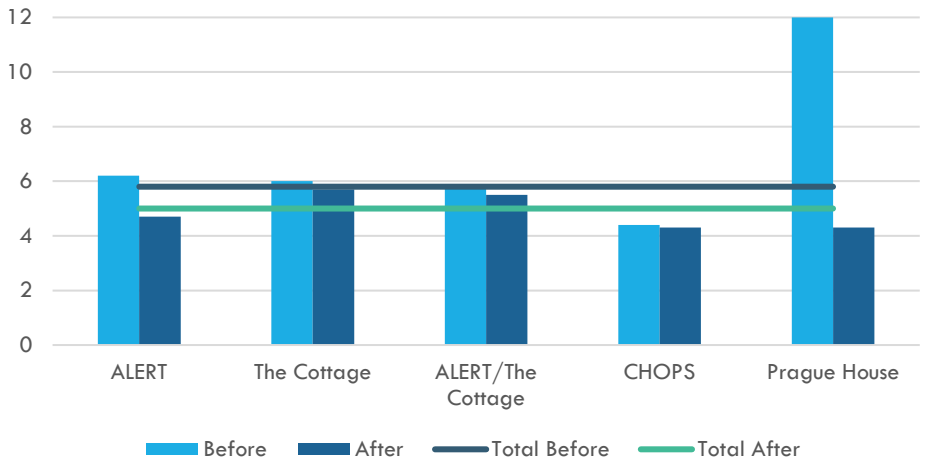

Figure 28: Average LOS (hours) of ED Presentations 6 Months Pre/Post Episode Start Date

Table 9: Length of Stay per ED Presentations 6 Months Pre/Post Episode Start Date

		ALERT	The Cottage	ALERT/The Cottage	CHOPS	Prague House	Total
Before	Average LOS in hours per ED presentation (sd)^	6.2(5.0)	6.0(5.0)	5.9(4.4)	4.4(4.8)	12.0(7.6)	5.8(5.0)
	Range in LOS per ED presentation in hours	0-24	0-24	0-23	0-24	3-23	0-24
After	Average LOS in hours per ED presentation (sd)^	4.7(4.0)	5.7(4.6)	5.5(4.8)	4.3(5.6)	4.3(2.6)	5.0(4.5)
	Range in LOS per ED presentation in hours	0-23	1-23	0-24	0-23	1-10	0-24

*p<0.05, **p<0.01

^ ED LOS was calculated per presentation, not per person; therefore those with no presentation were not included in average LOS.

4.1.1 ARRIVALS TO ED

Approximately half of arrivals to ED among clients who had attended in the six months pre and/or post service episode start date were via ambulance (51% pre; 47% post) (Appendix 3 and Figure 29). Overall, there was an increase in average number of ambulance arrivals per person (from 2.5 pre to 2.9 post). Frequent ED presentation via ambulance was identified in interviews conducted with service staff and internal stakeholders who discussed the frequency in which some homeless clients present via ambulance.

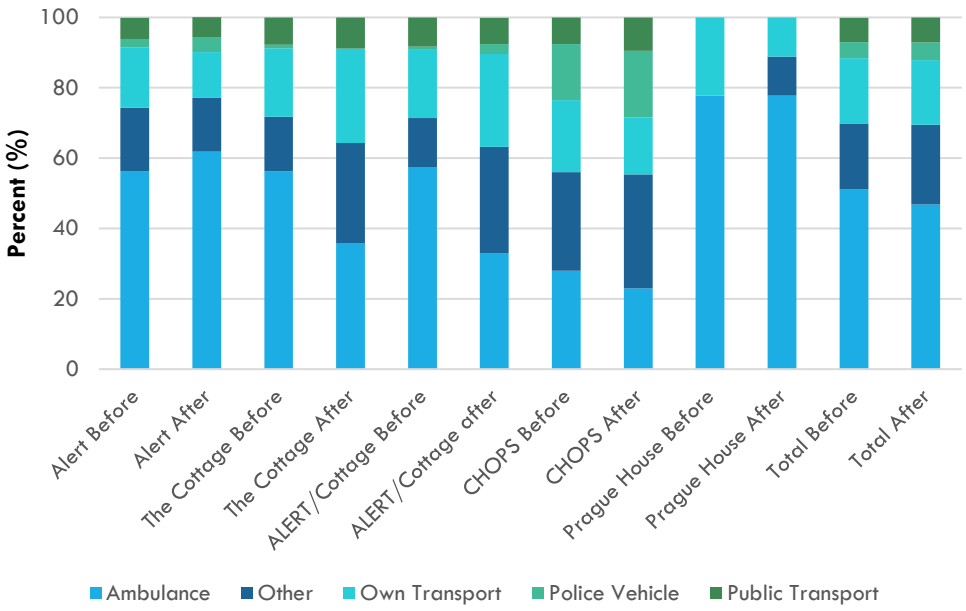

Figure 29: Mode of Arrival 6 Months Pre/Post Episode Start Date

4.1.2 INPATIENT ADMISSIONS AS A RESULT OF AN ED PRESENTATION

As a result of their ED presentation, a number of clients were admitted into an inpatient unit (unplanned admission). Overall there was an observed decline in the total number of unplanned inpatient stays as a result of ED presentation (from 320 to 210 admissions) (Figure 30 and Table 10). This is consistent with the total decline in presentations to the ED following service contact discussed earlier.

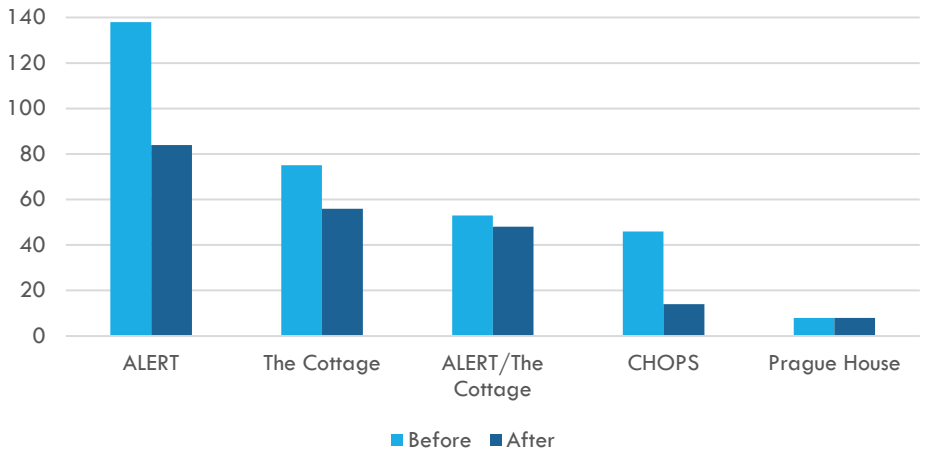

Figure 30: Total Unplanned Inpatient Admissions 6 Months Pre/Post Episode Start Date

Table 10: Unplanned Inpatient Unit Admissions 6 Months Pre/Post Episode Start Date

		ALERT (n=102)	The Cottage (n=103)	ALERT/The Cottage (n=36)	CHOPS (n=77)	Prague House (n=21)	Total (n=339)
Before	Total unplanned admissions	138	75	53	46	8	320
	Average number of unplanned admissions per person (sd)^	1.4(1.7)	0.7(1.1)	1.5(1.8)	0.6(0.9)	0.4(0.7)	0.9(1.4)
	Range in number of admissions per person	0-12	0-5	0-9	0-4	0-2	0-12
	Total people with unplanned admissions	72	45	27	30	6	180
After	Total unplanned admissions	84	56	48	14	8	210
	Average number of unplanned admissions per person (sd)^	0.8(1.6)**	0.5(0.9)	1.3(2.6)	0.2(0.5)**	0.4(0.8)	0.6(1.4)**
	Range in number of admissions per person	0-10	0-5	0-13	0-3	0-3	0-13
	Total people with unplanned admissions	40	37	16	10	5	108

*p<0.05, **p<0.01

^Average unplanned admissions were calculated over whole sub-sample including those who did not present in the specified period

Note: When outliers (n=8) were removed the average number of unplanned stays in an inpatient unit per person reduced from 0.9 to 0.8 in the six months pre episode commencements, and from 0.6 to 0.5 in the six months post episode commencement.

There was also an observed reduction in the total days spent in an inpatient unit (from 2,316 to 1,612 days) (Figure 31 and Table 11). It should be noted that only the days of an unplanned inpatient admission that fell within the specified period have been included (as was illustrated in Figure 24).

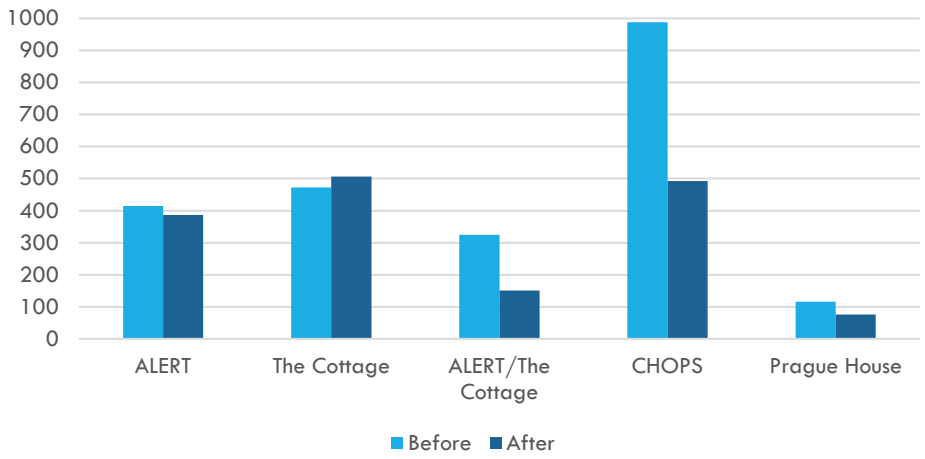

Figure 31: Total Days Spent in Unplanned Inpatient Unit 6 Months Pre/Post Episode Start Date

Table 11: Length of Stay in Days per Unplanned Inpatient Admission 6 Months Pre/Post Episode Start Date

		ALERT	The Cottage	ALERT/The Cottage	CHOPS	Prague House	Total
Before	Total days of unplanned admissions	415	472	325	988	116	2,316
	Average LOS (days) per person(sd)^	3.0(4.4)	6.3(8.3)	6.1(9.5)	20.2(26.4)	14.5(16.5)	7.2(13.5)
	Range in LOS (days) per admission	1-29	1-38	1-39	1-144	1-49	1-144
After	Total days of unplanned admissions	387	506	151	492	76	1,612
	Average LOS (days) per person(sd)^	4.4(7.2)	9.0(17.6)	3.1(5.8)	27.3(52.8)	9.5(12.5)	7.4(19.3)
	Range in LOS (days) per admission	1-37	1-92	1-36	1-171	1-37	1-171

^Average LOS was calculated for those who had admissions with days that fell within the specified period (pre, n=323; post, n=218), note, variations in the number (n) presented in tables 10 and 11 are attributable to admissions commencing outside the specified data window, but with overlapping days in that window.

Over half of all ED presentations where the client was admitted to an inpatient unit, were admitted to the emergency short stay unit (51% pre, 53% post). Other admissions were to general medicine (19% pre and post), to psychiatry (14% pre, 11% post), and to other departments (16% pre and post). There were no significant differences in admission unit prior and post first service contact in 2015 (Appendix 3 and Figure 32).

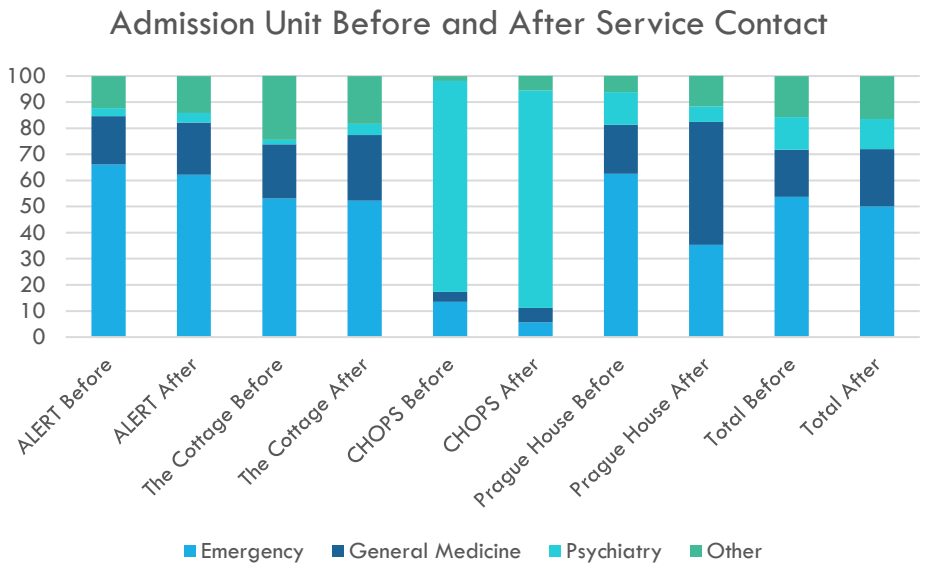

Figure 32: Admission Unit were Client Admitted from ED Presentation 6 Months Pre/Post Episode Start Date

4.1.3 ED DISCHARGE DESTINATION

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) (Appendix 3). 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 it seems in the discharge destination data collected at other Australian hospitals also, 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.

4.1.4 ALERT ED PRESENTATIONS

The overall number of ED presentations for ALERT clients decreased from 315 to 280; with a total decrease in the number of people presenting to the ED from 97 to 58 people from six months pre to post episode start date. On average ALERT client's total length of time spent in ED also reduced from 6.2 to 4.7 hours. The average presentations per person significantly ($p<0.01$) decreased from 3.1 to 2.7 presentations per person over the whole sample.

Over half of the arrivals to ED of ALERT clients were via ambulance (56% pre, 62% post), with only a small proportion arriving via police vehicle (2% pre, 4% post). There were no significant differences in mode of arrival pre and post episode start date for ALERT clients.

Overall ALERT clients had less unplanned inpatient admissions (138 to 84 admissions) following episode start date; with a collective length of stay reducing from 415 to 387 days. The average number of admissions per person significantly decreased ($p<0.01$) from 1.4 to 0.8 admissions over the whole sample. Of those who were admitted to an inpatient ward from ED, the majority were admitted to the emergency short stay unit (68% pre, 65% post).

The majority of ALERT clients were discharged to home/private accommodation/hostel (79% pre, 74% post), or left prior to being seen (9% pre, 13% post). There were no significant differences in discharge destination pre and post service involvement for ALERT clients.

4.1.5 THE COTTAGE ED PRESENTATIONS

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 (which is likely a result of nature of the service), 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 number of admissions per person from 0.7 pre to 0.5 post, however 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.

4.1.6 CHOPS ED PRESENTATIONS

The total number of presentations for CHOPS clients decreased from 132 to 74 presentations; with the overall number of clients presenting to ED also decreasing from 44 to 32 people. The

average length of stay in ED decreased from 4.4 hours to 4.3 hours. There was a significant decrease ($p<0.05$) in the number of ED presentations per person for CHOPS clients, reducing from 1.7 to 1.0 per person over the whole sample.

Overall the majority of CHOPS clients arrived to ED via ambulance (28% pre, 23% post) or via their own transport (19% pre, 26% post). Unlike other services, there was quite a large proportion of arrivals via police (16% pre, 19% post); this is likely due to mental health complexities of clients such as the large proportion with schizophrenia and the likely street presence of CHOPS clients.

There was a large reduction in the number of unplanned inpatient admissions for CHOPS clients (from 46 to 14 admissions); with an overall reduction from 988 to 492 days spent in an inpatient unit. There was an overall significant ($p<0.01$) reduction in the number of inpatient admissions per person reducing from 0.6 to 0.2. This is likely a result of the intense mental health support provided by the CHOPS team which has kept them from being admitted. The majority of the ED presentations of CHOPS clients were admitted to psychiatry (85% pre, 86% post).

4.1.7 PRAGUE HOUSE ED PRESENTATIONS

The total number of presentations for Prague House residents remained the same from six months pre, to six months post episode start day (9 presentations); however the number of residents that presented to ED reduced (from 7 to 5 people). The length of time spent in ED reduced from 12 to 4.3 hours. While there was no change in overall presentations for Prague House residents, Box 9 portrays one particular resident who had 45 separate ED presentations in the 12 months preceding his entry to Prague House which has dramatically reduced since gaining stable accommodation. It is important to view these individual situations, as such dramatic changes aren't always captured in the aggregated data.

Box 9: Case Study Demonstrating Reduction of ED Presentations and Admissions - Prague House Client

A 51 year old male who is currently residing at Prague House has a 30 year history of alcohol dependency, a diagnosed alcohol-related brain injury and depression (un-medicated). He has a long history of homelessness and unstable housing has been residing at multiple family members' houses and various temporary accommodations in the past. Prior to Prague House entry, he had frequent contact with police (at least every second day) and was often found sleeping on trains or station platforms. He had numerous outstanding warrants due to his failure to attend court for drunk-related charges.

Use of hospital and SVHM services prior to contact with one of the four services

He has had frequent presentations to multiple metro EDs with alcohol intoxication, falls and complaints of chest pain. He has had 100 ED presentations and 30 admissions to SVHM since he first presented in 2002. In the 12 months prior to residing at Prague House, he had 45 ED presentations compared with eight presentations in the six months directly after moving into Prague House.

Intervention via SVHM

He has been residing at Prague House since June 2015 after a referral from his ALERT social worker. ALERT and Prague house have worked together to create a case management plan. The reduction in ED presentations, admissions and police contact demonstrate a significant reduction in this individual's health system expenditure and improved stability/quality of life for the individual.

The majority of the ED arrivals of Prague House residents were via ambulance (78% both pre and post).

Overall, the number of unplanned inpatient admissions remained the same (8 admissions in both the pre and post six months following episode start date). However there was an observed reduction in the total days spent in these admissions (from 116 to 76 days). The majority of unplanned inpatient admissions were to general medicine (50% both pre and post). There were no significant differences in Prague House client admission unit prior and post SVHM first homelessness service contact in 2015.

4.2 OTHER HOSPITAL USAGE

Further analysis was undertaken with clients who had service contact in 2015 and an episode commencement date after the 1st of January 2011, who had other hospital contact with SVHM in the six months pre and post episode start date. This was analysed to determine if there were any changes in outpatient service attendance (Table 12) or non-attendance (Table 13) and planned admissions (Table 14) as a result of service access.

4.2.1 NUMBER OF OUTPATIENT APPOINTMENTS ATTENDED

Comparing data six months pre to six months post SVHM episode start date, overall the number of outpatient appointments for the cohort significantly ($p<0.01$) increased from 2.2 to 2.5 outpatient appointments per person. There was a decrease in the number of outpatient appointments attended by ALERT clients (from 3.7 to 1.7 appointments) only (not significant); this is likely because of the individual with 232 outpatient appointments in the pre episode commencement period. 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, $p<0.01$) (Table 12 and Figure 33).

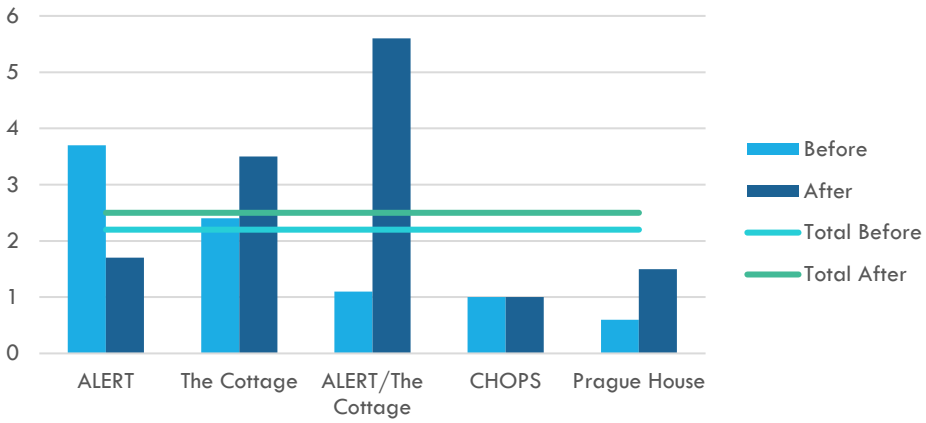

Figure 33: Number of Outpatient Appointments Attended 6 Months Pre/Post Episode Start Date

Table 12: Outpatient Appointments Attended per Service 6 Months Pre/Post Episode Start Date

		ALERT (n=102)	The Cottage (n=103)	ALERT/The Cottage (n=36)	CHOPS (n=77)	Prague House (n=21)	Total (n=339)
Before	Total outpatient appointments	382	251	40	75	13	761
	Average number of outpatient appointments per person (sd)^	3.7(23.3)	2.4(3.5)	1.1(1.9)	1.0(2.1)	0.6(1.1)	2.2(13.0)
	Range of number of outpatient appointments per person	0-232	0-22	0-10	0-10	0-4	0-232
	Total people attended	28	60	18	20	7	133
After	Total outpatient appointments	172	365	202	75	32	846
	Average number of outpatient appointments per person (sd)^	1.7(3.8)	3.5(5.4)*	5.6(8.0)**	1.0(3.0)	1.5(3.0)	2.5(4.9)**
	Range of number of outpatient appointments per person	0-23	0-30	0-31	0-16	0-10	0-31
	Total people attended	34	69	26	13	7	149

*p<0.05, **p<0.01

^Average outpatient appointments calculated over whole sub-sample including those who did not have an appointment in the specified period

Note: When outliers (n=11) were removed the average number of outpatient appointments per person reduced from 2.2 to 1.3 in the six months pre episode commencement, and from 2.5 to 1.9 in the six months post episode commencement.

The increase in outpatient appointments was significant for ALERT/Cottage clients only (p<0.01). This finding is congruent with those of the MISHA study, which found that in the first year of housing and support provision, the use of some health services among formerly homeless clients actually increased 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[25]. This was an observation that was articulated by a number staff members and external services.

> *They might actually present themselves more for say diabetes, because that's now being managed, but because they've got a better relationship and they're more stable, they're more likely to present in emergency for mental health than they would have in the past.* ***– Service staff***

> *Sometimes their hospital contacts might actually go up because their trust of services is better because we have built up trust and a relationship with them. The other thing that we haven't measured and could be an option is that yes they may well re-present, but is their episode of care shorter.* ***– Service staff***

> *there's some outcomes that we could look at that are measurable in regards to representations or actual attendances of our patient appointments or even GP appointments or actual linking into the services that we refer to… But again, you can say with our client group that it's not necessarily that they don't - it's not necessary that we reduce their presentations. For some that's great but for others it might actually be that they actually increase [their presentations].* ***– Service staff***

Box 10 demonstrates that support from the key services may reduce the use of acute health services, such as presentations at ED, whilst increasing appropriate service use, including attendance at outpatient appointments.

Box 10: Increased Appointment Attendance as a Result of Increased Support

A female living with end stage Kidney disease, Hep C, COPD and other serious health concerns has frequent stays at The Cottage. She has a complicated set of related issues including disease management, emotional and behavioural problems, mental health issues, relationship breakdowns, and financial mismanagement, sexuality changes and heavy marijuana and alcohol use.

Use of hospital and SVHM services prior to contact with one of the four services

The client has had 19 ED presentations and over 100 admissions since first presenting to SVHM in 2008. She first stayed at The Cottage in July 2009 and has since stayed on 11 occasions. In the six months prior to her first admission to The Cottage she presented at the ED on four occasions, with two of these resulting in unplanned admissions.

Intervention via SVHM

In the six months after first contact with The Cottage she attended the ED once, resulting in one unplanned admission. HARP social work has had regular contact with her via home or inpatient visits and phone conversations. Since December 2014, various HARP workers (social work, speech pathology, care coordination etc.) have made 114 contacts with her. HARP workers have gone the extra mile in her care by giving her wake up calls to assist in resetting sleep patterns, have assisted with decluttering of her house, assisted in helping find her stolen car, getting her to medical appointments, helped prioritise bills/demands from debt collectors. This support has increased her use of appropriate health services and improved regularity of attendance at scheduled dialysis appointments.

4.2.2 NUMBER OF OUTPATIENT APPOINTMENTS NOT ATTENDED

Overall the number of outpatient appointments where clients did not attend (DNA) (i.e. had an appointment scheduled and missed without cancelling or rescheduling) significantly increased from 1.0 to 1.3 appointments per person ($p<0.01$). Decreases were only observed for CHOPS clients (from 1.0 to 0.6 appointments missed). Significant increases in the number of appointments not attended were observed for Cottage clients (from 1.1 to 1.6, $p<0.05$), ALERT/Cottage clients (from 0.7 to 1.9, $p<0.01$) and Prague House residents (from 0.6 to 2.4, $p<0.05$) (Table 13 and Figure 34).

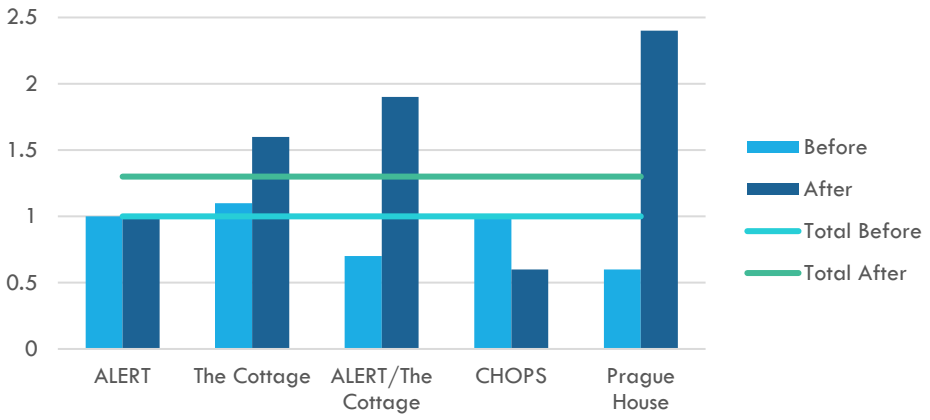

Figure 34: Number of Outpatient Appointments Not Attended 6 Months Pre/Post Episode Start Date

Table 13: Outpatient Appointments Not-attended per Service 6 Months Pre/Post Episode Start Date

		ALERT (n=102)	The Cottage (n=103)	ALERT/The Cottage (n=36)	CHOPS (n=77)	Prague House (n=21)	Total (n=339)
Before	Average number of DNAs per person (sd)^	1.0(2.4)	1.1(2.3)	0.7(1.5)	1.0(2.6)	0.6(1.0)	1.0(2.3)
	Range in number of DNAs per person	0-16	0-14	0-8	0-16	0-4	0-16
	Total people who DNA	29	35	12	22	8	106
After	Average number of DNAs per person (sd)^	1.0(2.0)	1.6(2.4)*	1.9(3.0)**	0.6(1.5)	2.4(3.5)*	1.3(2.3)**
	Range in number of DNAs per person	0-13	0-12	0-16	0-11	0-10	0-16
	Total people who DNA	41	56	23	22	9	151

*p<0.05, **p<0.01

^Average outpatient appointments calculated over whole sub-sample including those who did not miss an outpatient appointment in the specified period

While there was an overall increase observed for clients, at the individual client level however, there were clearly some clients where non-attendance rates did improve, such as one client who was interviewed who now more regularly attends his addiction counselling appointments. Another example pertained to a client with renal failure whose attendance at dialysis appointments had improved overall, but with staff noting that mental health issues still sometimes impacted on this.

4.2.3 NUMBER OF PLANNED ADMISSIONS

Overall, there was only a significant decrease in the number of planned admissions per person (over the whole sample) when comparing data six months pre and six months post episode start date for CHOPS clients (from 0.2 to 0.1 admissions, p<0.05)(Table 14 and Figure 35).

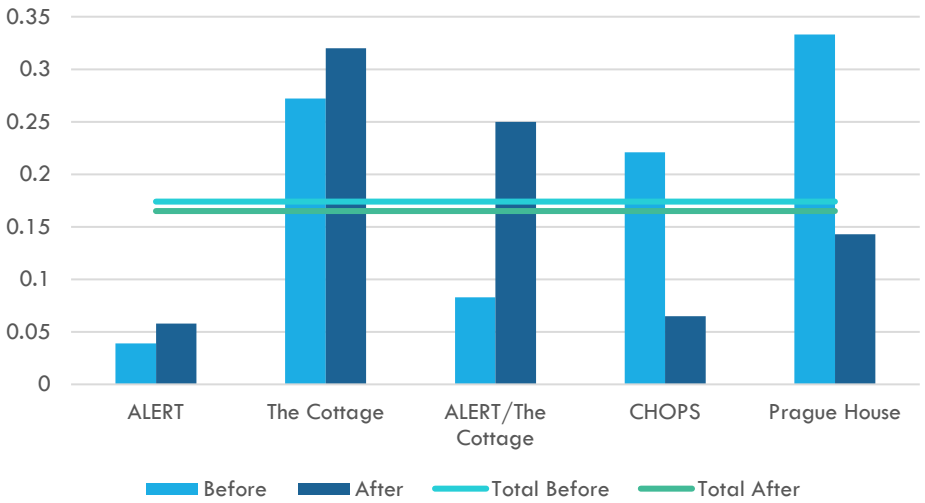

Figure 35: Number of Planned Admissions 6 Months Prior to and Post Episode Start Date

Table 14: Frequency of Planned Admission per Service 6 Months Pre/Post Episode Start Date

		ALERT (n=102)	The Cottage (n=103)	ALERT/The Cottage (n=36)	CHOPS (n=77)	Prague House (n=21)	Total (n=339)
Before	Total planned admissions	4	28	3	17	7	59
	Average number of planned admissions per person (sd)^	0.0	0.3(0.5)	0.1(0.4)	0.2(0.7)	0.3(0.7)	0.2(0.5)
	Range in number of admissions	0-1	0-2	0-2	0-5	0-3	0-5
	Total people with admissions	4	26	2	10	5	47
After	Total planned admissions	6	33	9	5	3	56
	Average number of planned admissions per person (sd)^	0.1	0.3(0.8)	0.3(0.6)	0.1(0.3)*	0.1(0.4)	0.2(0.5)
	Range in number of admissions	0-2	0-5	0-2	0-2	0-1	0-5
	Total people with admissions	5	22	6	4	3	40

*p<0.05, **p<0.01

^Average planned admissions calculated over whole sub-sample including those who did not have an admission in the specified period

There was a decrease in total days spent in planned inpatient admissions (from 1,135 days to 705 days) and a decrease in average days per planned inpatient admissions (from 19.2 to 12.8 days per admission) (Table 15). A decrease was observed for ALERT, CHOPS and Prague House, but increases were observed for The Cottage and ALERT/The Cottage planned admission lengths.

Table 15: Length of Stay in Days of Planned Inpatient Admissions per Service 6 Months Pre/Post Episode Start Date

		ALERT	The Cottage	ALERT/The Cottage	CHOPS	Prague House	Total
Before	Total days of planned admissions	82	255	12	374	412	1,135
	Average LOS per admission (sd)^	20.5(14.1)	9.1(12.8)	4.0(2.0)	22.0(28.9)	58.9(56.3)	19.2(30.0)
	Range in LOS per admission	7-35	1-60	2-6	1-111	3-161	1-161
After	Total days of planned admissions	72	434	46	86	67	705
	Average LOS per admission (sd)^	12.0(10.4)	13.2(14.8)	5.1(5.8)	17.2(22.0)	22.3(5.1)	12.8(13.9)
	Range in LOS per admission	1-26	1-46	1-16	1-52	18-28	1-52

*p<0.05, **p<0.01

^Average LOS was calculated per admission within the specified period, not per person.

5 SHARED CLIENTS, REFERRAL AND COLLABORATION BETWEEN THE FOUR SERVICES

In this chapter the client overlap and flow between the four services, within SVHM and external services working with those experiencing homelessness in Melbourne more broadly is described. Objective data on client pathways and flow was obtained where possible, and complemented by case studies, interview and focus group data on perceptions relating to this.

5.1 CLIENT FLOW AND REFERRAL BETWEEN THE FOUR SVHM SERVICES

5.1.1 SHARED CLIENTS AND CROSS-REFERRAL; WHAT THE DATA SHOWS

As each of the four services differs in the type and context of service being delivered, it is plausible that there will be clients seen by more than one service, or referred from one to another. For example, a homeless person could be first seen by ALERT in ED, then admitted to The Cottage for HITH recovery and then potentially referred to Prague House if they met the eligibility criteria and a bed was available. Conversely, a CHOPS or Prague House client could end up in ED and, whilst there, come into contact with the ALERT team.

Hospital record data for clients seen by any of the four services during 2015 was analysed to look at the extent to which there were clients seen by more than one of the services during that calendar year. The Venn diagram in Figure 36 shows the number of clients who were seen by more than one of the four services.

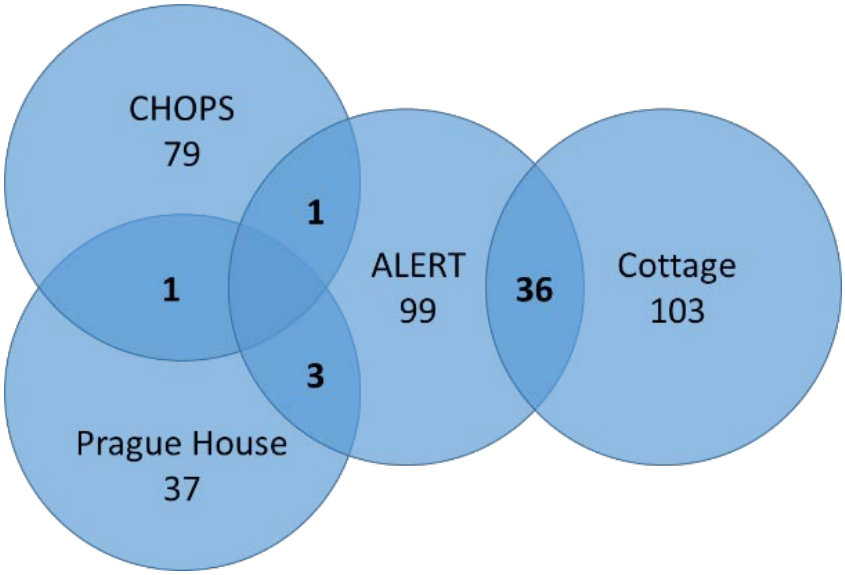

Figure 36: Number of Total and Shared Clients between the Four Services During 2015

As seen above, the greatest number of shared clients was between The Cottage and ALERT, with 36 shared clients. Only one client was seen by both ALERT and CHOPS in the 2015 period, three by Prague House and ALERT and two by CHOPS and Prague House. The ALERT/CHOPS client had first contact with ALERT then went on to receive ongoing support from the CHOPS

team. The CHOPS/Prague House shared client first received support from CHOPS before moving into Prague House. The three ALERT/Prague House shared clients were all first seen by ALERT before being referred to Prague House.

Approximately two thirds of shared clients between The Cottage/ALERT stayed at The Cottage first, for these clients contact with ALERT usually commenced during their stay; with five shared clients having first contact with both services on the same day. It should be noted however, that The Cottage and ALERT share a social worker who works between both services who is likely to have facilitated this rapid involvement of both services.

The overall number of 'shared clients' was not large in 2015; with the exception of ALERT and The Cottage, there were only a handful of shared clients identified between the other services. However, a review of hospital records undertaken for a sample of case studies yielded examples of shared clients between all combinations of services. Additionally, client history as documented in hospital records and notes provides valuable insight into the substantial collaborative work that underpins many of the instances in which a client was seen by more than one of the four services.

The vignette in Box 11 provides an illustration of a client seen by both ALERT and The Cottage, and the collaborative work underpinning this.

Box 11: Vignette Illustrating Collaboration between ALERT and The Cottage Around a Shared Client

A male patient came into contact with both ALERT and Cottage services following a bike accident. He has a history of insecure housing and alcohol dependency. As a result of the bicycle accident he was unable to remain at his current temporary accommodation and, after being discharged from the hospital, was admitted to The Cottage for a period of recovery. From The Cottage he was discharged to a Support Residential Service (SRS), where he felt that other clients were being 'ripped off' and the quality of the accommodation was low. Following a three week period in the SRS he was then assisted by ALERT to obtain more secure and suitable housing. ALERT staff assisted with grocery shopping, setting up appointments and ensuring all staff who had contact with him were kept up to date.

The patient valued the collaboration between services and being informed on what was happening:

"If I didn't' have The Cottage and ALERT, or … Cottage being in touch with ALERT … there would have been a real problem".

ALERT assisted him to navigate the system, explore different accommodation options and engage with services. He was also supported to continue engaging at the dependency support program once housed.

The vignette in Box 12 relates to a client seen by CHOPS, ALERT and The Cottage, and highlights the extensive collaborative work between both internal SVHM services and external services assisting to address her multiple, complex needs.

Box 12: Collaboration between CHOPS, ALERT, Prague House and External Agencies around a Shared Client

A female patient with a long history of schizophrenia, physical health issues and homelessness has been in contact with SVHM since 2001. She has stayed at various temporary accommodations, often disappearing and returning to the streets. She has presented to the SVHM ED on numerous occasions, the majority of which involve her abusing staff and leaving prior to being seen. She was under the care of CHOPS between March 2015 and January 2016 and has previously been offered ALERT services, which she refused.

She has been residing at Prague House since September 2015 after Launch Housing and ALERT arranged a case conference to work out a plan for her treatment, in which around 20 SVHM staff and external services participated. CHOPS provided case coordination and support to access housing after initiating rapport with Prague House. Whilst the patient initially refused and stated she would not go to Prague House. Prague House held the bed for her and after several days of living on the streets she eventually returned to Prague House and has remained there since.

Without ALERT, CHOPS and various other external services coming together for the case conference, and Prague House holding the bed for her, this client may have remained homeless and continued to bounce between multiple services. By coming together, relevant services were able to make rapid decisions and find a suitable accommodation for the client; as a consequence her health problems are able to be monitored by Prague and she has stopped presenting to ED so frequently.

5.1.2 SERVICE STAFF PERCEPTIONS OF SHARED CLIENTS AND CROSS-REFERRAL

Looking at the extent to which there are shared clients and referral pathways between the four services, there were some interesting differences between staff perceptions and the picture painted by the empirical data for clients seen during 2015. In particular, when the preceding summary data on the number of shared clients was presented to the service manager focus group, there was overall a degree of surprise about the minimal sharing or cross referral of clients between some of the services:

> *I would have thought there would be at least one Cottage to Prague.* ***– Service staff***

> *Certainly it would be great to have Prague as an option for some of the people we have at The Cottage.* ***– Service staff***

> *I guess it's surprising to see no-one from The Cottage being referred to CHOPS. But it might be where their ties are. If they don't have any ties in this area that wouldn't be - and into our catchment - then they probably wouldn't be staying around our area to receive treatment here, particularly if they've got ties somewhere else.* ***– Service staff***

A number of reasons for the lower than expected number of shared clients were discussed in the focus group. Given the diversity of clients seen across the four services and differing roles of the services, it was noted that cross-referral may often not be appropriate or relevant, either because of the nature of client needs, or if it falls outside of service scope or capacity.

> *I think maybe the complexity of the clients that CHOPS work with too is a barrier for any kind of housing, even something like Prague House.* ***– Service staff***

with the … staffing model that we have (Cottage) - and our inability to get mental health expertise in there if we need to instantly, we do have restrictions as in it can't be an acute mental health need… there's risk factors associated with acute mental health needs. So those people, we would say no to them. There are - as you mentioned the dynamics before - we do really have to be - with one staff on overnight - really be aware of how many complexities we are managing at one time with mental health. ***– Service staff***

A commonly mentioned explanatory factor pertained to inevitable staff changes within the four services contributing o lack of awareness among some staff of the eligibility criteria or client referral pathways for some services:

I don't know the clients at ALERT and…some of the people in the hospital here don't know much about Prague at all. Some of them at the hospital don't even know that we're part of St Vincent's. ***– Service staff***

I haven't really known about CHOPS ***– Service staff***

I would hope that people would know about the CHOPS mental health service and then if somebody's made a referral then we would triage it to CHOPS if that was appropriate, if they were homeless and primary or secondary homelessness in our area and had some kind of connection here. – ***Service staff***

I've actually myself never referred anyone to Prague House, but I know colleagues [ALERT] have and I think I know a resident who is probably there at the moment. I can only anticipate therefore what the process is for referral. ***– Service staff***

There were a couple of examples provided where client referrals hadn't worked out so well, which could deter subsequent referrals, although interestingly the joint focus group provided an incidental opportunity for reflection on how to avoid a similar issue in the future.

We had one failed referral from CHOPS recently … I think the reason it failed in that particular case was because some of the background work that we should have thought about didn't happen, like he probably needed to get State Trustees involved before we took the client, rather than trying to think the client would pay it ***– Service staff***

Reasons for a small number of shared clients, scope for greater collaboration and shared client pathways between the four services was positively discussed in individual interviews with service staff and in the service manager focus group; with a number of suggestions provided. These issues relating to awareness of other services and referral pathway options are discussed further in Section 5.2.2.

Notwithstanding some expressed surprise about the number of shared clients in 2015, and there were many examples of clients being seen by more than one of the four services, and of the collaborative processes enabling this.

If people do get to The Cottage and don't have any supports, [staff] will often call us and say, can you come and do an assessment I think this person will benefit from ALERT. ***– Service staff***

5.2 CLIENT FLOW AND REFERRAL OF CLIENTS WITHIN SVHM MORE BROADLY

5.2.1 WHO IS INVOLVED IN CARE FOR PEOPLE EXPERIENCING HOMELESSNESS AT SVHM?

In addition to the four homelessness services comprising the focus of this evaluation, it is widely recognised that people experiencing homelessness are a priority population group across SVHM, with many areas providing services to patients/clients who are homeless. The quote below from a 2009 paper on SVHM's response to homelessness reflects the collaborative and holistic ethos that has long underpinned SVHM's efforts to improve the health and lives of this vulnerable population.

The St. Vincent's model is one of collaboration with both inpatient and outpatient medical services, and external services. It is fair to say that the effectiveness of this model might be compromised if services were offered in isolation or if a collaborative, client-centred focus was not paramount. Operational characteristics that permit flexibility are key to effective engagement of the homeless" [3].

However, compiling a unified picture of the different areas/services within SVHM that have contact with homeless clientele proved challenging, and mapping the collaboration and client pathways between these even more difficult. Current organisational charts for SVHM tend to be based on departmental or staffing structures (as is the case with most hospitals), hence these do not easily facilitate the identification of areas, departments or services with a remit for delivering services for specific target groups.

Additionally, the complex reality is that there is a wide spectrum along which services having contact with people experiencing homelessness sit; ranging from services such as CHOPS where all clients are homeless and working with this clientele is core business, to services such as ALERT with a focus on clients with complex needs, through to service areas such as ED whose primary remit is emergency medicine and healthcare, not homelessness per se, but who see a high number of people in this demographic (including high representation of individuals among ED frequent presenters at SVHM). For wards such as general medical or mental health, these wards may or may not have patients who are homeless at a given time, given the SVHM location and the comorbidities associated with homelessness.

In the absence of an existing visual map of the different services and teams within SVHM active in the homelessness space, staff interviewees (within the four services and across SVHM) were invited to visually draw which areas of SVHM they saw to be involved in providing services to people experiencing homelessness, and to depict how they perceived these services to cross-refer and/or collaborate. In addition, interviewees were asked to indicate if there were external service providers that that collaborate with SVHM around homelessness.

The drawing exercise proved an interesting process, with considerable variability in both the range of services identified as working with homeless clients, and differing views on the working relationships between some of the services depicted. The 12 individual drawings were analysed and amalgamated to come up with an overall model depicting the perceived relationships and referral pathways between the services, as shown in Figure 37.

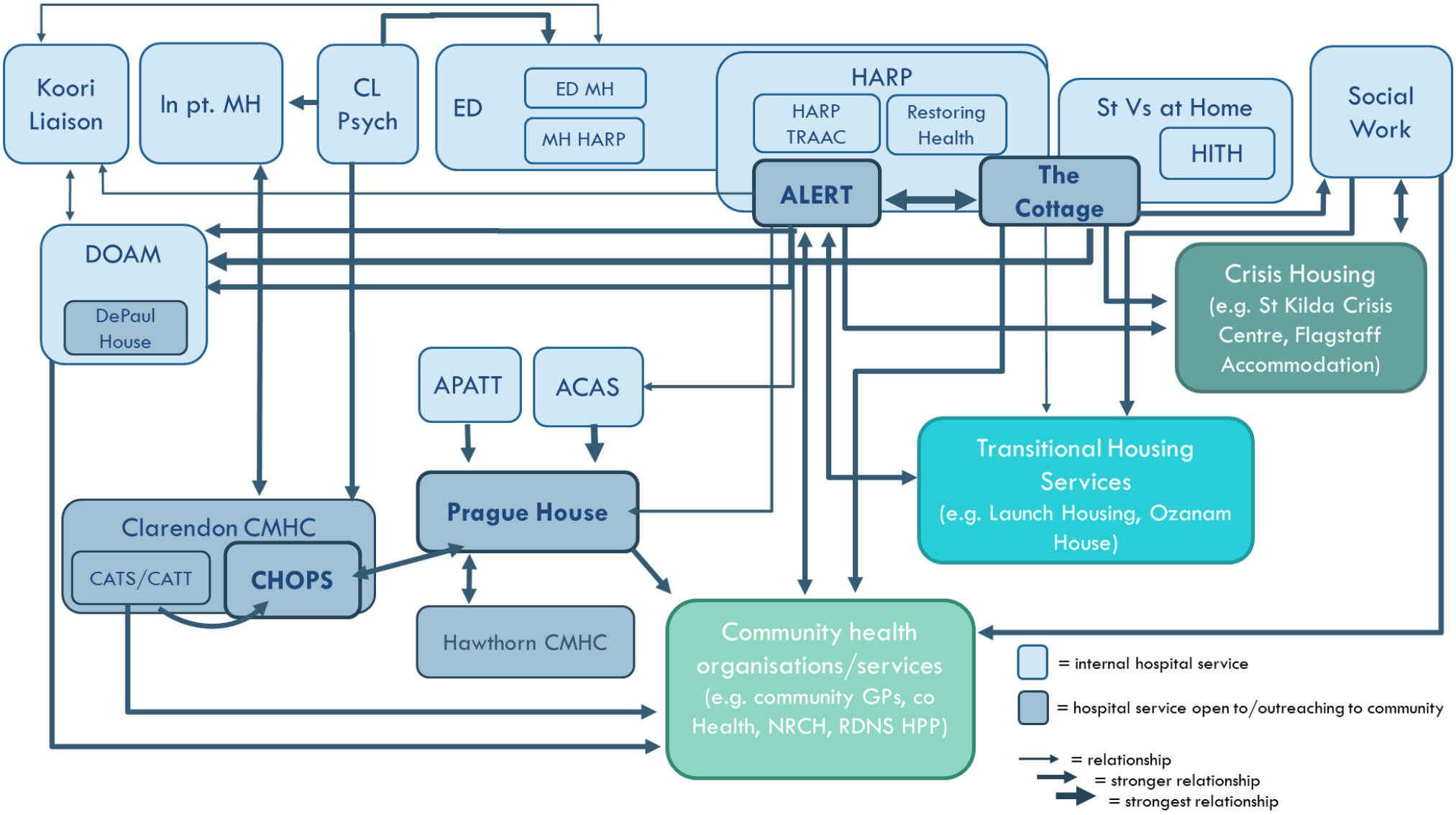

Figure 37: Relationships and Referral Pathways as Perceived by Service Managers and, Internal and External Stakeholders

In Figure 37 the light blue shading of services indicates SVHM services working internally within SVHM, whilst the darker blue shading denotes SVHM services that also operate in a community setting. It is pertinent to note that Social Work as shown in this diagram often also represented the liaison point at the ward level regarding clients.

The visual drawing exercise was telling in a number of ways; firstly it highlighted the array of different services and teams within SVHM who are currently working with people experiencing homelessness (albeit to differing degrees): secondly, quite a number of staff found it challenging and admitted to not necessarily having a clear understanding of who '*all of the players*' or respective roles might be, often knowledge was limited to the areas where they had most contact, or had established personal working relationships with staff in other areas; thirdly, there was even less shared clarity around where there might be client overlap, and no easy mechanism for quickly looking up whether a patient/client had a case history with the raft of other services within SVHM, and; fourthly, whilst there were many positive examples given of services working together, cross-referring or being in contact with each other about a particular homeless client, there were no clearly articulated pathways around this. Whilst informal client pathways can of course be effective, some discussions with staff during the drawing exercise suggested that there may be missed opportunities occurring for services to share client information, increase collaboration, or learn from each other's experiences. Moreover, when new staff come on board, it can take longer for them to unravel the care journeys of clients experiencing homelessness within SVHM, and it takes time to establish their own bank of knowledge about respective roles and develop working relationships with other SVHM services with whom they may or could share clients. These issues relating to the overall picture of services supporting the homeless within SVHM will be discussed further in Chapters 6 and 8.

5.2.2 AWARENESS AND UNDERSTANDING OF THE PURPOSE AND OPERATION OF THE FOUR SERVICES

Internal SVHM services interviewed were generally aware of the broad purpose of the four services we were evaluating, albeit with greater awareness of ALERT and The Cottage, with fewer interviewees indicating a good understanding of Prague House or CHOPS. Interviewees from the range of SVHM services also differed in their awareness of the actual operation of the services (i.e. contacts points, referral process, target clientele), potentially reflecting the diverse target client groups and networks of relationships between the services. Some of the internal stakeholder perceptions of the purpose and role of each of the four services are summarised below.

ALERT

ALERT was most typically perceived as a program for homeless clients with complex needs operating within the ED. Internal stakeholders perceived ALERT as having a well-established workflow with formalised and seamless relationships and open communication and many internal and external connections.

> *I think that those relationships have been forged over a long time and are quite functional and effective* ***– Internal stakeholder***

Internal stakeholders saw ALERT as providing an important role in the coordination of client care and arranging necessary referrals, which allows SVHM to provide more client focused care, minimising the burden on other services that are not directly involved in dealing with issues such as sourcing accommodation for clients experiencing homelessness.

While the ALERT team themselves are quite explicit about their dual roles within ED and within the community, outside of ALERT interviewees didn't tend to make this distinction so much, and there was some vagueness regarding whether the work of ALERT occurs primarily within the ED or community setting. More typically ALERT was described as being based in ED, but with some capacity to follow people up into the community.

> *There's so many different roles. So ALERT has an ED based role; we do all the discharge planning, Allied Health in emergency, prioritising patients that are discharged but we take a focus on different risk factors. One of them's homelessness but aged care, disability, chronic diseases, substance use, mental health. So I guess the ED is one side of our role and then we have a community role which is where we have a HARP program that we work for. So that's doing outreach work and following up patients post discharge from ED.* ***– Service staff***

The Cottage

The Cottage was generally described as a transitional care facility that provides pre- or post-hospital support for disadvantaged or marginalised clients with an identified health need who are not able to access appropriate healthcare before or after a hospital procedure;

> *…that's an environment for patients who may be homeless, who perhaps could go under hospital in the home - don't have a home. It may be people who live in an environment, who have a home but that home situation is not suitable for them to be managed as a - it's sort of a halfway between home and the hospital…* ***– Internal stakeholder***

The Cottage was typically seen as a unique and valuable referral option for patients who do not have home environments conducive for preparation or recovery from medical treatment. With some staff stating that admission to The Cottage also allowed time to complete assessments and appropriate referrals while they recover.

> *He was a really good example of where The Cottage was really important. Because he had no ID, no income, no ACAS paperwork, nothing… luckily he had a medical need, so we were able to keep him in The Cottage for quite some time to organise all of those things, for him to then go into respite.* ***– Service staff***

> *We will organise things like booking them into The Cottage the night before so that they can do their [bowel prep] or their fasting or whatever needs to be done. You know expecting someone who's homeless to get to a pre-admission clinic at nine o'clock that's been arranged through the ED is almost impossible.* ***– Service staff***

> *We've had a couple of clients that come to dialysis as our patients and then they did some respite. They needed to be admitted and so they've actually admitted them into The Cottage for a period of time. Allows them to still continue dialysis and we get to actually do a mental health assessment.* ***– Internal stakeholder***

Prague House

In relation to Prague House, internal stakeholders perceived it as a residential aged care facility for clients with complex needs. A number of internal services did not, however, perceive Prague House as a service dealing with clients experiencing primary homelessness, and were not fully aware that people who have been homeless constitute the majority of residents.

Few services mentioned Prague House unprompted, with interviewees stating that often their clients didn't fit admission criteria so contact was limited or non-existent. However, of those who had liaised with Prague House, there was an overall positive perception of the service, with good working relationships with staff conveyed.

> *Then Prague House came into the picture and the way they held that bed for her and the way they responded to her was just amazing... it's such a pleasure to work with these people* ***– External stakeholder***

It was mentioned in a few interviews that there can be lengthy waiting times in obtaining a place at Prague House and that this can be a limitation in referral to the service. However, services did discuss that Prague House was a good option for clients with mental health problems and other vulnerable clients, and that they would refer when vacancies were available.

> *you'll often get them saying oh, they're waiting on a bed at Prague House but a bed doesn't come up and by the time maybe it does it's too late, it's not appropriate.* ***– Internal stakeholder***

Some external services were not aware of Prague House. However, when they heard from the facilitator the purpose of the service, the external services were keen to use it.

> *…we don't have an awful lot to do with Prague House - program. I wouldn't know what it was.* ***– External stakeholder***

> *We have no access to that [to Prague House] or anything so far but we'd like it to.* ***– External stakeholder***

CHOPS

Overall, fewer internal stakeholders were aware of, or understood the role of CHOPS. However, this is potentially related to limited client overlap due to the complex and specific needs of the CHOPS client group, as well as its offsite physical location. Among those who had an awareness of CHOPS and its role, it was perceived as a flexible client centred mental health service for individuals with long standing mental health issues who are also experiencing homelessness, particularly rough sleepers or in those marginalised housing. Internal stakeholders noted that contact and hence awareness of CHOPS is limited due to different spheres of operation, with CHOPS operating primarily in the community setting, and not often at the hospital interface. As such, CHOPS is also seen as able to have community based follow up with clients that would otherwise not occur.

> *Even for the patients who sometimes get discharged or you don't see for a while … you still know there's a team of people out there who are looking and keeping connected with people who are living on the street.* ***– Internal stakeholder***

A number of internal and external services indicated a lack of eligibility requirements for CHOPS, or were uncertain of the referral pathway.

5.2.3 SHARED CLIENTS AND CROSS-REFERRAL BETWEEN THE FOUR SERVICES AND SVHM MORE WIDELY

The extent to which there are shared clients and cross-referrals between the four services and other areas of SVHM was not able to be assessed quantitatively, with the exception of ED presentations, unplanned admissions, and outpatient services for the 2015 cohort of homeless clients (see Chapter 4). As discussed further in Chapter 6.3, this is partly limited by the way in which patient data is collected, entered and able to be retrieved from different record systems. For example, a hospital staff member would need to manually look through various records and notes on PAS and Medical Records Online (MRO) to gauge whether a client has previously been seen by the Department of Addiction Medicine (DOAM) or been assisted by a social worker on a ward in a previous admission. It was this type of manual process that was undertaken for the 10 case studies referred to within this report, and the time involved in doing this confirmed the challenges facing SVHM staff who may wish to quickly appraise the past service contact history of an individual client, as well as the complexity of obtaining a composite picture of shared clients and referrals of homeless client between various SVHM services.

In the absence of empirical data on shared clients and referral pathways, the following discussion draws on interview data and case study vignettes relating to wider SVHM awareness of and cross-referral with the four services.

Overall collaboration between internal stakeholders and the four services was positive, although the strength and nature of working relationships between services did differ according to personal relationships with managers, proximity of services and perceived responsibilities. Up to date awareness of the mandate and eligibility criteria of services also appeared to influence the extent to which referral or collaboration occurred.

Cross-referrals with ALERT

The proactive role of ALERT in supporting the care of people experiencing homelessness was acknowledged in interviews with internal SVHM services, with many suggesting that it is usually ALERT that initiates collaboration between internal stakeholders, in line with the individual requirements of the client.

> *Normally they will call us. It's not going back the other way. So they will say hey, we need to just check in with you. Have you been involved with this person that presented X number of times?* ***– Internal stakeholder***

> *One of the things that we don't talk about a great deal but is behind a lot of the clinical work is the establishing of the relationships with our partner agencies in the community and it's a very - it's a beneficial relationship two ways in that for our clients it means that we're able to go to that service and say, we would like your A grade service please, to help this person, they're really in need. They will provide that because we have made a commitment to provide them with some education.* ***– Service staff***

One internal stakeholder also discussed how ongoing education and knowledge sharing allows for increased understanding of the services they offer and how these could be mutually beneficial.

> *We've done education with ALERT, about aged care and the services. Because often, from their point of view, there's often a lot of changes. So keeping them up to date so that they're aware of what we can offer.* ***– Internal stakeholder***

Cross-referrals with The Cottage

Internal stakeholders demonstrated a good understanding of the main purpose and eligibility criteria of The Cottage, and many reported frequently communicating with The Cottage staff about any vacancies and clients who could be referred. Internal stakeholders also noted that The Cottage can be quite flexible in accommodating their clients while suitable care is sourced.

> *…you know, sometimes The Cottage will look after some of those patients and hold them there if they sort of meet their criteria whilst we can look for alternative options. Then The Cottage is quite good at working with patients honouring that at least until we can get the community nurse or nurse in the home.* ***– Internal stakeholder***

Patient flow between internal stakeholders and The Cottage appears to be facilitated either directly by contacting The Cottage or the HITH Cottage Liaison Nurse. Many examples of contacting The Cottage about the availability of a bed or client eligibility were given.

> *So it might be that we see a patient in the emergency department and we help facilitate a detox bed at Depaul House, and then the patient may then go to The Cottage and we might see them again at The Cottage around possibly anti-craving medication for example, medication type management.* ***– Internal stakeholder***

Generally internal stakeholders described themselves as having good working relationships with The Cottage and its staff, and indicated that they were happy to provide consultations and assistance to The Cottage where needed.

> *I mean The Cottage may ring us and say, look can I bring a medication chart over for you to have a look at? We need to prescribe something to stop them with their nausea or whatever, or they might need their pain management reviewed or they may bring the patient with them when waiting for a review and we're happy to do that.* ***– Internal stakeholder***

> *We actually work really well, particularly with ALERT and The Cottage. I think a lot of it has been just working with one another and a number of talks that they've given us and we've given them, as well.* ***– Internal stakeholder***

Cross-referrals with Prague House

Whilst neither Prague House, The Cottage or CHOPS have a remit to only accept referrals from within SVHM, it was noted in a couple of staff interviews that priority can be given to a referral from within the SVHM network. Prague House for example had not had many referrals from the three services in 2015, but indicated that priority is usually given to a SVHM client when there is an open bed over other referring agencies:

We tend to give priority preference for Prague House places to referrals from within St Vincent's – about 70% come from within the St Vincent's family. It is kind of like we look after our own. So we are happy to take other referrals also and to keep the place full, but if I have two people waiting for a bed, and one is from a mental health unit that is part of St Vincent's we will take them in first. ***– Service staff***

Prague House also cited examples of clients who over the years have been referred via ALERT, The Cottage and occasionally CHOPS. Additionally, Prague House has a close working relationship with other SVHM aged care and psychiatric facilities, both in terms of receiving referred clients, and in some instances, referring on clients who now need more intensive aged or acute psychiatric support.

So we have Normanby which is an acute aged unit next door and we have APAC next door, the aged psych assessment and treatment team. So they do referrals to us. So we have the St V's acute which is the mental health unit in town, and then we also have Hawthorn and Clarendon where sometimes the people who are serviced by these end up in St Vincent's Mental Health and then come to us. But there's also part of Clarendon is CHOPS so occasionally we get referrals to CHOPS. ***– Service staff***

Cross-referrals with CHOPS or other areas of Mental Health

Overall, there was some lack of clarity around the confluence of mental health and homelessness, with uncertainty expressed by some as to who within SVHM would refer or confer with another service in relation to a patient/client who is homeless and who has a mental health issue. This particularly emerged in relation to the roles of ALERT and ED Mental Health when it comes to CHOPS.

Well I guess we've got an ED mental health team based in ED, they're the team that see patients presenting with acute mental health issues. So I guess they're the ones that would refer to CHOPS or liaise with CHOPS if you're already involved, rather than ALERT. ***– Service staff***

So if someone presents to ED with acute mental health issues, they're going to be seen by ED mental health and if they're frequent, then they'll refer them to HARP mental health. As we don't have CHOPS present on site, we don't liaise with them, we tend to liaise with those groups here on site at that time. ***– Service staff***

5.3 SHARED CLIENTS AND COLLABORATION WITH EXTERNAL SERVICES

SVHM services working with individuals experiencing homelessness within SVHM interact frequently with a raft of external organisations and stakeholders working with homeless people in Melbourne. Whilst many are from what is often described as the 'homelessness sector', they also include other services with a wider health or social service remit. Figure 38 depicts a geospatial map of the various organisations identified as key stakeholders or collaborative partners by the four SVHM services.

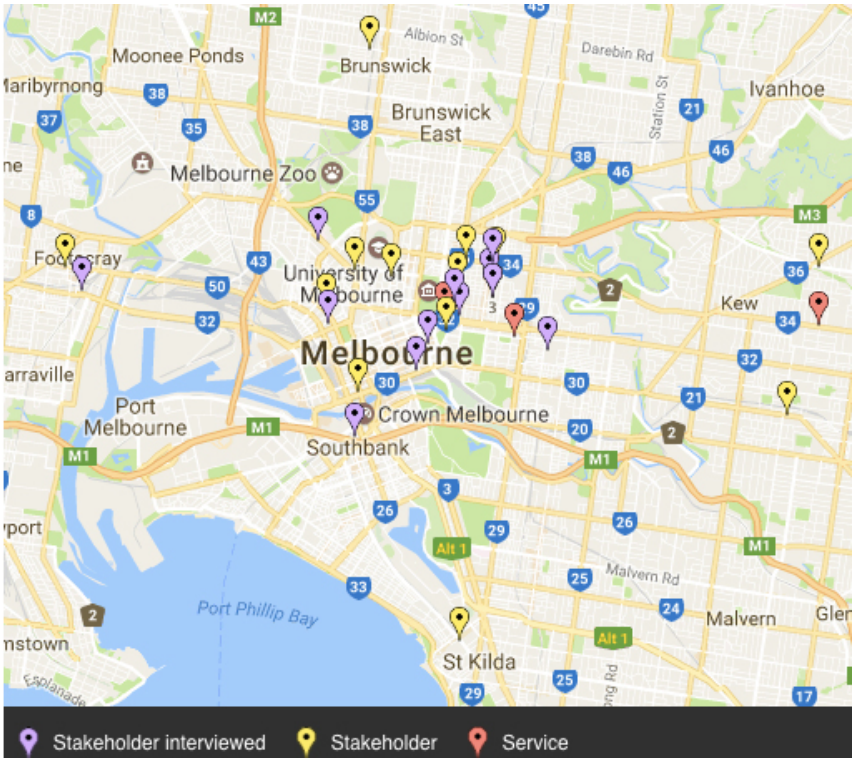

Figure 38: Location of Services Identified by the Four Services as Key Stakeholders

[Note: Purple flags indicate stakeholders that were interviewed; Yellow flags indicate additional stakeholders identified, but not spoken to, and; Red flags indicate the location of the four services]

Links with external services were mentioned in nearly all of the interviews with SVHM staff, taking multiple forms ranging from client referral, information sharing, secondary consultation and case management. Many of these linkages and collaborations are of a more informal nature rather than formally documented per se, or are enacted on an as needs basis; for example of there is a client known to SVHM and other external services, a joint case management meeting might be arranged, or those external agencies invited to a clinical review meeting.

Several collaborations of a more formalised nature were also identified, including a service agreement with Ozanam House that ensures that SVHM via ALERT has access to two crisis housing beds that it can refer clients to; a Memorandum of Understanding between SVHM and Launch, regarding access to female crisis housing at their Hanover Southbank facility; and a collaborative agreement (akin to a service agreement) between SVHM and NRCH.

Agreements between SVHM and some other organisations working with people experiencing homelessness were also mentioned anecdotally by a couple of external organisations but it was difficult to ascertain the degree to which these are formal, informal or historical.

> *St Vincent's actually got agreements with the local housing, [police] and other housing providers to actually get a response to [a client].* ***– External stakeholder***

As the core business of SVHM 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 SVHM services.

We have a lot of affiliation with housing services. So Launch Housing. St Mary's House of Welcome drop in centre. St Mark's. St. Peter's. We do work with Salvation Army, like even out of area. Different crisis accommodations. So we offer a lot of secondary consult to them. We actually do meetings with a lot of them as well. So we'll have like two weekly meetings with a lot of them, so that they can know who we are. Even just to ask advice. They can ring up and ask for a referral. ***– Service staff***

The determinants of collaboration and referral that emerged in interviews with external services mirrored many of the themes identified in internal interviews. Again personal relationships between staff of respective services was a prominent factor, along with the degree of awareness of other service roles, target clientele and ways of working.

Yeah. Also trust. I'm accepting a referral from the phone, from a social worker from the Royal Melbourne, they've got a homeless client in ED, he's not withdrawing, he's not psychotic, you know, if I know that social worker I'll be much more willing - but if I don't know them I might ask them for more documentation … ***– Service staff***

Really historically I would say that sometimes it's based on personal relationships. At the moment, we're working with [xx] and St V's quite a lot around another client and so then he'll need something from us and I will need something from him to benefit the client. There's a bit of something going on like that. ***– External stakeholder***

Yeah. With older people with complex needs, I have a good relationship with Sambell Lodge, which is a Brotherhood of St Laurence aged care facility, in Clifton Hill. I've got a good relationship with the manager. So he tends to be quite flexible in his approach, whereas other services can't. They've also got vacancies. ***– Service staff***

Whether or not staff from external services had physically been to or met with the four services emerged as a determinant of collaboration.

CHOPS yeah but mostly ALERT. They've actually come out here - which I think CHOPS had a representative here too and ED. We had a meeting a meeting with them which was really terrific. They were really willing to collaborate with us. ***– External stakeholder***

Referrals of clients and/or instigation of information sharing seems to go both ways (i.e. SVHM services initiating with an external organisation or vice versa).

Probably more [referrals] from them to us. I mean often they're involved with ALERT. They might go into detox, then The Cottage and then we'll get involved. They might have had an ED presentation, to detox or we'll be holding them in other - they've been in ED and they're in a holding pattern, doing a range of things to get them into detox, then to The Cottage and then yeah. ***– External stakeholder***

We get … constant referrals, I can't tell you how many from ALERT… they also ring us up about just to ask questions. ***– External stakeholder***

When I get a referral from here, - or the other people we take referrals from are community stakeholders like RDNS Homeless Persons, Mental Health, Clarendon, Hawthorn Mental Health, mental health teams, Community Aged Care Service Packages ***– Service staff***

Collaborations between the four services and external organisations are discussed further in Chapter 6 (Section 6.1.3) as this emerged as a key facilitator and critical success factor in the SVHM working in this space. A number of challenges and areas for strengthening the role in improving health and wellbeing of people experiencing homelessness in Melbourne are discussed further in Chapter 6 (Section 6.2).

6 SUCCESSES, BARRIERS AND CHALLENGES IN OPTIMISING CLIENT, AND SVHM OUTCOMES

Two of the overarching objectives set forth for this evaluation (objectives 5 and 6) relate to the identification of what is currently working well, in addition to barriers, gaps and ways of strengthening targeted and outcome-focused service delivery at the client, service and organisational levels. Inextricably linked to this, is objective 7, which pertains to the identification of opportunities for improved collaboration and integration between the four services to support sustainability.

This chapter provides a synthesis of findings relevant to these objectives and the overarching aims of the evaluation. Facilitators and critical success factors enabling the four services and SVHM to make a difference in the lives of people experiencing homelessness were grouped into themes and domains from the analysis of empirical, case study and interview data (Section 6.1). An identification of the themes is followed by a discussion of the challenges and barriers faced (Sections 6.2 and 6.3), with an emphasis on framing these in a way that strengthens client and service outcomes whilst remaining congruent with the core ethos and culture of SVHM in its care for the holistic wellbeing of homeless people.

6.1 FACILITATORS AND CRITICAL SUCCESS FACTORS

Effective service provision indicators include improved clinical, psychosocial and social condition, smooth referral and transition between services, and improved housing outcomes. Clear and unique facilitators to positive outcomes for clients who received care by SVHM were identified in the interviews. Key factors identified by clients, staff at the four services, and internal and external services that facilitated positive outcomes for clients experiencing homelessness have been grouped into 12 themes across four domains, depicted below in Figure 39.

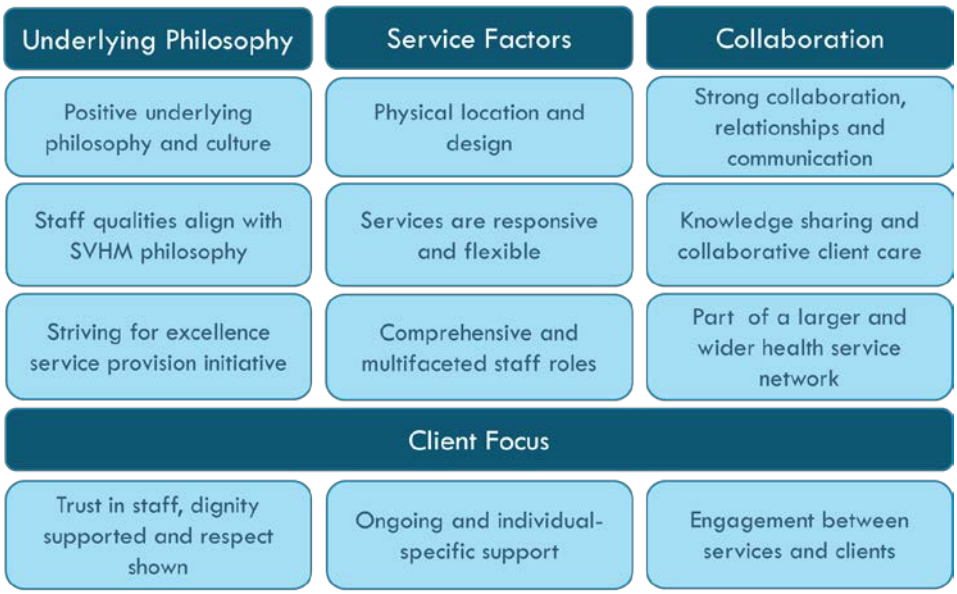

Figure 39: Facilitators and Critical Success Factors to Positive Client Outcomes

6.1.1 SVHM HAS A POSITIVE UNDERLYING PHILOSOPHY AND CULTURE

A key recurrent theme that arose throughout a multitude of staff and service interviews was the shared underlying philosophy of the four services. Though the four services evaluated are not formally integrated, the notion that these services exemplify and embody the overarching SVHM mission to help the poor and vulnerable was apparent. This was something that was repeated over and over again, and demonstrates that while there may be no formal documentation, these services are all working to achieve the same outcome.

A similar sense of purpose and resonance with the overarching mission and values of SVHM was evident in interviews with staff from all of the services.

> *The purpose of The Cottage as I see it, is to be able to provide equitable health care for people that are homeless that may ordinarily struggle navigating their way through the health system. I think our purpose is to help people receive the health care that they deserve, and embrace the challenges to achieve this.* ***– The Cottage***

> *It fits really well because they're people that are really vulnerable and disenfranchised, so itinerant, often you've got some very difficult circumstances going on in their lives. So I think it fits really nicely with the St Vincent's ethos that we are providing a health service to the most vulnerable people in the area.* ***– CHOPS***

> *ALERT is there as a multidisciplinary team approach in seeing clients that are at risk or present to emergency department with various complex issues, often around homelessness but also substance abuse, chronic disease, assault and violence. We provide a service that is one, around advocacy for the client group, and two, around linking in with appropriate supports and discharge planning from the emergency department for that client group. So yeah, it is around working with that client group around their goals, from an acute setting into a community setting.* ***– ALERT***

> *The main purpose would be to cater to the needs of people who struggle to find accommodation elsewhere. Our ethos is about the acceptance of people, the acceptance by staff. You have to be non-judgmental to be on staff and to stay here.* ***– Prague House***

There were also a number of more overt mentions of service efforts to reflect and practice the mission of SVHM.

> *Ethically I think as part of St Vincent's Australia's overall mission it's about allowing really vulnerable, complex homeless people - giving them the health care that they deserve like anybody else. When The Cottage was first proposed, one of its champions wrote that health care is not medicine alone; holistic health care being absolutely vital, particularly for this group of people.* ***– Service staff***

> *We're not going to discharge someone at three or four in the morning, in the middle of winter if we know that they're homeless.* ***– Internal stakeholder***

Prague House, whilst physically not co-located on site with other SVHM services, reflected the fact that services need not be physically co-located to feel part of the wider mission and ethos. This can be attributed largely to the fact that it sees its purpose as closely and actively aligned with the SVHM mission.

At Prague House, one of the things that we do here and I don't think it's done anywhere else in St Vincent's, is when we have staff meetings we actually read the mission and values and then challenge ourselves about what we have done and we can feel good about where we have done well. It is even the little things, like at Christmas time we all put in for the Hamper Man, or recently the Art Gallery had a Sorry Day reflection and we sent along a busload of residents as an activity. Then we've done the Scrubs Run and we try to be involved in the St Vincent's family as much as we can. ***– Service staff***

We used to have our own mission statement, but since we became part of St Vincent's we actually have just taken on board their mission statement. ***– Service staff***

Overall, SVHM has achieved a reputation as a dedicated service provider for marginalised individuals with complex needs, for example those experiencing homelessness, alcohol and substance dependency, mental health problems, or a combination of these conditions. Many external services expressed how some of their most complex clients have had contact with SVHM:

We've certainly had quite a few clients, high-risk clients, going through St V's. ***– External stakeholder***

Internal and external services perceived the *organisational culture* as one of the most important drivers for the quality of service offered to marginalised clients, with a number of interviewees stating that they believed ambulances and the police would bring complex clients to SVHM, despite these clients not being in the catchment area. However, an ambulance officer insisted that this is not the case and that the ED to which they took a patient is based on "*purely geography*" and that Ambulance Victoria requires them to take patients to the closest ED. It was noted however that ambulance staff can deviate from this if a patient was is known to a specific hospital. This apparent contradiction regarding ambulance preference to bring homeless people to St Vincent's is somewhat difficult to explain and may reflect historical practice, memorable exceptions, or anecdotal validation from others of the paramount SVHM ethos of care for those most in need.

Interviews with external organisations confirmed that SVHM has a strong reputation for its commitment to helping the disadvantaged, its ability to help and assist complex and marginalised clients, and significantly, for the way people are treated at SVHM with dignity and respect. As two interviewees articulated:

I would say St Vincent's deserves its reputation as the most welcoming of diversity, and that includes people with high levels of complexity and homelessness of any of the inner-city tertiary health services. Mostly they're not too bad but St Vincent's I think has retained that focus because it has styled ALERT in the particular way that it is and The Cottage in a particular way it is. The sense of inclusiveness is fairly culturally spread across the [staff]. ***– External stakeholders***

St Vincent's whole attitude and level of cooperation and level of really understanding any patient let alone this marginalised is just streets ahead. ***– External stakeholder***

Box 13 provides one out of a number of examples given of an external service intentionally seeking out SVHM to assist a client with complex needs. This was in part because SVHM is

renowned for its quality-driven and dignified care for people experiencing homelessness, and also because of its reputation for being able to problem solve and achieve outcomes for clients where other services haven't necessarily been able to assist.

Box 13: An External service's Perception of SVHM as the Preferred Hospital for Homeless Clients

A RDNS HPP nurse provided outreach services to a formerly homeless female client who had moved into an Office of Housing property. The client has long standing alcohol issues and was experiencing domestic violence. At one point the client was seriously injured and the Royal District Nursing Service (RDNS) applied for an urgent guardianship order so that she could be treated. Due to the client's complicated health and housing status the RDNS nurse felt that it was important she was admitted to SVHM, despite the client's public housing falling into the catchment for Alfred Hospital. "*I really, really pushed that she be taken to St V's. Because I thought if she goes anywhere else we're not going to get anywhere. I'd only been on the team a few months but I knew that was the place to go.*" ALERT staff kept RDNS up to date on the client's progress whilst she was hospitalised and arranged for her to be discharged to The Cottage for a further period of rehabilitation.

One external service interviewee noted that SVHM is where they would want to go.

> *It's no doubt where I would want to go. It's where I do go if I need to go to the emergency department, but it's also where I'd recommend people who are highly challenged and disadvantaged to go.* ***– External stakeholder***

Clients also noted the unique SVHM positive culture and philosophy. For some of them it was a turning point in their trust of services.

> *They tolerate the individual - in the person. So they don't just pigeon-hole you…They do respect you and they'll advise you* ***– Client***

> *… I wasn't stranded anymore. You know what I mean, eh? They found me and I could talk to people about my issues openly and not be judged.* ***– Client***

6.1.2 BEING PART OF A LARGER AND WIDER HEALTH SERVICE NETWORK WITHIN SVHM

The benefits of the wider range of services within the SVHM network were acknowledged in interviews with both the four services and other SVHM services, and highlighted the advantages of being part of a larger multi-function organisation. For example the following quotes from staff at Prague House point to advantages that may not exist for a stand-alone aged care or homelessness facility:

> *I feel that we work really well because we've got those connections [to the wider SVHM hospital].* ***– Service staff***

> *Over the time that I've been here there's been relationships built up with the inpatient areas and with APATT so that when I say … this isn't right, something's going on, they take notice; whereas if I had to go to another health service and say oh I've got somebody who's elevating they wouldn't respond in the same way.* ***– Service staff***

Also just when people are in hospital knowing who to contact in the hospital…so I'd know if one of my residents went in and there were going to be problems, I'd ring the person in psych liaison I know and say you look out for this person. ***– Service staff***

The sense of SVHM being like a family came through many staff interviews, with interviewees indicating a willingness for services to go the extra mile to help each other out, particularly around clients who are homeless or have other complex needs.

When it's appropriate they certainly put their hand up to help us out with - yeah I think the patient we referred was only probably 57 or something. Our ACAS was willing to sign off the paperwork despite the fact that he wasn't over 65. Prague was willing to prioritise him for a bed. So I think we do all work together as a cohesive group. I think everybody is trying to do the best that they can ***– Service staff***

Mutual trust and understanding between services within the SVHM network was also described as having benefits for services and for client care.

…our job is so much easier because we have that understanding and trust with ED. We don't have to sell it that this person needs an admission because of this issue because of the fact that their home situation means they can't manage their mental care. The doctor will say fine, no worries. Let's advocate. ***– Service staff***

6.1.3 STRONG COLLABORATION, RELATIONSHIPS AND COMMUNICATION BETWEEN SERVICES

Collaboration between the four services, internal and external services was generally reported favourably. This was often framed in the context of strong personal relationships between specific staff members who have worked together over a number of years. Interviewees would often use the name of an individual rather than a service or position role when talking about positive experiences of collaboration. For example, they would state that if they needed advice about a client they would ring [xyz] or state that they know they can contact [xyz] if they want to get a client into their service. Whilst this clearly works well for staff that have been in either service for some time, it appears that the informal nature of many relationships between internal and external services, or between internal services within SVHM, could disadvantage newer staff who are yet to build up a personal network of contacts. Additionally, there is a risk that clients receive different degrees of connection to other relevant services depending on the networks of the individual staff member working with them.

This entire sector is based on good relationships with each other. Every service that I have good success in referring into because I know some of them. ***– External stakeholder***

Developing my relationship with CHOPS more so I can liaise with them closer has made a really significant difference. ***– External stakeholder***

We've been here a long time…and we know The Cottage staff quite well and we know the St Vincent At Home. Yeah, I think a lot of it has got to do with knowing the staff. ***– Internal stakeholder***

Box 14 provides an example of collaboration between services to achieve the best possible outcomes for the client.

Box 14: Collaboration to Secure Detox, Alcohol Rehabilitation and Transitional Housing for Client

A female client stayed at Launch Housing after completing a 15-day detox at Depaul House in September 2016. After relapse in mid-October 2016, she secured another place at Depaul House, during this period an ALERT worker was able to secure a three to six month residential rehab place in Wagga Wagga where she was discharged to at the end of October.

Regular liaison between Launch Housing, Depaul House and ALERT ensured that all involved parties are kept informed of the client's current circumstances, with notes being shared between the three to improve client outcomes and ensure a smooth transition to her residential rehabilitation placement.

Internal stakeholders interviewed often referred to an embedded culture of collaboration and exceptional client service at SVHM with regard to the health and care for people experiencing homelessness. Internal stakeholders discussed that working side-by-side with other services is especially important when trying to address complex needs of homeless clients.

> *The interface between The Cottage and ALERT and those programs is excellent, it's truly excellent, and I think that's come about through the links with the student unit and quality projects and complex patients. There's a link in the vulnerable older person space with ALERT, we often have consultations with them.* ***– Internal stakeholder***

> *[We] try and keep each other abreast of where things are at so that, yeah, we're all on the same wavelength.* ***– Internal stakeholder***

> *… so with ALERT, we kind of verified that there was a good discharge plan. We also talked a lot to Addiction Medicine because there were some concerns about her ability to stay in The Cottage and remain drug and alcohol free…* ***– Service staff***

Similarly, some services articulated highly valuing opportunities to share information about clients or around service practices and procedures, with the sense that this inevitably leads to more effective efforts than if each service operated in isolation.

> *I think the relationships, in terms of the outcomes, is that we meet a few times a year with St V's discharge nurse… We meet with CHOPS every second week… It's that sense they've got ease of access, is that we in a sense respect each other's level of expertise and their knowledge around resources. So I feel really quite comfortable - I know from my perspective I really enjoy that.* ***– External stakeholder***

A number of clients also made comments referring to the collaborative nature of care between staff members at SVHM.

> *They all work with me. It's pretty much a team effort between them* ***– Client***

Indeed, it was apparent in client interviews that clients often don't compartmentalise which service they are receiving medical care or support from, with St Vincent's or St V's often used as a catchall term, even when referring to their interactions with one of the four services in

particular. As noted by one service manager, it is actually preferable and a compliment when clients and patients view SVHM as a single entity as this is congruent with the importance of providing client-centred and more integrated models of care.

Some internal staff perceived SVHM to have a better integrated structure and culture in terms of service provision for people experiencing homelessness compared to other hospitals. One staff member noted frustrations expressed by staff at another hospital where it has not been possible to establish the inter-departmental clinical review meetings that have been found to be effective at St Vincent's:

> *I think there are enormous benefits from having those discussions, because often when you bring in people from different areas of involvement with a particular patient, they often have a very different perspective on the patient.* ***– Internal stakeholder***

> *Which doesn't mean that it's perfect because it [SVHM] discharges people into homelessness pretty much as much as anybody else into substandard accommodation because it's driven by its targets, but I think it's fair to say…I think they're better than the other hospitals.* ***– External stakeholder***

Box 15 provides an example of the collaboration between one of the four services and an external agency, highlighting the positive ripple effect of The Cottage treating an RDNS client with respect and dignity, leading to increased attendance at appointments and improvements of their overall health status.

Box 15: Collaboration between RDNS and The Cottage

The management of a 75-year-old female client who requires three monthly urethra dilation to prevent UTIs provides an example of collaboration between RDNS and The Cottage. The RDNS client has a number of mental and physical health issues including autism, borderline personality disorder and has experienced prejudice as she is transgender. These issues were resulting in the client frequently presenting at ED's, often with challenging behaviours. RDNS and The Cottage have arranged for client to stay at The Cottage the night before and the night after her procedures, ensuring she is hydrated, fed and has the opportunity to rest. RDNS transports the client from her public housing to The Cottage and either RDNS or The Cottage staff escorts her to her procedure the next morning.

Having The Cottage as a safe place where the client knows she will be treated with dignity and respect has significantly improved her health status. "*It's an amazing arrangement, it's very well done. The client really appreciates it and there is no sabotaging of appointments and not turning up and not being able to find, because at the beginning, a couple of years ago, that's what was happening. Then it was ED presentations and it was all over the place.*" The collaboration with The Cottage and increased compliance with appointments has enabled RDNS to manage the client's UTIs in a community setting.

Clients also discussed the importance of staff from the four services linking them in with other services (including within and external to SVHM), and in particular assisting them to navigate the system and advocate on their behalf.

> *I don't know who was planning it or working it, but I think they were concerned about what was going to happen with me, because I can look after myself, but when it gets tough, I'll do anything. Not that bad though. The good thing is that being in The Cottage*

kind of gave me the sense of there are good people. People are people… That's what I really appreciate about it. **– *Client***

6.1.4 STAFF ROLES ARE COMPREHENSIVE AND MULTIFACETED AND NOT CONFINED TO NARROW NOTIONS OF HEALTH

There was clear indication from interviews that the multifaceted roles played by staff working in the four services were integral to positive client outcomes. Whilst each staff member is generally assigned a primary role, the tasks they completed varied enormously depending on client needs, with roles including providing administrative and legal support, advocacy, needs assessment, clinical care, client education, sourcing accommodation, assisting with living (for example moving into a new house or grocery shopping), psychosocial support, planning including additional services, and social support. The imperative to address both the medical and psychosocial needs of clients was frequently reiterated.

> *I guess you'd say it's medical and it's psychosocial coming together, which probably would equal a whole humanistic care really.* **– *Service staff***

> *Without the two parts I don't think we'd have the whole that makes us successful. That's why I think our model is really unique, but also vital in terms of caring for these people. So really it's the nursing or psychosocial, but it's actually both.* – ***Service staff***

> *Like the psychosocial issues, I mean nurses and doctors are very good at identifying that there is an issue, but in terms of problem solving and I guess addressing it they certainly do rely on us. I think having us there to be able to have those conversations with, meet the patient, start the engagement process, get their consent and the level of motivation to actually want our assistance to follow up, put a face to a name. I know I personally prefer to follow up the patients that I've seen in the ED. You know if I can see them in the ED, come up with a plan and then do a home visit for them later that week. I think that's sort of a perfect flow really.* **– *Service staff***

Such commitment and multifaceted supported was noted by clients to be life changing.

> *CHOPS sped the transition and my allocation of mental health where I chose not to do drugs. From my time in drugs…I had one year in a plumbing apprenticeship, had a phone plan, had a flat - good flat, and spent a year running around the block keeping everything - it was pretty good.* **– *Client***

> *They were the big change, and they still are to this day. They're just so good at what they do. They're inspirational for me. They help me know when - as far as coming out of my cupboard about my mental issues. I can discuss about them to anybody and not feel judgemental, not feel pressured, not - I don't look at people and think to myself they think I'm crazy.* **– *Client***

The commitment of the staff at SVHM to do all they can to assist clients was noted not only by clients themselves, but also external service providers.

They don't give up. So that's been my experience with that particular facility, and again it's the propensity of that health system to keep people within the system not try and dump them elsewhere. ***– External stakeholder***

They'll actually work to make you behave a bit better and make it more tolerable for the other people that are being inconvenienced by your performance. They're amazing. ***– External stakeholder***

6.1.5 STAFF QUALITIES ALIGN WITH SVHM PHILOSOPHY

One of the strong themes emerging from the interviews were the positive attributes displayed by SVHM including knowledge, skills and experience as well as compassion, commitment and passion. Staff within each service, other SVHM services and external services noted that these attributes contributed to positive outcomes for client.

Knowledge, Skills and Experience

Staff at SVHM were noted by service providers and clients to be knowledgeable about services, with an overall understanding of how to navigate the system, skills in introducing purpose and self-esteem into client's lives, flexible service delivery, and able to provide education including life skills to clients in a comprehensive manner.

I mean it probably happens at other places but it's just the acceptance of people, the acceptance of the staff. You have to be non-judgmental to be on staff and to stay here. We have some staff who come and they just don't cope with being here. Also if you do come and you like it you stay a long time. So we've got a lot of staff here who are 10 years or more which is pretty unique I think in itself. It can be a really difficult place to work so you have to have that commitment to the people who are in need. ***– Service staff***

They've also got the smarts they know what they're doing with this marginalised population. ***– External stakeholder***

[Staff member], who I really connect with, is only too understanding. He'll listen to everything I've got to say, give a valued opinion on how to approach it. If it sounds weird to him, he'll start laughing and then I'll let him know what I'm thinking. Then we both start laughing ***– Client***

They gave me enough teaching that I guess was lacking in the care without mum or dad and my family and friends… ***– Client***

Compassion, Commitment and Passion

Interviews identified that service staff engaged, generated trust, listened, were non-judgemental and respectful, developed positive relationships with clients, were relaxed yet responsive, showed compassion, and were dedicated and passionate about helping clients.

One of the ladies said to me - and she's 58 - she said to me the other day in all my life I've never had people who've said good morning, how are you. It's like well you expect

that. You and I expect those things so it's just being able to give people what we take for granted. – ***Service staff***

St Vincent's is good because I've got clientele who'll tell you that they like to go St Vincent's. They get treated with respect and dignity. ***– External stakeholder***

But the level of care, thoughtfulness, flexibility that Prague has is just amazing. ***– External stakeholder***

…and that's what's really good about St Vincent's - the way they treat people; they speak to people. ***– External stakeholder***

Staff are perceived to be highly dedicated and to go above and beyond what is expected of them in their role – examples of this were cited for all four services. This is seen to lead to many positive outcomes for homeless clients. For example, when discussing patient flow, one interviewee described how their service will follow the patient as they go from the ward or ED to Depaul House to The Cottage, and finally enlist them in an outpatient capacity. This is to ensure continuity of care and prevent the client from being transferred from service to service, thus needing to recite their history multiple times. Another interviewee also mentioned that employees voluntarily contribute to a fund to support and help the most disadvantaged clients. This is a strong indication of the unique, caring SVHM culture.

SVHM staff are focused on meeting the health needs of clients in a way that maintains their dignity. Clients are made to feel comfortable using these services and are appreciative of their assistance.

I kept in touch with The Cottage and she made sure she helped me set up my appointments for physio and this, that and the other and it was good. ***– Client***

They're all nice people here and it's been a great big help for me, and they're trying to help me get back on my feet ***– Client***

6.1.6 PHYSICAL LOCATION AND DESIGN

The proximity of ALERT to ED, and The Cottage to the hospital was identified as assisting in the care of clients.

I think our presence in ED is so beneficial to the work we do outside of ED. ***– Service staff***

Also quick medical access, like if patients need to go back to ED for instance. So close proximity to a hospital. Close proximity to crisis housing services. ***– Service staff***

The multiple advantages of ALERT being physically located within ED were frequently referred to in both internal and external interviews. Some examples were even given of similar types of services in other countries or hospitals that are not as effective as they are separate from ED.

The close location of The Cottage is also a unique advantage of SVHM, and homelessness services in Western Australia (for example) have lamented that there is not a similarly co-located service at its inner city hospital.

SVHM differs uniquely from many conventional tertiary hospitals in its commitment and capacity to accommodate underlying issues in its model of care, for example the physical environments of both The Cottage and Prague House enable people to have social contact and support (from staff and others), whilst creating a space for clients to retreat to.

> *Within a hospital setting it would be different to the relationships you form within The Cottage.* ***– Service staff***
>
> *This is more homely. It's - you feel like you're part of a family or you're at home or something.* ***– Client***
>
> *It's nothing like a hospital facility. I wouldn't describe it as anything like a hospital facility. It's totally different.* ***– Client***
>
> *No, you can do gardening if you want to. You can help with the garden…We play pool here, a competition* ***– Client***

One Prague House resident even noted how much he enjoyed staying there and the friends he has made since living there:

> *Just that it's a great place to stay. You meet some good friends.* ***– Client***

6.1.7 CAPACITY TO PROVIDE ONGOING AND INDIVIDUAL-SPECIFIC SUPPORT

There are no quick fixes to ending homelessness nor to the complex health needs of many people who are experiencing homelessness, as these have often accumulated and been inadequately addressed over many years. Despite the pressures on hospitals, and the health and social service sectors to meet efficiency and service targets, it is widely acknowledged that SVHM is pragmatic and accepting of the long term nature of their relationship with clients. Interviewees were not surprised when told that over a third (35%) of the 100 most frequent attenders to ED in 2016 were homeless; with a gracious acceptance of the recurring nature of presentations among patients with homelessness and health co-morbidities.

Of the four services, CHOPS is the only one with a formal and funded capacity to work with community clients in a non-time limited way, whilst Prague House is a long term residential setting, and is one of the limited facilities in Melbourne that provides residential accommodation to older homeless individuals. More typically, accommodation for people experiencing homelessness is for a finite period with the aim to transition residents to independent community living. Prague House by contrast recognises that its residents are most often not likely to be able to live independently in the community, and instead offers the security of tenure.

By contrast, The Cottage and ALERT are not able to provide nor are they funded for long term client care (The Cottage is generally a short term stay, and ALERT clients typically remain

assigned a case worker for between three to 12 months). However, staff recognise the need for individualised care and are flexible in their service delivery.

> *I mean the reason why the stay is lengthened is ordinarily because how we're still being unable to get them linked with community housing services or - that would the top of the list.* ***– Service staff***

> *Generally it used to be short term…But I think as The Cottage has changed, it's become more individualised… we've just had someone on four weeks of IV antibiotics. We knew when we accepted her that she needed that plan.* ***– Service staff***

> *They'll often come back, yeah. We encourage that. We don't want patients to - you do everything you can to link patients in with community agencies, and - but at the same time you recognise that after one or two weeks in The Cottage, it's a very vulnerable time that first couple of weeks. So we'll often say when you come into outpatients, come and have a cuppa, or come and say hello. You could be really busy, but you kind of - it's really good when they do. You can bet your bottom dollar if they're not doing so well they won't come in. If they're coming in it usually means they're engaged.* ***– Service staff***

The scope for CHOPS to provide ongoing and more intense individualised support enables them to begin to tackle the underlying social determinants of health and homelessness that may often exacerbate their mental health.

> *Well the engagement is key and it's very broad, it's not just straight medical psychiatric care, it can be assisting people with forensic stuff that might be going on in their lives, helping people get ID, getting their passport, helping them reconnect with family, connecting them with the primary healthcare networks within the catchment so their general health is attended to.* ***– Service staff***

> *Its intensity allows us to develop strong relationship with that client and move them through a journey at pace that's comfortable for them, using a lot of partner organisations.* ***– Service staff***

Whilst duration and intensity of client care is increasingly dictated in Australian health and social services by funding constraints and service targets, CHOPS is in quite a unique position in its capacity to build up and maintain long term and ongoing relationships with clients. This is particularly valuable for people such as those seen by CHOPS, as long term mental health support is often needed, and distrust of the 'system' is common.

> *I've had one client for like four years. That seems like a long time, but he has done wonderfully. Beautifully. He's got housing now and engaging with a GP, but it takes that time.* ***– Service staff***

> *It's ongoing - and I don't mind. I need them in my life, I really do. They're literally the anchor. They keep me rock steady in a rough sea. You know what I mean, eh? They really are instrumental in just about everything I do.* ***– Client***

This individualised approach was evident in the description of support that clients reported they received from SVHM services.

> *People in CHOPS, they give me the medication. They give me the needle every fortnight. … which, basically, tones the voices down so they're not at you and so…on the ball all the time, in your head and so full on.* ***– Client***

One aspect that Prague House is very thoughtful about is the challenge that mental health presents to clients, and they take each individual's circumstances into consideration into the way they operate their service.

> *Because a lot of people who have mental health problems the get-up-and-go is often gone, so they don't want to necessarily be involved, and just getting out of bed for the day is hard enough. So it's about providing the support where they need it and letting them help where they want to.* ***– Service staff***

All of the clients interviewed discussed the role of the service staff in providing them with social support and connection and how they helped addressed other (non-health) needs. Overall, clients valued straightforward communication and felt that they developed real relationships with the staff which enabled them to discuss sensitive issues without fear of being judged or discriminated against.

> *They explain things - like, that's the best thing about it. They tell you what's going to happen before it happens.* ***– Client***

> *From ALERT, yeah, she's been really helpful. She's been really helpful indeed. Consistent and sincere. Genuinely sincere. she's been genuinely interested in me being able to progress further down the line… Whereas other departments, they sort of fob you off… or they give you a different worker each time you phone them. So you don't build up that rapport with them. So you're having to repeat yourself.* ***– Client***

> *She took away the worry. Well, she took the edge off the worry and also at the same, she was completely honest. She sets you straight instead of hearing second hand talk. I knew when she was telling me something, that this is what's transpiring.* ***– Client***

6.1.8 SERVICES ARE RESPONSIVE AND FLEXIBLE

External services were particularly praising of the responsiveness of some of the four services. With the particular nature of clients, the response often needs to be immediate; and this was appreciated by external services that are supported by SVHM.

> *Because you could say could you tell someone from the ALERT team I'm here, I'm from HPP, straightaway things would happen.* ***– External stakeholder***

> *No, I think they're flexible within their team. Sometimes things come up quite quickly though. For instance I had a client whose brother died, and he was struggling a bit already, wasn't it, with addiction issues. ALERT wasn't involved, but [ALERT worker] could quickly recruit him.* ***– Service staff***

It is continuum of care for the hospital, somebody is actually needing medical treatment and they've received it and they're actually practicing that continuum of care but making sure they get into some sort of accommodation and then they continue to work with them… ***– External stakeholder***

Many interviewees also noted the flexible nature of the services SVHM provides and how they think outside of the box in order to find the best treatment options for their clients.

When people…from ALERT…who we've worked with as well and the way they just go we have to think outside the box, we have to do things differently, we have to get together… it's such a pleasure to work with these people ***– External stakeholder***

When people read over someone's history, they don't say no straight away. I think there needs to be flexibility with drug use and with alcohol use – ***Service staff***

I think other services potentially don't have that same flexibility but I think if you say you're from St Vincent's services are normally already receptive. Our ED is amazing. Our doctors are amazing. Very accommodating people. ***– Service staff***

ALERT workers spoke about the need to take an individualised approach to providing care for clients by engaging with them and finding out what they're actually capable of achieving.

It's not just putting someone into crisis and then hoping that things pan out for them - that they fit one square box and that's it. But it's really engaging with them and seeing what they're capable of. ***– Service staff***

Willingness among staff in the four services to think laterally for the benefit of client outcomes was also commended, and was seen particularly critical for clientele whose needs are not confined to health alone. The following quotes illustrate this sentiment in relation to Prague House.

Part of the reason is because their ability to step outside the box sometimes, with the really complex patients that we have, that we're trying to house and have housed - and we've had some sensational results that's worked with Prague House. ***– Service staff***

Prague House staff really stepped outside the box in what they were prepared to do to help them feel less restrained and less restricted, and just tailoring care to their care needs. Letting them go out on daily outings, et cetera. Tolerating [certain lifestyle choices]. They were just too models where they were both - both men were really well supported into that transition and it wouldn't have worked otherwise. ***– Service staff***

Prague have done some fabulous work in joint with some of our clients. They've worked in such a flexible way that's been really, really helpful for the clients with them being able to discharge because they're in a safe, supported environment where all their needs are being met. They're not on the street anymore so they don't need the CHOPS team involvement. They've done some incredible work. ***– Service staff***

6.1.9 ENGAGEMENT BETWEEN SERVICES AND CLIENTS

The ability of the SVHM staff to engage the clients with the service was noted to be instrumental in the care provision. Many interviewees noted that it was this engagement that ensured that clients stayed with the service and achieved positive outcomes.

> *I think engagement is probably the main thing. It's really all about that. I think our client group, if they don't like someone or a service they just won't engage* ***– Service staff***

> *It's a big part of our staff working with clients is the engagement. That's really all it is at the start, because we're talking about our client group, they've been through every service once or twice. They're either burnt by that service or banned or whatever reason. It's trying to re-establish that.* ***– Service staff***

> *…but it's the way they go about it and the way they engage.* ***– External stakeholder***

It is important to note that often clients are linked in with multiple services beyond SVHM and that this can be overwhelming for the client. Thus assisting clients to navigate and understand the roles of multiple services, and how they complement each other is important.

> *I've got a psychologist and I've got an alcohol counsellor here and I've got a PHaMS worker* ***– Client***

> *I was seeing quite a few people. I've seen [social worker] from Addiction Medicine, but he's retired now. So I was seeing him once a week. I was seeing a psychologist also once a week and I was seeing drug and alcohol worker from Quin House as well, whilst I was staying there. So I felt as if I was over-exposing myself to - and I thought it was more of a - risked, creating more of a hindrance than a benefit. So I sort of cut a few people out of the system. But I've gone back to seeing [Doctor] through the psychologists.* ***– Client***

> *One of the reasons that might be is that with people with these complex needs, they are going to need to be referred to a number of various agencies for what they're needs. The fewer that you can keep involved, that you have involved are, then the more meaningful that connection will become. If there are ten agencies, it really becomes very confusing for the individual. Many times within St Vincent's, somebody at ALERT or we're going through some of the other programs, they're largely able to replicate a little, almost what the other do.* ***– Service staff***

For clients with complex needs, linkages between multiple internal services is often required, as well as links to external services who can complement the medical care provided through SVHM.

> *… linking them with primary services so that they're not coming into the ED as often, linking them with homeless services such as Launch Housing … Getting them on the wait list for Flagstaff… directing people to where they can get material aid, food vouchers. Getting the RDNS HPP to make any referrals to them for people who can get follow up.* ***– Service staff***

The vignette below shared by NRCH from its Inner Melbourne Post-Acute Care (PAC) program illustrates the client and service outcome benefits of collaborations between SVHM and an external service.

Box 16: Vignette Illustrating Collaboration between NRCH and SVHM Services

An Aboriginal male in his early fifties had 25 presentations to SVHM ED in a six-month period; usually with injuries sustained whilst intoxicated. He was referred to PAC and the ALERT Aboriginal care coordinator whilst in inpatient detox to support his discharge to residential rehab interstate. He has a history of AoD issues and poorly managed diabetes, and attends a local community health centre to see a chronic disease nurse and aboriginal health worker. A community health service was able to fund the client's flight & travel costs, accommodation and meals and provided an Aboriginal worker to escort him to the interstate rehab facility. PAC funded the workers travel, accommodation and associated costs there and back.

This required a lot of work for both agencies to pull the $$ together within the various funding requirements. Follow up after several months demonstrated that the client was successfully engaging and participating in the rehab program and feedback from his chronic disease nurse stated:

> *"Getting [the client] to his rehab at Orana Haven has truly been evidence of a collaborative process by an amazingly dedicated team. The Aboriginal care coordinator's support work has been amazing and we all (including client) thank you for your program support as well. Without sounding dramatic, getting him to this rehab may prove lifesaving."*

Whilst serious ground has been made in the Australian mental health system in recent years, a continued concern is the over-emphasis on acute care in mental health and not enough of a focus on early-intervention and community based support[72]. In recognition of this, and the obvious needs of patients, St Vincent's Melbourne has sought to overcome some of the non-acute barriers to mental health.

One example of this has been the incorporation of housing workers within the acute mental health inpatient unit (see Box 17); The Housing Mental Health Pathways Program (HMHPP) assists people who are currently homeless or at risk of homelessness while they are inpatients in the acute mental health inpatient unit. SVHM was the first hospital in the country to add this role to its clinical mental health service team[72].

The HMHPP program aims to assist the hospital with discharge planning, with a focus on finding accommodation for a client before discharge or for those who have housing, a focus on assistance with keeping their tenancy through supporting their independent living skills. The overall aim of the program is to reduce unnecessary psychiatric hospital admissions and improve the quality of life of the client (Box 17).

Box 17: The Housing Mental Health Pathways Program at SVHM

HMHPP at SVHM

At SVHM, the HMHPP worker is employed through Launch Housing and works closely with the social workers on the ward. HMHPP is a voluntary program that eligible clients can opt into, but due to hospital discharge requirements around discharging clients to homelessness, often clients will need to enter the program as it's the only way they are able to be discharged: "*So often despite the fact that we call it a voluntary program, it's the only means for people who want to get out of the hospital to get discharged. So their hands are pretty tied.*"

The HMHPP worker works closely with social work, the treating team, other nurses/doctors/psychologists involved in the treatment and the Discharge Coordinator and collaborates closely with Area Mental Health services to achieve the best outcomes for the client: "*inevitably with my role if there's people going off the ward and they're going into St V's catchment for follow-up, they're homeless because they're coming to me and so they're going to go to CHOPS.*"

How clients get involved in the HMHPP program at SVHM

The admitting/treating team first contacts social work to say that they have a client that needs social work assistance including housing assistance. Social work then involves the HMHPP worker, who then goes to the ward and obtains consent: "*So I go out to the ward and ask if they will get a consent for a referral to be placed to me. Then I will come out and meet with them and do an assessment and talk them through what options there are and we go from there.*"

6.1.10 CLIENTS' TRUST IN STAFF

Services identified the importance of trust in paving the way for staff to be able to assist clients. Trust in services was also suggested as a performance indicator that could be applied to the four services.

> *I think it's access to the right services. I think it - ideally, it's around somehow assessing the client's level of trust and engagement with the service is a good way I think of measuring quality, because it doesn't matter how good the service is. If the client doesn't trust that service, it's not going to go well.* ***– Service staff***

> *To engage with a client group that's generally quite tricky to provide mental health services to. So, the homeless outreach team has the capacity to take time to actually engage or get to know and build some trust with some people that generally are not very trusting of mental health services for a variety of reasons.* ***– Service staff***

Speaking to CHOPS clients, it was evident how much trust they placed in not only their worker, but also the whole CHOPS team.

> *V is my social worker on regular if she's available; but also W, X, Y, Z. They all work with me. It's pretty much a team effort between them.* ***– Client***

Others perceived service workers and case managers as friends. As discussed with a couple of staff members, this can potentially have a downside in terms of client-staff boundaries and risk of dependence, but nonetheless are powerful relational testimonies from clients.

> *I consider [worker] in particular to be a friend; not just a comrade, but a true friend. He really is unique, a really nice bloke. I'm getting all teary. Just a really good bloke.* **– *Client***

> *Being in a structure where it is, it's good to know that you can just pop in and say hello, because they can always tell whether you're travelling well or not by doing that. It's, like, I'm often walking the street, but if I'm going past the place, I'll pop in, show my face. That way they know I'm alive.* **– *Client***

Establishing trusting relationships with clients enables workers to provide support to assist in stabilising all aspects of a client's life (Box 18). For example, CHOPS worked with a client that had a long history of schizophrenia and distrust of services over a long period of time to establish a trusting relationship, and as a result he has been able to move into independent accommodation.

Box 18: Case Study on Importance of Building Trust with Clients to Address Needs

A male in his mid-thirties has a long history of schizophrenia and has had an ongoing relationship with CHOPS since 2010. He was admitted at Inner South Area Mental Health in 2005-2009, but discharged due to avoiding follow-ups and itinerancy.

Over the first few years of contact with CHOPS, he remained ambivalent about accepting accommodation and continued to sleep rough. However, gradual engagement with CHOPS has enabled him to build a trusting relationship with the service. Prior to contact with CHOPS, he had a history of fear and distrust around other support services. In 2013, he accepted independent accommodation and has slowly developed a more stable lifestyle, which has played an active part in his treatment and psychological recovery.

His SVHM consultant psychologist has since provided letters of support and encouraged him to donate blood, to be considered for special accommodation requirements (low-medium density housing), and provided assistance with community treatment orders.

6.1.11 STRIVING FOR EXCELLENCE IN SERVICE PROVISION

SHVM staff were often noted to be continuously seeking ways to improve service delivery for clients experiencing homelessness and or other complex needs through championing various initiatives. Some of these initiatives are broad and not homeless-specific, but nonetheless were mentioned as examples that have improved care and outcomes for individuals. For example, cultural safety training for social workers and nurses was developed and implemented to improve the patients' journeys. Another interviewee discussed how their service has integrated the consumer driven care model to guide a comprehensive assessment of client needs and care arrangements based on goals identified by the client. Another practice beneficial to the delivery of improved client care was a rotating staff roster that promoted sharing of knowledge and best practices, the development of personal relationships, and allowed staff to maintain versatile skill sets.

We've got a confusing roster where people rotate three different roles. I don't have lots of distinct teams. But that's intentional, because it's healthier for people…They don't get de-skilled. ***– Internal stakeholder***

The merits of inducting and orienting new staff to the roles of other services was commended, although it appears that this currently occurs on a more ad hoc basis. Staff from one of the services described how new staff are introduced to other internal and external services during their orientation to facilitate better understanding of how everyone works together.

6.1.12 MECHANISMS FOR KNOWLEDGE SHARING AND COLLABORATIVE CLIENT CARE

An initiative frequently mentioned in the interviews with internal stakeholders is a weekly multidisciplinary meeting/clinical review to discuss complex and challenging clients. This forum allows staff from different departments and services at SVHM, as well as external stakeholders, to present and discuss challenging management plans in a more relaxed environment. This initiative was widely acknowledged as promoting collaboration and understanding of different perspectives.

"One of the benefits we have is the weekly multidisciplinary meeting where we discuss complex patients. It's run by ALERT and called Clinical Review and it has been running for a number of years. Each week, they discuss - and it varies from week to week, who presents so it might be one of the nursing staff from ED. It might be one of the doctors. It may be one of the Care Coordinators, maybe Mental Health, maybe Addiction Medicine. You get all the key players involved. We often have outside guests. We may invite ambulance, because we have a lot of people who are brought in repeatedly by ambulance. These are usually frequent attenders, who often have challenging management plans and we bring out of that. We develop management plans and we sometimes invite people from other health services, because we know that we have a lot of shared patients…we may invite other people from other community services, who have direct involvement with those patients. Or their case managers." ***– Internal stakeholder***

There is also some evidence that a number of services have been proactively approaching others in order to improve the current procedures and processes in order to boost collaboration, and ultimately, provide better quality of care for the clients.

Sometimes when there's a really high needs client in the past we have had case conferences with ALERT and the police - people that have presented to ED 90 times in six months and stuff ***– External stakeholder***

One service suggested that services do not currently meet enough and that if they even had a quarterly meeting to discuss the services that they offer, it could improve collaboration/the ability to work together.

I don't want to suggest another meeting, but even just if they were quarterly or something, the St Vinnie's services like Ozanam, Living Room, all these people that work together. ***– External stakeholder***

This following quote encapsulates how internal and external stakeholders worked well together and how the case conference impacted the service provided and outcomes achieved for a client.

"We've worked with ALERT, yeah, over the years and we've actually - when we had the woman that we put in Prague House, what we did was - there was a whole heap - she'd been street homeless for years, then she had accommodation and then she used to disappear… What we needed to do is we needed to get together. So what I did is that I rang ALERT and I said can you organise a case conference and they go yeah, sure and booked it in and every man and his dog was there. So this is where - I have this real - I love St V's. These people within this bureaucracy just go let's make it happen and everybody was there and a plan was made and it was followed through.

In the end we ended up taking responsibility for this woman even though she was still unwell but it kind of went, you know what, they're not going to put her on an order, we'll try and get her some treatment, she's probably treatment resistant. So the decision was almost made, well let's stop pushing her around and see what happens. Then Prague House came into the picture and the way they held that bed for her and the way they responded to her was just amazing…

It was in a sense all the interested hospital people who really didn't want this person to go back, kind of showed up, and there were about 20 people in that room. So it's quite interesting that individuals can take up a lot of resources, we know that. So in a sense if we've got something very clever and thoughtful around that, that sometimes you just need to be all in the same room and going Jesus what needs to be done, what's going to work, what hasn't worked and what needs to be different." ***– External stakeholder***

Another positive example of a mechanism to facilitate collaboration was a forum organised by the Social Work Department, where invited internal and external services discussed their roles in relation to hypothetical homeless client scenarios.

It was very useful on very, very many levels in that all the players were together and so it was not only the forum, it was a chance to chit chat and come together as professionals and have a look and understand each other's services a little bit more. I think that often you have your experts in your department but that opened it up for the whole department for us to understand what has to happen in that space. ***– Internal stakeholder***

Whilst the above forum appeared to be a one off, it is the type of forum that could be replicated periodically, and expanded to include a wider range of both internal and external stakeholders.

Other ideas proffered in interviews included staff from services attending the meetings of other services to raise awareness of what they do and discuss how they can support each other, and rotation of staff.

> *I think just that interaction and it may mean that we need to go and attend their meetings to say this is what we're offering to do. It's not a thing that GPs do just to go and sell a service but it's something that we're prepared to do here and vice versa, having people from ALERT come and attend our...* ***– External stakeholder***

> *I think staff rotating is also another really good way for people - opportunities for staff to rotate and work in another area and actually bring that knowledge and expertise that have got [unclear] as well.* ***– Internal stakeholder***

6.2 CURRENT CHALLENGES

Challenges to optimum service provision are multifaceted and ultimately reflect the complex requirements, vulnerability and characteristics of the clientele. From interviews, six main challenges of effective service delivery were identified; 1) client complexity; 2) sourcing appropriate housing; 3) overall higher level system issues; 4) service criteria; 5) resourcing; and 6) not duplicating services.

6.2.1 CLIENT COMPLEXITY

Client complexity was a challenge identified by all four services, and internal and external services. Such complexity includes clients' a) longer term needs; b) treatment compliance; c) perceived friendships with staff; d) needing multifaceted services; e) requiring intensive support; and f) itinerant behaviour. Client complexity is discussed in more depth in Section 3.3.

> *…quite often have a number of things happening. So they're homeless, they may have mental health issues which contributes, they may be disenfranchised from their family, they may have drug and alcohol issues.* ***– External stakeholder***

> *Because the issue is most of our clients do have complex and chronic health conditions, so you're not really going to cure them, they're always going to have them. But I guess it's around how they manage that, and even just linking them into a GP which is another part of a big role for our nurses. If someone doesn't have a GP that would be the first thing we'd be doing* ***– External stakeholder***

Many clients seen by the four services have a long history of homelessness, often clustering with other social issues. From interviews with staff and clients, and from reviewing a sample of client hospital records, it is clear that a large proportion of clients have had numerous services try to assist them in the past, often without long term success. Homelessness and past experiences with services can unfortunately become an additional challenge for SVHM and other services seeking to assist such clients.

> *One of the great difficulties and challenges of working with homeless people is their difficulty to fit in to the services that are currently available.* ***– Service staff***

It's more the needs of the person. That's where it gets complicated. So if you have someone with, I guess, a brain injury or pretty chaotic substance use, or other kind of psychosocial needs, typically homelessness has been an issue for them for a long time. They've perhaps exhausted services. Particular providers can't accommodate them. So that's probably where I see the gap - more around those complex people. ***– Service staff***

We find it difficult for services to take on our clients really ***– Service staff***

SVHM plays an integral part in improving the lives of people experiencing homelessness in Melbourne. Speaking to clients that have had contact with these services, it is true testament to the role they play in the many facets lives. Overall, they are able to engage with a client group that is generally quite tricky to provide care to, establish trust, build relationships and hopefully improve the health whilst reducing the need to present to ED. Below is an example of one ALERT client who has multiple health needs and how they work with him to encourage attendance at appointments.

Box 19: Vignette Relating to the Complex Needs of ALERT Clients

A male patient in his 80s has complex medical conditions including nerve palsy and significant alcohol issues, and frequently presents at SVHM and Royal Melbourne ED. He isn't eligible for Centrelink or crisis accommodation and despite significant mobility impairment has declined to stay at The Cottage in order to continue working at his casual cleaning job. ALERT have supported him when he presents at ED, assisting with facilitating medical tests when needed and follow him up in a community setting to offer additional support and encourage attendance at outpatient appointments.

It was noted during an interview with a staff member from ALERT that one of their challenges is in providing the same access to healthcare regardless if they are homeless or not. The challenge particularly lies in the fact that often the health need of the client is not the most important thing going on in their chaotic lifestyle and ALERTs role is in trying to make it easier for them to prioritise their health.

…coming to an outpatient appointment is not important when you haven't had breakfast and you haven't had a shower for three days. But trying to make that a little bit easier for them, whether it's giving them a cab charge to get here, whether it's giving them a food voucher. ***– Service staff***

I think everybody wants access to healthcare but sometimes it's not their priority and our job is to try and make that a bit easier…You know they're not trying to change what people want, it's about giving people access and the opportunity if that's what they want. ***– Service staff***

They'll go I've been cut off Centrelink and I've got no ID so I can't get my money anyway and I'd really like you to help me with my medical malpractice law suit. My electricity is disconnected and I heard you can get a grant. I need my methadone. ***– External Stakeholder***

The chaotic nature of some clients lives can sometimes manifest in difficult behaviours that can test how services work collectively to address these. However, staff accept that this cannot

always be prevented and learn valuable lessons for the next time they are in a similar situation.

> *… there are times where we probably don't collaborate as well as we probably should with some clients demonstrating difficult behaviours…It's always on a case by case basis and 99% or 95% of the time it's fine. But it's those times when things don't go well and the client's self-discharged from The Cottage for this reason and that. What is it that ALERT and The Cottage could do better to prevent that from happening next time - because they do happen.* ***– Service staff***

6.2.2 ASSISTING CLIENTS TO SOURCE APPROPRIATE HOUSING

Housing is a fundamental social determinant of health, and there is increasing recognition in the literature that absence of housing needs to be addressed if people are to journey out of homelessness and be able to care better for their health. Numerous issues with assisting clients with housing needs were identified with all services. These included bed availability, clients past behaviour at services, not fitting into a service, differing needs of clients (e.g. the need to be away from drugs), lack of appropriate housing, poor housing quality, the need for longer term or step down housing, and housing services that are inflexible or poorly staffed.

> *There is an In-Reach housing service or there used to be in acute care unit, but we struggle with supply.* ***– External stakeholder***

> *There's talk about a plan and things like that. But sometimes its logistics, they just don't - they've got a certain amount of beds or certain amount of spaces* ***– Service staff***

> *Yeah. I think a lot of my clients just want apartments alone or want to be by themselves really. Like they've lived on the streets for a long time…* ***– Service staff***

> *We could then put them up in a hotel for a couple of nights, transfer them to Oz when the bed became available but it's lots of phone calls around* ***– Service staff***

> *You know you're talking to people all the time. You may have three services you're trying to refer to. They're on three different wait lists, you're ringing them regularly to see who's got a vacancy, eventually one of them may* ***– Service staff***

> *Sometimes past behaviour of clients impedes their access to housing. Sometimes people in a period of when they've been unwell, may have set a place on fire that they've lived in. When that's in their history, has a history of burning down their residence, how many places are going to give them a try?* ***– Service staff***

Repeatedly, the quality and safety of some housing options was raised by clients as well as SVHM and external stakeholders. The inappropriateness of many boarding houses was an important issue and difficulty encountered by staff and clients. Whilst these problems are beyond the remit of SVHM to address, they are critical issues impacting on SVHM clients and are a shared frustration by staff and external services.

> *Well, what we would call suitable and safe. There's an absence of that at the crisis end because the general availability of something in that moment is a [substandard] motel*

down the road which is day by day almost because it's got to be funded which means difficulties for people. Chaotic and having to attend some housing appointment, it's really difficult. That's usually coming out of hospital, that's what available to them which is not ideal. Or a boarding house that's noisy, chaotic, dangerous. ***– Service staff***

Yeah, terrible. Sometimes our guys get out of there quick because it's dangerous for them let alone someone having to live there who's vulnerable and psychotic. So the housing at the crisis end but anywhere along the continuum because it's really hard to house people who have really complex needs and who have perhaps not developed the skills to be able to live independently ***– Service staff***

I was staying in a motel, a real hovel of a place. Top dollar for a real hovel. I can't remember the name of it. It was just so bad that I - err… Private. Syringes everywhere and just everything. ***– Client***

I transferred into a different form of rooming house and stuff…Which is very minimised too - so I would stay on the streets and keep my pension because I didn't like the environment. ***– Client***

6.2.3 HIGHER LEVEL SYSTEMS AND POLICIES THAT CAN STRAIN SERVICES

SVHM does not of course operate in a vacuum, and there are political, economic and other drivers that can impact on service funding, capacity and outcomes for homeless health services. Resource constraints and pressures to meet performance targets within the health system, were most often mentioned.

Well, you could throw buckets of money at it and I still think there'd be problems. But the difficulty with the pressures on the pointy end of the system, particularly in ED is they get fined if people aren't out within a certain number of hours. ***– Service staff***

I mean the difference in the emergency departments is everyone acts like there's no targets but if someone's sitting there not admitted for 24 hours that's a black mark for the emergency department. The amount of defensive paperwork that that generates is a week's work for somebody. I've had to do it; I understand that. ***– External stakeholder***

Well I don't think they can perform against it [targets] because we don't have the housing supply or the exit options for people. So it's not the prisons' fault, it's not the hospitals' fault, but we should be counting and we should be… ***– External stakeholder***

In this era of efficiency targets for discharge and wait times in ED, ALERT and ED staff frequently noted the pressures of this given the complexity and multiplicity of health issues faced by many of the patients who end up becoming clients of the ALERT team.

There is a lot of pressure on hospitals to meet targets such as the four-hour rule in ED. But it doesn't work like that at on the ground; the homeless, those affected by alcohol or drugs, the marginalised, people who may also be mentally ill, they don't fit in at all well with the concept of a time based target. But it is hard to convince the government of this. We are not going to sling people out on the street however, just because we're meant to be trying to meet a target; it's just not the right thing to do. We will try and

accommodate people at least until daylight hours and try and sort something out for them, get them seen by ALERT. Sadly - emergency departments are one of the avenues by which we can stop people from slipping through the net. ***– Service staff***

… you've got someone in the emergency department who's about to blow 24 hours and who's been driving people crazy for 23. You have got a very full acute inpatient service with people saying nobody's well enough to go home. You ask [worker] in equity please review the situation yet again, please. Those things drive behaviour that's not about whether [patient's] neighbour's going to be able to come and make sure she's not suicidal tonight because she hasn't got anybody else in the world. ***– External stakeholder***

6.2.4 SERVICE CRITERIA

Whilst the philosophy of SVHM is very inclusive and there is clearly a reluctance to turn anyone in need away, individual services clearly have some eligibility and exclusion criteria, shaped by a raft of factors including their terms of funding, stated purpose, type or level of staffing, level of medical care needed or sometimes, by client characteristics. This can occasionally cause frustration when one service would like to refer a client to another.

Yeah, I mean you wouldn't refer anyone to The Cottage that had extreme behavioural issues because they have sleepover people overnight and it's just unfair to put that on a small organisation like that if they're going to arc up and cause a disturbance. ***– Internal stakeholder***

DOAM really only do the drug and alcohol, they don't case manage. They don't do housing. They don't do [xyz]. They just do the drug and alcohol. So they will often refer to us. They will say, we've got this guy who's homeless, we're working with - they guys come and do an assessment and get involved which we will do. ***– Service staff***

Increasing understanding of other service roles and the rationale for their criteria could ameliorate this potential for frustration or confusion about client eligibility.

Whilst each service understandably has its own eligibility criteria for potential clients, it was also apparent to the research team that none of the services had a dogmatic position regarding eligibility criteria, and where possible flexibility and needs based discretion are exercised. For example the taking on of younger acquired brain injury (ABI) clients at Prague House is an example of flexibility being enacted to prevent a person becoming homeless. Other examples observed during the evaluation included a Cottage client, where they were permitted to stay longer due to lack of support options at home, and a vulnerable ALERT client with complex needs who felt they had developed a strong bond with their case worker, where a more gradual phased out approach to reduce their need for ongoing support was taken.

As acknowledged by Prague House staff, accommodating younger people with an ABI at what is technically an aged care facility is not ideal, but there is widely recognised lack of accommodation options in Victoria and Australia for suitable accommodation options for people with ABIs. Concern was expressed about this in a number of stakeholder interviews

as people with an ABI are seen as often vulnerable to homelessness when they fall through the support option cracks.

> *I think people with an ABI are a gap in the system. We've got a guy at the moment; he's got a brain injury and he's 38. It seems to be that when there's nowhere else they will refer or they will do the ACAS assessment because they don't want them just having a hospital bed forever, but the Disability Services aren't really meeting the needs of these people as yet.* ***– Service staff***

6.2.5 RESOURCING

Issues with a lack of resources were raised throughout interviews with all service provider groups. The main resource gaps identified were lack of beds, staff, overall funding and wait times.

> *There's a finite number of beds and too many people needing them and they're stacked up in ED and they need to clear them out and our guys, because our clients have got sort of seven-day a week support they might be seen as a lower priority to somebody who doesn't have anyone else involved in any other way. I don't know what the answer is.* ***– Service staff***

> *The reality is if you're in that extreme stressed environment, it's pretty hard to start trying to engage in a therapeutic process and that's when CHOPS comes in and the service they provide is really amazing. But we need three times the number of people for CHOPS realistically because they do that intense work. They find people, they follow them up, they stay with them but they can't do that with everybody.* ***– External stakeholder***

It was also noted that due to the complex needs of many homeless clients, it can be time consuming to ring around contacting various other services or staff to find them the support they might need.

> *Just people are busy. They're busy, we're busy so sometimes it's a bit of backwards and forwards with phone calls but you eventually get through and do it. That's just part of the system.* ***– External stakeholder***

Another factor identified as a barrier to providing optimum care was capacity to take on or accommodate a client at their point of need; there were examples provided of clients who may have benefited from Prague House, CHOPS or The Cottage, but there was not the capacity at that time to take them on.

> *It can come down to the timeliness of a vacancy which is very rare.* ***– Internal stakeholder***

> *There was no space at The Cottage… and Depaul House … So I went over to Flemington Road and I detoxed at Flemington Road* ***– Client***

> *That's really important to have more than one facility. Prague House is great but it's often full* ***– Service staff***

We do sometimes get - from what I've heard, sometimes they [The Cottage] have to reject because it's only six beds housing. It's a shame, yeah, they don't have anything bigger. It would be nice if they did. But at times they might have to say no. ***– Service staff***

6.2.6 NOT DUPLICATING SERVICES

When discussing the sharing of information and collaboration of services, some staff mentioned the importance of not duplicating services. Whilst each service was aware that other SVHM services completed similar tasks (such as sourcing housing), interviewees explained that such tasks could not be centralised. They emphasised that the relationship between the client and service staff was paramount and that to plan and source appropriate services and accommodation the service needed to know the client well.

If a patient is always case managed by CHOPS, we don't tend to get involved because they've already got a case manager, we're duplicating a service. ***– Service staff***

We've often got involved when there's mental health. But then once CHOPS picks them up we would normally withdraw. – ***Service staff***

All these clients have mental health issues and in the mental health system is completely separated and that - you've got a mental health HARP and mental health HARP in ED and you think this is crazy. Why haven't we just expanded the current service? ***– External stakeholder***

6.3 WHAT ARE SOME OF THE BARRIERS ENCOUNTERED AND SERVICE GAPS?

Whilst these challenges exemplify the difficulty in working with complex clients in a fragmented and under-resourced system, some barriers to service provision that could be addressed within SVHM were also identified. These included: 1) lack of clarity about service functions, criteria and referral processes; 2) collaboration, communication and relationships; 3) information sharing and communication between services; and 4) relationships between staff impacting referring and acceptance into services.

6.3.1 CLARITY AND AWARENESS OF SERVICE FUNCTIONS, CRITERIA AND REFERRAL PROCESSES

Overall, there were a few core internal and external services that lacked understanding of the function or referral process of some of the four services.

I don't know if ALERT actually go to Depaul House. Do they go there? ***– Internal stakeholder***

Some interviewees mentioned several different pathways for dealing with complex clients, and although these clients had somewhat similar needs, it was not clear when and why each pathway was chosen.

Well if they [homeless patients with addiction] are on the ward, we would get social work to see them and we would liaise pretty closely with the social worker, and then we might make the recommendation to involve ALERT who then may recruit them. The other pathway that happens is that the patient we are seeing on the ward we might facilitate an admission to The Cottage where they can stay for a week or so. ***– Internal stakeholder***

Gaps in awareness of each other's services and their roles and functions was observed between the four services and extended to other internal and external services. Within SVHM, different services had over time built their own network of external agencies they work with and were clear about the roles they played. At present there is no unified mapping of the services or their roles across the organisation, or overt sharing of information about potential collaboration. For example, in some interviews with mental health services, interviewees commented that although their service has been established for a longer time, it has not been promoted, and are only called upon when there is a serious issue with a specific client.

Only when it becomes problematic for the treating team to discharge the person. ***– Internal stakeholder***

They may have that sort of thing already but it's all about knowing what's around and who's doing what. I've been here for 17 years and I still have no idea about all the different services that are around. They change all the time and it's hard to keep up to date but when you interact one-on-one with people then it all falls into place. ***– External stakeholder***

Some interviewees reported that the whole referral system was unclear, and that sometimes it was hard to determine who the most appropriate contact point is.

It's ALERT. It was HARP, now it's ALERT I think… ***– External stakeholder***

Just I mean obviously I start work earlier and sort of the mental health crew are there. Half of them are really surprised - some of them don't even know that we exist. ***– Service staff***

Yeah because it's horrible when a client comes down and says I was sent from ALERT. They said that you'd get us a house. It's the last thing that we can do. It's not just them that does that. We get it everywhere. Who knows whether a client is spinning it as well, but often maybe something will happen like someone will present to ED over the weekend. They're flagged by ALERT and one of the things that they'll need is ongoing medical care in the community or they need to be put on methadone. We can assist with that. I also like to say so we will work with this client together, because I understand that they have got access to resources that we don't have and vice versa… ***– External stakeholder***

Everyone is defensive because you feel time poor and resource poor and so it's like - just like I feel jack when someone says we will get you a house. They get [upset] when it's they'll fix your mental health. We don't work like that, but once you get - once someone is in they're good. Once someone is accepted they acknowledge that we're not making [stuff] up and going they're crazy. Then the working relationship seems to flourish. ***– External stakeholder***

6.3.2 COLLABORATION, COMMUNICATION AND RELATIONSHIPS

Collaboration was a common theme in both positive aspects and challenges relating to the four services. Scope for greater collaboration and communication both between SVHM services and with external services often mentioned as a potential area that could be strengthened.

Staff in individual meetings and in the combined focus group also acknowledged scope for greater collaboration and shared client pathways between the four services.

> *But I don't know that we [CHOPS] use it [Cottage] all that much as we could or should.* ***– Service staff***

It emerged that each service and sometimes each staff member has developed their own network of external organisations that might be able to assist in meeting client needs. For instance, staff within ALERT and in Social Work could be active in referring clients to services that assist finding appropriate housing, but do not necessarily share information about useful services or helpful contacts in external organisations. This appeared to be the case across the board at SVHM rather than peculiar to relationships with the four services that are the subject of this evaluation. One staff member in another area of SVHM, for example, reported that they sourced their own housing options for clients and would not involve or consult with other services in the hospital. It was felt that they have their own necessary contacts and established relationships with housing organisations.

It also became clear that attempts to secure accommodation and support for Aboriginal clients with complex needs was often frustrating and unsatisfying, evident in the below quote.

> *"It can go back and forth. Sometimes - I'm just thinking of one particular case where there were quite a few - this person had, I guess, stable accommodation although there was an issue with the partner, so the patient didn't feel safe going back home. So that you can talk around a few options; Well, the accommodation is in your name. We can speak to police. There could be an intervention order so that you can go back home and be safe and things like that. If that's not an option then where else do we get in? Can we get you to stay with parents? One parent is regional. One parent is metro but the metro parent needs a lot of support put in place.*
>
> *So this particular patient had a lot of other coordinators involved so coordinating that was a bit tricky because it's kind of like who is doing what? Where is the referral going? Elizabeth Hoffman House had been involved as well and was willing to support. But the tricky part, I guess, was that this person needed to have a nurse visiting every single day and was also a carer. Well, she was a mum with two young kids, so there was a lot going on. It would have been ideal for her to go home because she was quite local to the hospital and we could have got her better support but that wasn't ideal for her. So it was like, right, let's look at other options. So it is a bit of a [fact] finding mission sometimes for some patients in terms of seeing what's out there and where could they go."*

It was noted by one internal staff member that the working relationship between two SVHM services was "*not fabulous*", due to lack of joint assessments and coordination; suggesting that

if they were able to facilitate joint assessments then some of the pressures around targets and the four-hour rule within ED. Fragmentation of services was sometimes perceived to have fostered some overlap or duplication of some functions. One example was given of ALERT and ED mental health conducting sequential, rather than joint assessments of patients in ED, even where it is apparent that mental health and homelessness (or other complex needs) may be evident early in the patient's presentation to ED. However, discussions with both ALERT and ED mental health highlighted that 'joint assessments' are not always possible, nor necessarily the most efficient use of resources if issues can be dealt with by one or the other team.

> *So on the ward we usually get - it actually depends who the person gets allocated under, which psychiatrist. Sometimes we might get a call from the consultant psychiatrist, depending on…Who it is, yeah and their relationship with us. Usually there's one psychiatrist that we'll call and go, can you come and meet this person, I think he or her is good for CHOPS. Some other - there's like the psychiatric registrar has called, can you - they ask us to come to the ward round. We go up to the ward round and then we talk about it there, is this appropriate referral for CHOPS.* ***– Service staff***

Overall complexity of mental health issues and appropriate referral and service criteria was raised by multiple staff. Some services indicated that once a mental health service became involved in the care, their service was no longer needed. It was unclear if this related to policy and processes or a general approach that had developed overtime. Some interviewees noted that increased collaboration and formalised structures were needed between homeless and mental health services.

> *Often it's not necessarily oh I know this is going to be mental health or I know this is going to be ALERT, let's go together. So often it's one person or the other that starts and then they come in and go I've been doing this assessment, they've got nowhere to live, and the conversations starts. Or I've been doing this assessment and I think there's a big mental health issue and I think it's beyond me or I think I need your input and then the conversation starts. So you might go and see them together and then one agrees to write the notes while the other does some follow up or things like that. So it does happen. It's not like it doesn't happen but it's much rarer than it should be.* ***– Internal stakeholder***

> *We're a little bit siloed I think, particularly mental health from the rest of the general hospital. Prague we have a lot to do with. Probably less from the kind of HARP services.* ***– Service staff***

> *I think there could be - yeah I think the mental health stuff is a huge gap - a huge gap. When you've seen - they work in partnership with the prevention recovery centre here up in Carlton or wherever it is. That's with Mental Illness Fellowship and St Vincent's mental health, so they're teamed together in an inpatient unit. You know it can be done, but if you can do it with external partners internally, I just can't see why you'd have mental health HARP sitting up there* ***– External stakeholder***

> *Look, out of all [the] CHOPS teams around Victoria, St V's is pretty good, I guess. But to me mental health is such a mess, but I'm going through a CHOPS situation at the moment and the lack of liaison and finding out what's going on, finding out stuff by*

default. This woman is pretty unwell and I'm their case just about every day and the services ring me and I say can you please ring CHOPS now… ***– External stakeholder***

So there's pressure and then they're out too soon and it just becomes a revolving door. That's the problem with mental health services more broadly but particularly for our guys that are really vulnerable. ***– Service staff***

Mental health is - I think that's an area we could develop. We don't have a broad relationship… ***– Service staff***

Another barrier to improved collaboration and integration that emerged from the analysis of internal stakeholder interviews was a lack of clear clinical pathways or processes in place to guide the decision-making with regard to addressing client needs. Currently each service seems to undergo a complex decision-making process for individual clients with multiple comorbidities. The potential advantage of this client-centred approach is that it aims to provide the best possible solution for each unique client.

Depending on the actual individual client's needs, we kind of tailor make and mix and match. ***– Internal stakeholder***

6.3.3 CLIENT INFORMATION SHARING, DATA COLLECTION AND COMMUNICATION BETWEEN SERVICES

Sharing of client data and management plans differed depending on the service. Some staff reported that processes were in place, but these were not always adhered to, other staff mentioned that there were no formal processes for sharing information. Whilst confidentiality was raised as a possible constraint on sharing information, it was generally acknowledged that this could be done better.

One underlying issue relating to data sharing was different ways of collecting and reporting data across various services within SVHM, with multiple systems for keeping patient records (e.g. patient journey boards, PAS). CHOPS data for example is on the Victorian mental health database, and so other SVHM services cannot readily access background information about clients' mental health needs or care plans. A number of interviewees across different areas of SVHM noted that it would be beneficial if relevant mental health information could be accessed. Depaul House for example noted that patients being admitted for detox often have mental health comorbidities but they may not be aware of these or the care plans in place. Having multiple different systems, different ways of recording data, and sometimes manual data retrieval methods (e.g. having to click on numerous individual patient notes to form a composite sense of their treatment trajectory to date) also hinders access to the most up to date or most relevant information. As information about clients is fragmented, it transpired that some services within SVHM might not be aware that they are dealing with a client that is currently experiencing homelessness.

I know from my experience working as a nurse in St Vincent's especially on the wards and stuff that they do get documentation. So I think our clients tend to lose it or rather they don't care. ***– External stakeholder***

I think the point is everyone is doing really good work and a lot of it's really grassroots because you don't have those IT systems and things like that and sometimes maybe funding. Everyone's doing fantastic work but no one knows what else everybody's doing. It takes the client - relying on the client to feedback and say no I know that person. ***– External stakeholder***

It's random. Look I - and I'm tagged…like a lot of our colleagues are, we're tagged with clients and, depending who it is, I'll get an automatic discharge summary, particularly over the weekend, and I'll get a call. Sometimes oh, I forgot to ring you, and it's on the Wednesday when the client was there on the weekend. It would've been helpful to have known Monday, yeah. Look, everybody's busy, everyone's pressured… ***– External stakeholder***

I do say look, it would've been helpful if you'd just phoned me and let me know she was in because now she's arcing up and I can't work out why, what's going on and what do we have to do. What have you put in place, what meds did you put her on, yada yada. It just is a helpful thing. ***– External stakeholder***

Internal staff suggested that collaboration with CHOPS usually occurred when they were seeing a CHOPS client and required additional information, noting that there was no formal system for sharing information on shared clients. Some internal staff discussed referring clients experiencing complex mental health issues to CHOPS and others explained that they sometimes liaise with CHOPS to manage the client's physical health needs.

We will sometimes…get a referral to us, and when we clarify a bit more, we go - it's more CHOPS and we'll have a discussion with them. ***– Internal stakeholder***

If the patients on other medication like wound care or something, it's not their brief to do it so we will do that care and work with them closely. ***– Internal stakeholder***

One of the communication barriers discussed by internal stakeholders was lack of a single communication channel or system shared by SVHM services and programs. Interviewees mentioned that there are multiple communication channels used (e.g. phone, e-mail) and there was also no explicit, structured communication flow at SVHM. This can be summed up with a poignant quote:

It [collaboration and communication] could be better, but I don't know what better would look like. It's a bit hard. Even the systems that we use to communicate in here are just – they're multiple…I mean, look, we have email. We have pagers and there are patient journey boards and there's another patient PAS system. There's lot of different systems but it doesn't necessarily mean that when you get the information that's the most up to date information. It depends on when you check it. Do you know what I mean? ***– Internal stakeholder***

6.3.4 RELIANCE ON PERSONAL RELATIONSHIPS BETWEEN STAFF

Whilst personal relationships between staff in different services was cited as a facilitator to collaboration, referral and movement of clients between services, the reliance on personal

relationships also has a downside. This was evident in examples relating to staff moving into or out of a service, or internal changes in staff roles; this can leave a void in 'who to contact', and new staff may not be familiar with the working relationship between services that previously existed. If the system operates with an emphasis on personal relationships, there may be a gap in the provision of services as new relationships are developed.

> *What I've been saying is that it would be dependent on the relationships that you build up. So personality styles and relationships have created structures in the system as opposed to the system developing structures to support.* ***– Internal stakeholder***

> *Not that I recall in the 18 months that I've been here. There might have been some conversations but I don't know that anyone has come our way through them. There was a previous [person] who had been around for some time and would see people in The Cottage. Probably because we've lost that relationship and we've got a new person and there might be, until he gets to know the service* ***– Service staff***

> *I don't know really. I mean they can refer into The Cottage, and they will sometimes. It's something that we probably could improve on, that relationship.* ***– Service staff***

6.3.5 UNMET CLIENT NEEDS

One of the largest unmet needs mentioned in the interviews with nearly everyone we spoke to was the lack of appropriate housing options, both transitional and longer-term, and the poor standard of the ones that were available.

> *We had someone discharged back to his place with no food and no furniture and no electricity.* ***– Internal stakeholder***

> *Some of the places I've seen and stayed at are unbelievable.* ***– Client***

> *The Gatwick is a dive. It's like - I think Victoria or Australia's hottest crime spot.* ***– Client***

> *It's just full of prostitution, drugs.* ***– Client***

Some clients felt that boarding houses took advantage of vulnerable people and did not provide suitable facilities at an affordable price, especially when you consider other living costs and medication expenses.

> *The people are paying 1,600 bucks a month, that's what it starts off at. There's 25 residents there. Some people are paying $3,000 a month because they've got an ensuite. They don't clean the showers properly, they don't clean the toilets properly, they don't put toilet paper out, you're getting fed rubbish from Aldi that they've just concocted. There's only one real good meal of the day and that's breakfast because they don't have to do anything except burn toast. There's 25 residents there paying, I did a small bit of maths, and I worked out they were pulling about 45K a month and if they were spending 1,000 bucks a week on food and amenities, I'll go he. I thought it was disgraceful. I actually said to them, I said there's people living on the streets that are getting better food from a soup kitchen than what you're dishing up here and these people, you're*

taking all their money. Because it's 1,600 bucks a month and they've got to pay meds on top of that. ***– Client***

A couple of clients even spoke about how they would prefer to sleep rough and save their money due to the poor conditions, great expense and the prevalence of substance use in boarding houses/rooming houses.

So it was always the rooming house or whatever, and I would prefer just to spend my pension and do it hard ***– Client***

I stayed in a place in Hawthorn one time and it's supposed to be the same kind of set up and it was just so bad. I stayed one night and then I left. ***– Client***

So you pay your rent, it comes out of your Dole and you get fed twice a day and they do a suicide watch twice a day. They check your room twice a day but that's it. Other than that, anything goes. You see blokes walking in there with new flat screen TVs that they've just ripped off from somewhere. It's just - it's just full on. ***– Client***

One stakeholder spoke about the difficulty of housing people in crisis accommodation due to the long waiting lists and unmet demand.

So with crisis accomm - the joke is crisis accommodation, supported crisis accommodation like at Flagstaff or Ozanam, they're both for men, Southbank which is for women and men. We almost need not a front door, we need a back door to kind of go there's a few beds. Because we put people on waiting lists and they don't get in. ***– External stakeholder***

We do access some diversion beds at Oz House. We do have a priority at Hanover, but we also have very limited housing. ***– Service Staff***

Yeah exactly, their needs, the length of admission, the risk around them. Sometimes it might only need to be not too long an admission but there isn't appropriate housing so sometimes the ward will get - they'll get stuck and they'll be stuck in the ward until appropriate housing can be sourced because it's very hard to find appropriate housing. ***– External stakeholder***

In recent years, there appears to be fewer external housing options available, due to changes in housing provisions at the state level and that some of the newer housing options are not accessible for SVHM clients. Interviewees observed that the housing problem is not an isolated SVHM issue, but a state-wide problem.

…the whole state is experiencing a crisis in this area. ***– Internal Stakeholder***

The whole system seems to be in a state of flux, with the need for beds and resources far surpassing the current availability. ***– External stakeholder***

External housing options that are available to SVHM clients may not be adequate given the complex needs of some patients; with several interviewees mentioning concerns about the safety of some boarding or rooming houses due to different types of consumers that access these services.

If it's a boarding house or a rooming house, you know. Some places will have food available. Some places won't have food available. You need to assess whether or not it is the most appropriate place to send people if they are unwell or if it's family members. Is it close enough to the hospital to get in and out of? You know, I sort of question how safe some of these places are because it's real mix bag of consumers that go there and use the service. So I don't know how that would make other people feel ***– Internal Stakeholder***

There were few other unmet needs mentioned, however, some clients mentioned that they felt that they could have benefited from staff following up or checking in with them, after their official contact with the service had ended. In particular, some ALERT clients felt that they would have liked to have been checked on once they obtained their accommodation. Clients also felt that in some cases handover between new case managers could be improved.

But then the worker went on holidays and hasn't returned. ***– Client***

But I haven't seen her since she put me in there…but that's the way it works apparently, but I didn't like that. ***– Client***

7 POTENTIAL IMPACT ON HEALTH CARE UTILISATION COSTS

7.1 INTRODUCTION

As reflected throughout the earlier chapters of this report, caring for the health of people who are homeless speaks to the heart of the SVHM ethos, and there is often a discomfort in discussing the benefits of such services in purely economic terms. Nonetheless, there is growing body of literature demonstrating that targeted interventions for people who are homeless can reduce their use of more acute hospital services and potentially yield associated fiscal benefits.

Such arguments are of policy and pragmatic importance in an era of strained health and social service budgets. Economic analyses can examine whether the cost of service provision can at least, in part, be offset by cost decreases associated with a reduction in use of high-cost health services when health issues are appropriately managed through less frequent and intense use of health services and/or by clients accessing lower cost health services. Economic tools can also be used to help evaluate strategies for reducing inappropriate service demand (such as occurs in EDs across the country), or improving the management of patient flow and its impact on resource allocation.

This chapter examines the costs of providing the four services and the economic value associated with the observed change in use of SVHM health services. It does so by comparing client use of health service in the six months pre- and post- first homelessness service contact in 2015. As will be discussed in Chapter 8, we recommend expansion of this comparably short data window in the future to enable longer term trends to be detected. This is particularly pertinent for empirical assessment of service demand reductions and the associated economic impacts, as a number of other studies show that service use and costs can initially rise while people's health is being stabilised and identified health issues addressed, and may not fall until the second year.

It should be noted upfront that due to data limitations and the interconnected nature of the homelessness services within SVHM (both these four services and other services that can work with people who are homeless) the findings in this chapter cannot be used draw definitive conclusions as to the cost effectiveness of the four services, nor of the extent to which the cost of the services is offset by a change in broader health system costs. Rather, these findings can of only provide an indication of the change in demand on SVHM funding associated with the four services. Going beyond the present evaluation, a future study could seek to extend the pre and post- time frames and consider whole of Victorian health cost impacts of the SVHM support services.

7.2 EVIDENCE TO DATE OF SIMILAR SERVICES IMPACT ON HEALTH SERVICE DEMANDS AND ASSOCIATED COSTS

7.2.1 OVERVIEW OF RESEARCH TO DATE

Current research on the health benefits of homelessness interventions has generally focused on the changes in hospital and health service use (and associated costs) from initiatives driven from outside the health sector such as Housing First initiatives where the site of the intervention is housing. Housing First programs for example have been associated with decreases in presentations to EDs, detoxification centres and other medical services[73]. In a recent systematic review of the literature, Rog et al[74] concluded that there is moderate evidence that permanent supportive housing can reduce homelessness, and decrease emergency department visits and hospitalisation. Other wrap-around support programs for people who are homeless have also reported positive health as well as housing outcomes. For instance in a study undertaken in Chicago by Sadowski et al[14], the provision of housing and case management to homeless adults with chronic mental illnesses results in fewer hospital and emergency department visits when compared to usual care. In a Californian evaluation of a Full-Service Partnerships response to homelessness, reduction in inpatient, emergency service and mental health service use and associated costs declined, such that total cost reductions in health and justice systems offset over 80% of the cost of the partnership initiative[75].

Fewer studies have looked at the impact programs or interventions instigated *within* the health system itself, as is the case at SVHM. Given that most existing evaluations relate to services which provide broader homelessness support, they are not directly comparable to the present evaluation. However, these studies do provide insights into the types of health service use that can fall when people who are homeless are better supported. Generally, such studies have found that, in the 12 months post commencement of support, on average, the use and, therefore, cost of health services decrease. This is particularly true for high-cost health services which rely on stays in hospital. In some cases, however, the overall decrease is small, and use of some services increase for a period as previously unaddressed issues are dealt with or as people move in and out of homelessness[24,45,76]. Where support is ongoing, it is not until the second or third year after support commences that a broader decrease in health service use is observed with an associated more substantial decrease in health system demand and costs[25,76].

Among the international intervention literature, the findings emerging from the UK Pathway initiative are perhaps the most comparable to the SVHM context: the Pathway model involves a hospital based multidisciplinary care coordination team that responds to the needs of homeless patients or those living in insecure housing[5,77,78]. Like ALERT, Pathway teams help connect clients to housing and other support services following discharge. A 2012 evaluation of the Pathway model found that it reduced the length of unscheduled admissions by 30%[78]. The proportion of extended admissions (over 30 days) decreased from 14% to 4%[78]. However, the proportion of patients admitted for between 6 and 10 days rose, potentially indicating that patients were encouraged to complete their treatment, rather than leaving against medical advice[78]. The Pathway model also appears to be contributing to reduced homelessness, with a 2016 randomised controlled trial finding that 4% of patients receiving

the Pathway approach were discharged to homelessness, compared with 15% of those receiving standard care[77].

7.2.2 AUSTRALIAN EVIDENCE TO DATE FROM A HEALTH SERVICE PERSPECTIVE

In Australia, there have been several recent evaluations that have actually looked at interventions driven from within the health sector itself:

The recent evaluation of two homelessness services run by SVHS *(COMET and Tierney House)* reported an initial increase in ED presentations and hospital admissions following contact with both services, followed by a decrease in these numbers over time[38]. The research team concluded that this initial increase followed by a reduction reflected the fact that many COMET and Tierney House clients initially presented with acute health problems, which required follow-up health visits and treatment, but that over time the frequency of health service contacts lessens with improved management of the health presentation. For Tierney House clients, the length of each hospital admission also decreased after contact with the service, but no change in admission duration was observed for COMET clients. In the economic analysis undertaken as part of the SVHS homelessness evaluation, Tierney House generated substantial cost reductions in the first year post-contact (-$3,827 per person), predominantly from the reduction in inpatient days, with a greater predicted decrease per person predicted in the second year (-$11,620). The cost reductions were larger than the cost of the program resulting in a net *benefit* over a two year period. Cost savings for COMET were not evident until the second year, resulting in a modest net *cost* over a two year period[38].

Evaluation of the *Homelessness to Home Healthcare After Hours Service* (HHHAHS) in Brisbane found the benefits from reduced inpatient admissions and ED presentations substantially outweighed the cost of support[79]. The service provides outreach health support and works with Brisbane Street-to-Home to rapidly rehouse homeless people and provide cost-effective healthcare services. Comparing annual hospital use for 2010 (prior to HHHAHS commencing operation) and 2013 (when the service was operating) there was an approximately 24% reduction in ED attendances and 37% reduction in inpatient admissions. The evaluation found that when the service was operating, a greater proportion of the homelessness population reported no contact with ED, and/or no hospital admissions. Among those who did access hospital services during the HHHAHS period of operation, the frequency of ED presentations and hospital admissions was also lower[79].

Also in Brisbane, the *Pathway Hospital Admissions and Discharge Pilot Project evaluation* estimated savings of $2.14 million from reduced hospital admissions across the 88 people with complex needs who were provided with long-term support in 2015. The integrated support program partnered Micah projects (which provided case managed support) with three Brisbane hospitals. The evaluation reported improved housing and healthcare outcomes, reduced hospital admissions, improved engagement with GPs and self-management[80]. In contrast, evaluation of the *Way2Home program*, which similarly combines intensive case managed homelessness support with health outreach support by SVHS, found no clear pattern in clients' use of health services when comparing 12 months pre and post commencement of support[81]. However, this evaluation did not examine how service use changed within the 12 month period.

Some of the strongest evidence around service demand reduction has emerged in relation to homelessness support targeted specifically towards people accessing psychiatric services. Several Australian studies suggests that such targeted interventions can result in a more immediate and significant reduction in demand for health services than when considering the broader homelessness population [45,82]. For example, the Homelessness and Accommodation Support Initiative (HASI) provides clinical care and rehabilitation delivered by specialist mental health services for people with mental health issues, in addition to intensive case managed homelessness support. Comparing the two years pre- and post-joining HASI, a 24% reduction in mental health admissions and 68% reduction in the number of days spent in hospital was observed. This resulted in a cost savings to the NSW government of $27,917/person/year, or around $30m/year across the program, thereby freeing up capacity for other patients. Hospital admissions decreased in the first year after clients joined HASI and stabilised in the second year [82]. Similarly, examination of National Partnership Agreement on Homelessness (NPAH) tenancy support programs in Western Australia found that those specifically targeting people exiting mental health institutions were associated with the largest reduction in use of hospital and other health services, with associated savings to the Western Australian government of $84,135/person/year, compared with $13,273/person/year across all NPAH programs examined [45].

7.3 THE COST OF PROVIDING THE FOUR SERVICES

There were a number of limitations in defining the operating costs for the four services, and the economic analysis that follows needs to be considered in light of this and the caveats outlined in Section 7.7 of this chapter. First, it should be noted that the four services do not operate on a standalone basis and service cost estimates should be interpreted in this context. As discussed in previous sections of the report, approximately 11% of clients access more than one service in a given year. Second, service budgets are from multiple sources with staff preforming a range of functions, making it difficult to disentangle the relevant expenditures. In particular, ALERT is financed through both the Emergency Department Care Coordination (EDCC) and HARP programs and has both homelessness and non-homelessness clients (e.g., other clients with complex needs who are not homeless). The estimated cost of providing ALERT to homeless clients is based on the estimated proportion of EDCC and HARP client contacts (15% and 64%, respectively) which relate to homelessness clients. CHOPS operates as part of Clarendon CMHC and the cost of CHOPS is estimated based on the proportion of FTE associated with CHOPS.

7.3.1 OVERALL OPERATING COSTS AND COST PER CLIENT

Subject to these limitations, the operating expenditure for the four services for the 2015-16 period was is estimated at $4,146,000 (Table 16). The breakdown by service is: ALERT $775,000, The Cottage $700,000, CHOPS $628,000 and Prague House $2,043,000. Appendix 4 contains further information about the composition of this breakdown by service. Program cost and the associated cost per client should be considered in context of the individual programs and cannot be directly compared across programs. Consideration must be taken of the differences in service model (e.g. The Cottage provides short-term residential

care, whereas ALERT focuses more on co-ordination of care), the client group, intensity of support provided and the length of support. Also, some clients also receive support through ALERT whilst in The Cottage.

The cost per client supported in 2015 was estimated based on the 2015-16 operating expenditure and the number of clients supported by each program in 2015[f]. This assumes program cost did not change significantly from 2015 to 2016. The cost per client for ALERT and The Cottage are similar; at $5,574/client for ALERT and $5,036/client for The Cottage. There is however, a considerable difference in the cost/day of care: $505 for The Cottage and $101 for ALERT. This difference reflects the different nature of the two services, where The Cottage typically provides more intensive and residential based support over a much shorter period (average of duration of open and closed periods of care in 2015 was 8.3 days for The Cottage compared with 53.8 days for ALERT). This may also reflect different client criteria. Whilst the ALERT cost is estimated on the basis of the proportion of homeless clients seen by ALERT in 2015 (i.e. is not the total cost of ALERT as it also works with clients with other complex needs), The Cottage cost estimates are based on the total cost for the service, as it was determined that nearly all clients are homeless or at risk of homelessness.

The CHOPS cost per client is slightly higher at $7,747, but it is important to note that the cost/day of care is comparatively low at $44/day of care. Thus the higher cost/client reflects the comparatively long period of care for CHOPS clients, averaging 177.1 days in 2015.

The cost/client for Prague House is $49,939 per person, or $161 per day of care. The cost/client reflects the long-term nature of full time residential care provided (309.5 days per episode of care in 2015).

7.3.2 MAJOR COST COMPONENTS

The major components of the service costings for the four services are wages and salaries, overheads and patient related expenses, as summarised below.

Wages and salaries: As with many health services within SVHM and more widely, wages and salaries represent a major portion of the service costs. For the four homelessness services, these represent 70.1% of total cost of operating the four services; over 75% of the cost of ALERT and The Cottage, 66.7% of Prague House costs and 96.7% for CHOPS. For ALERT and CHOPS the vast majority of these costs relate to clinicians, with a comparatively small amount for management and administration. In addition to staff directly employed by the service, wages and salaries for The Cottage includes the cost of clinical support services provided via other areas within SVHM, such as social work, nursing and physiotherapy services. Wages and salaries associated with St Vincent's Hospital nursing and physiotherapy services account for approximately 40% of total wages and salaries associated with The Cottage. The cost of providing nursing in The Cottage, estimated at $403/bed day, is considerably lower than if it were provided as part of a hospital stay. For example, the cost

[f] Alert 139, The Cottage 139, CHOPS 81, Prague House 41, Total clients 359.

of nursing in the medical ward is $622/bed day, and in the short stay unit the cost of nursing and medical is $764/bed day[g].

Patient related expenses are also a cost that varies across the services. These represent a major cost for Prague House (representing 21.5% of service costs), which is to be expected given the residential care nature of the service (and the more aged population). For ALERT patient-related expenses includes the cost of crisis accommodation and brokerage. As demonstrated by the following quote from ALERT, these are essential if the service is to contribute to the more efficient use of ED resources.

> *when you look at cost effectiveness from a community perspective, from the point of view of an acute hospital where someone stays in the emergency department because they've got nowhere to stay for one night - which is about $800 when you include everything else into that - as opposed to paying the $80 for a night for someone to go to an accommodation in the community and then follow them up from a health point of view. The savings are there.* ***– Service staff***

Overheads: CHOPS and Prague House overheads consist of those incurred directly in operating the service (for example utilities, repairs and maintenance) and account for approximately 3.3% and 11% of program costs, respectively. ALERT and The Cottage operate as part of the HIP directorate and overheads consist of both those incurred directly as part of delivering the service plus the service's allocated share of HIP costs. This includes the service's share of the CCS manager, evaluation and data support, program wide administration, and facility fee (property rental).

[g] Cost per bed day is provided by SVHM and are inclusive of direct and indirect costs (2015-16).

Table 16: Service Expenditure

	Service Expenditure 2015-16					Proportion of Service Expenditure (%)				
	ALERT*	**The Cottage**	**CHOPS**	**Prague House**	**TOTAL**	**ALERT***	**The Cottage**	**CHOPS**	**Prague House**	**TOTAL**
Wages and salary ($000)	601	319	607	1,378	2,905	77.5	45.6	96.7	67.5	70.1
SVHM nursing/physio-staff ($000)		236			236	0	33.7			5.7
Patient related expenses ($000)	41	5		440	486	5.2	0.8		21.5	11.7
SVHM nursing patient related expenses ($000)		21			21		2.9			0.5
Direct overheads ($000)	88	39	21	225	373	11.4	5.6	3.3	11.0	9.0
HIP overheads ($000)	45	80			126	5.9	11.5			3.0
Total program cost ($000)	775	700	628	2,043	4,146	100.0	100.0	100.0	100.0	100.0
Number of clients (2015)	139	139	81	41						
Average cost/client ($)**	5,574	5,036	7,747	49,839						
No. of episodes of care (2015)	142	167	81	41						
Ave days per episode of care Open and closed support periods (2015)	53.8	8.3	177.1	309.5						
Ave cost/day of care ($)**	101	505	44	161						

* Estimated expenditure associated with homelessness clients. See NOTES (Appendix 4) for further detail.

** Program cost is available by financial year. Number of clients and days of care is available by calendar year. Average cost/client and average cost/day of care are therefore estimates and assume no significant change from 2015 to 2016.

7.4 CHANGE IN USE OF SVHM SERVICES

The change in use of SVHM health services reported in Chapter 4 has a number of resource, capacity and economic implications for SVHM. Reduced hospital demand and service use and/or a change from higher to lower cost services by the homeless, frees up available resources to meet the needs of other patients. Consistent with Chapter 4, the economic impact is examined for the 339 clients who received support from one of the four services during 2015 and that episode of support commenced after the 1st of January 2011 (Alert 102, The Cottage 103, clients who accessed Alert and The Cottage 36, CHOPS 77, Prague House 21). The change in health service use is estimated by comparing use in the six months prior to commencing the episode of homelessness support with use in the six months immediately after commencing homelessness support.

As discussed below, the short data window and geographical limitations of the analysis means this evidence cannot be used to draw any conclusions as to the cost effectiveness of the programs or the extent to which the cost of the homelessness programs is offset by a change in broad health system costs. The economic impact also represents a very narrow assessment of service benefits. An increase in health service costs may represent a positive outcome where people engage better with the health system and ongoing issues are addressed. Also, only a narrow range of health services are considered and economic implications for sectors outside SVHM are not included. For example, as highlighted in the quote from an internal stakeholder:

> *There's been a spike of police-brought - clients that are brought by police. There's been a spike, an increase this year, this financial year, and a gradual increase over the last three or four years.* ***– Service staff***

In computing the estimated economic impact of the change in SVHM health service use (shown in Table 17 and discussed below), the following definitions were used:

- The *change in ED presentations and outpatient visits* is defined as incidence which occurred during the six months pre- and six months post commencement of an episode of homelessness support.
- The *incidence of unplanned inpatient days* is defined as the number of unplanned inpatient days which occurred during the six months pre- and six months post commencement of an episode of homelessness support, irrespective of when the person was admitted and discharged.

For example, if a person was an inpatient during the six months prior to commencing an episode of homelessness support, but was admitted prior to that six month point, only the inpatient days which occurred within the six months prior to commencing support would be included. Similarly, where a person is admitted during the six months post commencement of support and the discharge date is after the six months post-support cut-off, only the inpatient days within the six month period post commencement of support would be included. Where an inpatient stay extends over both the six month pre- and six months post- support period, the total number of inpatient days would be allocated appropriately to these two periods.

7.4.1 AVERAGE INCIDENCE AND COST OF SVHM SERVICES USED, SIX MONTHS PRE/POST SUPPORT EPISODE COMMENCEMENT

Table 17 shows the average incidence and cost of SVHM services used by homelessness service clients in the six months pre- and post- commencement of an episode of support, and the change in cost of health services used. The average cost of SVHM services prior to commencing support is $14,602/person/six months. This varies across the homelessness services, with Prague House clients incurring the highest cost of $31,071/person/six months, followed by CHOPS clients at $23,166/person/six months, clients who accessed both ALERT and The Cottage at $14,176/person/six months and clients of The Cottage at $10,068/person/six months. By contrast, ALERT clients incur SVHM costs of $9,486/person/six months.

Except for ALERT clients, these average health costs are higher than those reported in the literature, which typically ranges from around $9,000/person/year to $20,000/person /year[24,25,36]. However, this evidence typically relates to a broad homeless population, with a mix of health issues and many homeless are found to have either very small or low health costs[24]. Higher health costs are driven by those who are homeless and also have mental and/or long-term physical health issues[45,83], which is also the segment of the homelessness population targeted by the four homelessness services.

Table 17: Average Incidence and Cost of SVHM Services, 6 months Pre/Post Episode Commencement Date

Ave incidence/person

		ALERT (n=102)	The Cottage (n=103)	ALERT/The Cottage (n=36)	CHOPS (n=77)	Prague House (n=21)	Total (n=339
ED presentations	Pre	3.1	1.0	3.0	1.7	0.4	2.0
	Post	2.7	1.1	2.9	1.0	0.4	1.7
Inpatient days (unplanned)	Pre	4.1	4.6	9.0	12.8	5.5	6.8
	Post	3.8	4.9	4.2	6.4	3.6	4.8
Planned admission days	Pre	0.8	2.5	0.3	4.9	19.6	3.3
	Post	0.7	4.2	1.3	1.1	3.2	2.1
Outpatient attendances	Pre	3.7	2.4	1.1	1.0	0.6	2.2
	Post	1.7	3.5	5.6	1.0	1.5	2.5

Ave cost/person ($s)

	Cost/ incident ($s)		ALERT	The Cottage	ALERT/The Cottage	CHOPS	Prague House	Total
ED presentations	820	Pre	2,532	820	2,460	1,406	351	1,613
		Post	2,251	892	2,414	788	351	1,405
		Diff	**281**	**-72**	**46**	**618**	**0**	**208**
Inpatient days (unplanned)	1,215	Pre	4,943	5,568	10,969	15,590	6,711	8,301
		Post	4,610	5,969	5,096	7,763	4,397	5,778
		Diff	**334**	**-401**	**5,873**	**7,826**	**2,314**	**2,523**
Planned admission days	1,215	Pre	977	3,008	405	5,901	23,837	4,068
		Post	858	5,120	1,553	1,357	3,876	2,527
		Diff	**119**	**-2,112**	**-1,148**	**4,544**	**19,961**	**1,541**
Outpatient attendances	276	Pre	1,034	673	307	269	171	620
		Post	465	978	1,549	269	421	689
		Diff	**568**	**-305**	**-1,242**	**0**	**-250**	**-69**
TOTAL COST/person		Pre	9,486	10,068	14,176	23,166	31,071	14,602
		Post	8,184	12,958	10,648	10,177	9,046	10,398
		Diff	**1,302**	**-2,890**	**3,529**	**12,989**	**22,025**	**4,203**

Source unit costs: Emergency attend/admit: Provided by SVHM. Average cost (direct and indirect) for ED incidence (2015-16) where the person was identified as homeless. Inpatient days: Provided by SVHM. Average cost (direct and indirect) per inpatient day (2015-16) where the person was identified as homeless. Outpatient attendances: Average cost/incident, Victoria. IHPA, 2016, National Hospital Cost Data Collection Australian Public Hospitals Cost Report 2013–14, Round 18 [84]

As indicated in Table 17, there was an overall average health cost decrease across clients supported by the four services of $4,203/person/six months. Across the 339 people costs were estimated for, this equates to a total cost decrease of $1.425m in the six month period. The largest per person SVHM cost decrease relates to Prague House, at $22,025/person/six months. This equates to a cost decrease of $462,531/six months across the 21 people costs were estimated for. This represents approximately half of Prague House clients assisted in 2015. People supported by CHOPS had a SVHM cost decrease of $12,989/person/six months, or $1,000,120/six months over the 77 included people. The SVHM cost decrease associated with CHOPS clients represents 70% of the total dollar savings. Smaller cost decreases are associated with clients who accessed both ALERT and Cottage of $3,529/person/six months or $127,028 over the 36 people, and those accessing just ALERT, being $1,302/person/six months for a total of $132,830 across the 102 people.

Congruent with findings from a number of other studies in this space, it is plausible that there will be increases in the use of some services and their associated costs when people who have been homeless commence receiving more targeted support and healthcare, particularly where previously unmet health needs are now being diagnosed and/or addressed. In this evaluation, the costs of services used by people who accessed just The Cottage increased by $2,890/person/six months from the six months prior to the six months post accessing the service, or $297,639 across the 103 people. Several of the client interviews and case studies undertaken for this evaluation provide possible explanatory insight into the observed increases; for example one client whose compliance with dialysis treatment has increased substantially following contact with The Cottage and ALERT and has been assisted to manage a long term alcohol dependency as illustrated in the following case study.

Box 20: Case Study Illustrating Increased Use of Secondary Prevention Services

Background

A male client in his mid-sixties has a complex medical history including a 29 year history of heavy binge drinking, liver disease, diabetes, anxiety and depression. Social isolation and struggles with self-care when intoxicated are also issues.

Use of hospital and SVHM services prior to contact with SVHM homeless service(s)

Since first presenting to SVHM in late 2011, the patient has had 51 ED presentations and 54 admissions to SVHM, and stayed at The Cottage on 5 occasions. In the six months before his first contact and stay with The Cottage he presented to ED on 9 occasions with 8 of these resulting in unplanned admissions.

Intervention via SVHM and changes in health service use

The client has had multiple contacts with ALERT throughout 2012 and 2014-2016, and considerable progress has been made in assisting him to address his alcohol dependency and the management of his chronic disease. Three of his stays at The Cottage since 2011 have been following detox at Depaul House, and another time as a referral from ED following ethanol withdrawal. The client now has a psychologist, a PHAMS worker and an alcohol counsellor seen regularly at DOAM. Since 2011 there have been 220 outpatient visits. ALERT assisted him to find more appropriate and less isolated accommodation (Sambell Lodge), and an eight month period of sobriety followed, during which time there were no ED visits. Unfortunately a recent anxiety-inducing diagnosis of HCC triggered an alcohol relapse. However, the client is committed to detoxing again with the support of Sambell Lodge and his DOAM drug and alcohol workers.

7.4.2 CHANGES IN PLANNED AND UNPLANNED INPATIENT DAYS AND ED PRESENTATIONS

Changes in planned and unplanned inpatient days are the major contributing factors influencing observed changes in the total cost of SVHM services used. For clients supported by ALERT and The Cottage, increases in outpatient visits was also a major contributor to the change in health service costs. As discussed previously, greater health service use and associated costs in the short-term is often observed when previously unaddressed issues are dealt with. Longer term data is needed to determine whether improved management of health issues will result in longer-term cost reductions. The observed changes in unplanned and planned admissions and ED presentations are outlined below.

Unplanned Inpatient Admissions

Overall, the change in unplanned inpatient days contributed to the largest decrease in healthcare costs, representing 60% of the total computed savings ($2,523/person/six months across all services, in total $855,360/six months). There was variability across the services, with the largest decrease in unplanned admission costs associated with CHOPS, followed by those accessing ALERT and The Cottage, and then Prague House clients (equating to $7,826, $5,873 and $2,314/person/six months, respectively). Across the 134 clients accessing these services, the cost decrease associated with reduced healthcare use equated to $862,360/six months. ALERT clients also provide a small cost decrease associated with decreased unplanned inpatient days of $334/person/six months. In contrast, the cost of unplanned inpatient days for The Cottage increased slightly, resulting in a cost increase of $401/person/six months. This equates to a cost increase (for 103 people) of $41,303. It is relevant to note that average changes in service use, such as the unplanned admissions reported here, can mask the dramatic changes that have been observed at the individual level for some clients. The case study shown in Box 21 illustrates this.

Planned Admissions

A cost decrease from reduced planned admission days was observed for all services except for clients accessing The Cottage and those accessing both ALERT and The Cottage. The decrease in cost per person was largest for Prague House; $19,961/person/six months or $419,181/six months (21 people). The decrease in SVHM planned admissions costs for CHOPS and ALERT were $4,544 and $119/person/six months, respectively, equating to cost decreases of $349,888 (77 people) and $12,138/six months (102 people), respectively. For those accessing The Cottage and both ALERT and the Cottage planned admission days increased after support commenced, by $2,112 and $1,148/person/six months, respectively. This equated to an increase across the combined cohort of $258,864/six months (139 people). This increase in cost of planned admission days to some part offsets the decrease in cost of unplanned inpatient days for people accessing these services, consistent with improved management of health system utilisation to address ongoing health issues.

ED Presentations

Change in ED presentations represented a comparatively small proportion of the decrease in demand on SVHM resources, with an associated cost decrease of $208/person/six months

across all services, representing a total cost decrease of $70,520/six months. While such 'cost decreases' are not directly realised (or even recognised without the benefit of a research lens) they result in a release of resources so that more services can be supplied and more needs met. CHOPS had the largest impact on ED costs, with a cost decrease of $618/person/six months, representing 67% of the cost decrease associated with the change in ED presentations.

Box 21: Reduced ED Presentations and Unplanned Admissions after Contact with The Cottage

A Cottage client in his mid-forties has a long history of substance dependency issues (cannabis and alcohol), has issues with aggression and an acquired brain injury.

Use of hospital and SVHM services prior to contact with SVHM homeless service(s)

The client has had nine ED presentations since first presenting in 2013, several which were related to him falling off his bike; he reports this occurs regularly.

Intervention via SVHM

The client first stayed at the Cottage in September 2015 after several ED presentations in the previous two years. On this first occasion, he had sustained a hand injury from punching a window after an outburst of anger and had been referred to The Cottage for wound care and meds compliance. The Cottage facilitated his referral to ALERT. He is often hard to get hold of, as his mobile phone had been hocked to cash convertors. During his time with HARP, he was well linked with Ozanam day centre and Salvation Army Bourke St drop in centre. After sleeping rough he was referred to the Launch Housing program and was accepted into Flagstaff crisis accommodation but was exited and banned after an altercation with a co-resident.

Cost to SVHM

In the six months prior to receiving support from The Cottage the client had presented to the ED on two occasions, with one of these presentations resulting in an unplanned admission of 18 days. Based on the average cost of ED presentations and hospital admissions for the homeless, the total estimated cost of the two ED presentations and hospital admission is $23,510.

In the six months after contact with The Cottage he had one ED presentation and was treated and discharged in three hours. The estimated cost of this presentation is $820. This reduction in unplanned admissions has a cost saving of $22,690.

7.4.3 CHANGES IN OUTPATIENT ATTENDANCE

The small overall increase in outpatient attendances resulted in a small increase in cost across the four services, of $69/person/six months, or $23,460/six months. Only ALERT showed a cost decrease, of $568/person/six months, or $57,940/six months. CHOPS showed no change and the cost of outpatient services for all other service increased. The largest increase was associated with clients who accessed ALERT and The Cottage, with a cost increase of $1,242/person/six months, or $44,700/six months. As with the increase in planned inpatient admissions, this represents a cost of people accessing required medical services with the aim of effectively managing health conditions, which can potentially reduce or delay the future need for more acute treatment arising from poorly managed conditions and/or other medical complications associated with this[85]. Increased attendance at outpatient appointments following contact with a service can sometimes be a successful outcome as illustrated in the following quote from one of the services.

if we can see that someone after they've left The Cottage is coming to outpatients, for instance, attending outpatients appointments, hasn't had any readmissions related to the original diagnosis, like if they've come in with a fall post-detox they haven't had any repeat admissions for that… or if they're not coming back with a reoccurrence of cellulitis that's a good outcome from a medical point of view. ***– Service staff***

Not many studies to date have explicitly examined changes in outpatient service use or costs, but among those that have, some have similarly observed initial increases in outpatient service use. For example, in a two year US study of an intervention combining comprehensive housing and healthcare services for chronically homeless people[86], there was greater improvement in housing outcomes among the intervention group, but more use of outpatient services (medical, mental health and substance use) reported, compared with the usual care group. The associated costs of outpatient service use also therefore increased. As noted by the authors however, it was expected that intervention group clients would receive and have access to a fuller array of primary healthcare services[86]. In another US study, outpatient mental health service use increased, but this was offset by other reductions in hospital use and associated costs[14].

Thus for SVHM, the increase in outpatient visits and associated cost can be considered a positive outcome if associated with improved management of health issues and a change from use of more costly inpatient and ED services. Service staff also noted that increased outpatient visits from clients receiving support can reflect willingness to engage and address chronic health conditions. However, the data window is too short to determine whether this is the case in the medium to longer term.

There are outcomes that we could look at in regards to what we normally would - is measurable in regards to representations or actual attendances of our patient appointments or even GP appointments or actual linking into the services that we refer to. So from a quantitative point of view I think there could be outcomes that could be measured with that. But again, you can say with our client group that it's not necessarily that they don't - it's not necessary that we reduce their presentations. For some that's great but for others it might actually be that they actually increase [their presentations]. . . They trust services. They're accessing services. So I guess a good outcome can be quite variable and on either side of the spectrum. I think a really good outcome for our service is that if there's a way to, I guess, measure that a client has gone through their health care or their health crisis smoothly - smoothly and had a good outcome from it in some way, whether they've understood the service, they were comfortable with navigating through the health system and that we've helped them link into appropriate services that address psychosocial components, then that's a good thing. ***– Service staff***

The comparatively large decrease in SVHM costs associated with CHOPS clients is consistent with previously discussed evidence from the literature which shows comparatively large health system savings associated with programs assisting the homeless with mental health issues[45,82].

The change in SVHM costs cannot be directly compared with the cost of supporting clients of the four homelessness services. The service cost/client represents the average cost/client for all clients supported over the year 2015-16. In contrast, the change in SVHM costs represent changes over a six month period for a sub-set of these clients and the change relates to when the episode of support commenced, which for some clients was prior to 2015. This is of particular

significance for Prague House, where approximately 75% of clients commenced support prior to 2015 and only approximately half of clients supported in 2015 commenced support after the 1st of January 2011. For those long-term clients supported in 2015 who are not included for the economic analysis, the relevant comparison is health costs which may have been incurred if this longer term support were not provided. This is not observable and further evidence would be required to determine whether observed changes provide a reasonable proxy.

In addition, evidence from the literature suggests that change in health service use is likely to be different in the longer term than the shorter term. Therefore, it is not possible to extrapolate the observed six month changes to provide an estimate of annual change in SVHM costs for comparison with the annual cost of providing the homelessness services.

7.5 WIDER HEALTH SYSTEM COSTS

The observed change in use of ED and other hospital services also has cost implications for sectors outside of SVHM. For example, reduced use of ED also results in a reduction in use of ambulance and a small decrease in police incidents associated with transportation to ED. The impact on ambulance arrivals to ED is not a cost borne by SVHM itself, but has been examined here as an example of the wider health system benefits that may potentially accrue from the homelessness services at SVHM and their impact.

Across all four services, comparing ambulance arrivals in the six months pre- and post-support, there was a reduction, on average of 0.13 arrivals by ambulance per person for clients assisted in 2015 where the episode of support commenced after the 1st of January 2011. This equates to a further decrease in broader health system costs of $118/person for a six month period[h]. This is equivalent to a reduction of 46 ambulance trips across the four services, with an associated cost decrease of approximately $40,000/six months. The largest per person cost decrease related to clients assisted by CHOPS ($237/person/six months) and by The Cottage ($152/person/six months).

Client interviews provide some insight into how assistance to manage health issues may contribute to reductions in ambulance use and the associated cost decrease. For example, one client with alcohol dependency and poorly controlled diabetes described how when he drinks he tends not to take his insulin and often needs to go to ED. When he goes to ED he usually arrives via ambulance:

> *I'd get an ambulance. … I just waited 'til it got too bad and then I would put myself into ED and then I would either go to Depaul House and then The Cottage, or The Cottage or Depaul House.* ***- Client***

The homelessness interventions are likely to result in changes in use and associated cost of other services, such as general practitioner visits, hospital in the home, alcohol and drug rehabilitation treatment services and community based care. However, data is not available to assess the economic impact on such services. Improved health care management is also likely to result in

[h] Cost/ambulance incident $870. Source: SCRGSP, 2016, Report on Government Services, Volume D. tables 9A.33 and 9A.46

improved quality of life (QoL) for clients, which has an economic value to society. However, no information is currently available to assess QoL of the service clients, and as indicated in the discussion around limitations, there are significant difficulties in applying an economic value to any observed changes in QoL. Nonetheless, there remains merit in SVHM considering ways of measuring QoL as this has been done in evaluations of the UK Pathway project that similarly seeks to improve both health, housing and wellbeing outcomes for hospital clients who are homeless[1].

7.6 COMPLEXITY OF HEALTH ISSUES

The discussion above examines the average impact on costs only, and so potentially can mask the significant impact at an individual client level, particularly among some with complex needs that are amenable to intervention and support. As discussed previously, the literature shows that in the shorter term health costs often increase as people engage with the health system and address ongoing health issues; broad decreases in health service use and associated cost is often not observed until the second year after support commences.

Client case studies provide some insight into the complexity of issues experienced by some clients and the associated potential homelessness and health system cost savings associated with helping people to address these complex issues. The case study in Box 22 demonstrates cost savings to SVHM associated with reduced ED presentations and unplanned admissions after a client entered Prague House.

Box 22: Cost Savings Associated with Reductions in ED Presentations after Admission to Prague House

A male client in his early-fifties with a 30 year history of alcohol dependency, diagnosed alcohol-related brain injury and depression (un-medicated) has been living at Prague House since June 2015.

Cost Savings

Since 2002, based on the average cost of ED presentations and hospital admissions for the homeless, the total cost to the health systems was $345,169 ($82,000 for ED and $263,169 for hospital admissions). Over the 13 years between 2002 and admission to Prague House this represents an average cost of $26,550/year.

Based on the average cost of ED presentations and hospital admissions for the homeless, the cost to the health system in the six months prior to entry to Prague totalled $13,530. When compared with the $6,135 cost of the six ED admissions plus overnight hospital admission in the six months after entry to Prague House, this represents a savings to the system of $7,775 per six months.

The case study in Box 23 illustrates the confluence of AoD, housing and hospital usage that is often observed among longer term homeless people, and illustrates also the multi-faceted intervention that this requires. In complex cases such as this with a strong addiction component, dramatic changes are unlikely in the short six month time intervention period for which data was available. However as shown in Box 23, the pre-intervention hospital related costs even for a six month window are substantial, hence the potential to make a difference is also significant.

Box 23: Case Study around Multi-morbidity, Chronic Homelessness and Burden on Health and Other Sectors

A male client in his late-thirties first came in contact with SVHM in 2013. He has a long history of alcohol dependence and unstable housing and frequently presents the ED as a result of falls while intoxicated, abdominal pain and wanting clothes/food.

Contact with a wide range of services

The client has had sporadic contact with ALERT since 2013 while residing at Ozanam House where he continued to drink heavily. After falling and breaking his ankle whilst intoxicated he was discharged to Stewart Lodge, but returned to street drinking. ALERT referred him to the SVHM DOAM and he agreed to attempt detox. He was discharged to Depaul House, however, 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 the RDNS 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 To 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.

7.7 LIMITATIONS

As indicated at the outset of this chapter, a number of data limitations mean that this analysis cannot be used to assess the economic effectiveness of the four services. The analysis should therefore be considered in the context of these limitations and be considered as providing an estimate of the cost of the homelessness support services and a preliminary assessment of the potential for associated reduced health care cost. The limitations are discussed in detail below.

i. *The four services being analysed are not stand alone*; clients potentially access health services in addition to those accessed at SVHM and the analysis covers a very short data window. Therefore it is not possible to directly attribute outcome changes, including

health service use outcomes, to the individual homelessness support services examined. This also means that the cost/client estimates presented in this report represent a conservative estimate of the total cost of supporting these people. The integrated nature of support services and the potential for people with complex needs to access an array of these services is demonstrated in the following quotes.

> *I've just come from a home visit. I've been out to the high rises to visit a gentleman that we got a referral from, from the Royal Melbourne. He's got a significant alcohol issue. He's in his 80s. Has had multiple presentations both here and Royal Melbourne, we'll try and - which he's agreed to recruitment. We'll try and get him to outpatient appointments* ***– External stakeholder***

> *I ended up in the Alfred, where they put me into the mental health ward. When they done some checking and found out that I'd been in the Ballarat mental ward, they discharged me with an outlook of getting more help from the mental health services. I come over to Fitzroy, stayed in that motel I was telling you about, boarding room. It was just a disgusting place, roaches, everything. It was really bad, really bad. Out of the blue, the surprise, the mental health team decided to turn up and come and see how I was.* ***– Client***

ii. *Changes in health service use represent only one aspect of the potential benefits* to accrue for the four services. Thus a more holistic view should be taken when assessing the value of these services to individuals assisted and to the community. For example, an ideal evaluation would include longitudinal data that can provide insight into changes in client QoL, mortality rates or housing stability and how improved health outcomes impact on these domains. In turn, these domains also have economic implications. In addition to the clear economic benefits of housing stability; improved QoL and decreased mortality rates also yield economic benefit and have been estimated to add significantly to the economic value of homelessness and health care related programs[79]. For example, the Brisbane HHHAHS estimated Health Related Quality of Life (HRQoL) gains associated with the service of between $6.16m and $13.49m, depending on the estimation method used[79]. This wide range in estimated value points to the difficulties in assessing the economic value of HRQoL, with a range of both estimation methods and attributed values (For further discussion see[79,87].

iii. *Cost estimates should be interpreted in the context of the integrated nature of the homelessness services.* Service budgets are from multiple sources with staff preforming a range of functions, making it difficult to disentangle the relevant expenditures. In particular, ALERT is financed through both the EDCC and HARP programs and has both homeless and non-homeless clients. The estimated cost of providing ALERT services to homeless clients is based on the proportion of EDCC and HARP client contacts (estimated at approximately 15% and 64%, respectively) which relate to homeless clients. CHOPS operates as part of Clarendon Community Mental Health Centre and the cost of CHOPS is estimated based on the proportion of full-time equivalent staff associated with CHOPS.

iv. *Examination of health service use is limited to services provided through SVHM*. There is the potential that clients also access other health services, including other hospital services in Melbourne and more widely. No information is available on the extent to which this occurs pre, during and post support and the extent to which it has changed. This may result in the reported change in hospital use to either under or overstate the actual change. For example, if a person was accessing another Melbourne hospital on a regular basis pre-support, but due to receiving support under one of the St Vincent's programs examined, they commence accessing SVHM; the data would show an increase in hospital use incidence post- support, when total hospital use may have actually decreased. Similarly, if a person was accessing SVHM prior to and during support, but moved location post support and accessed an alternative hospital, it may appear that hospital use has decreased when it has actually increased from pre- to post- support. Building on this evaluation to link in other Victorian health system data to this cohort via unique identifiers is one way to gain a more comprehensive picture of health service utilisation beyond SVHM, and this is discussed further in Chapter 8 in our recommendations for future research.

v. *The very short data window of six months pre and post commencement of a support episode* does not provide adequate information to adequately assess the effect of support on health service use. An increase in health service use, and associated increase in health costs, post commencement of an episode of support may represent a positive outcome as the person experiences improved engagement with health services and previously unaddressed health issues are dealt with. This is consistent with evidence from the literature, which shows that for many previously homeless people health costs often increase in the first year after support commences and costs then decrease in the second year post support commencing as health issues stabilise[25].

vi. *Changes in health service use for clients receiving long term support may not be as well captured using the 2015 data*. The subsample of sample size for the overall analysis consisted of all people identified as homeless who were provided with support during 2015, with only Prague House having a comparatively small sample size of 41 people. However, the value of the change in use of SVHM services was only estimated for a subsample of clients of support service clients. This issue affected CHOPS and Prague House, which provide longer-term support. The outcomes reported for this subsample may not be representative of outcomes for the whole sample. In particular Prague House had approximately 75% of clients who commenced support prior to 2015 and only approximately half of clients had commenced support after the 1st of January 2011, and so were included in the sub-sample.

vii. *ED clients not picked up by ALERT are not included.* The hospital use data does not capture potential ED presentations of homeless clients that were prevented by EDCC, therefore never made it onto ALERT's client list.

viii. *The unit costs applied to hospital usage data represents average unit costs only, not the actual cost of health services provided* to the actual cohort being examined. In particular, the average price per bed day for inpatients and ED presentations represents the

average cost across all persons admitted to SVHM who were identified (by coding at admission) as homeless for 2015-16. It is likely to primarily present the inpatient cost of people identified as primary homeless, rather than secondary or tertiary homelessness. The costs of outpatient visits and ambulance costs are average costs for Victoria.

Finally, it should be noted that the cost of providing the homelessness services examined here cannot be compared with the cost of providing specialist homelessness services, where assistance with health issues represents only one aspect of support. Costs quoted in the homeless literature are more typically for services which do not provide support from medical and health staff, whose daily costs are higher and typically have to work in teams rather than in isolation. Hence the service costs presented here for SVHM homeless services are not surprisingly higher than those reported in some other Australian studies of community based homelessness services[24].

8 IMPLICATIONS AND RECOMMENDATIONS

This chapter sets forth a range of implications and recommendations that emerged from the evaluation findings. Importantly, many suggestions for the future were provided by staff from the four services themselves, from other SVHM staff and/or from external stakeholders. Additionally, the experiences of clients themselves add weight to some suggestions given by staff and stakeholders. These views have been synthesised and incorporated into the implications and recommendations drawn by the evaluation team.

As clearly evident throughout the report thus far, the work of SVHM and in particular ALERT, The Cottage, Prague House and CHOPS to improve the health and lives of people experiencing homelessness is highly regarded internally and externally. A multitude of successes and strengths were identified, with many lessons that other hospitals and services can take away from the experiences and SVHM models of care offered within this report.

This evaluation was also tasked, however, with; identifying the successes, barriers, and gaps in homelessness service provision at SVHM (objective 5); determining how SVHM homelessness services can be improved to provide more targeted and outcome-focused delivery (objective 6), and; identifying key opportunities for improved collaboration and integration between of SVHM's homelessness services to support sustainability (objective 7)

It is these three objectives in particular that have informed the synthesis of implications and suggestions that follow. These have been grouped into themes (Figure 40); the corresponding discussion of each theme incorporates ideas emerging from the interviews with service staff and internal and external stakeholders.

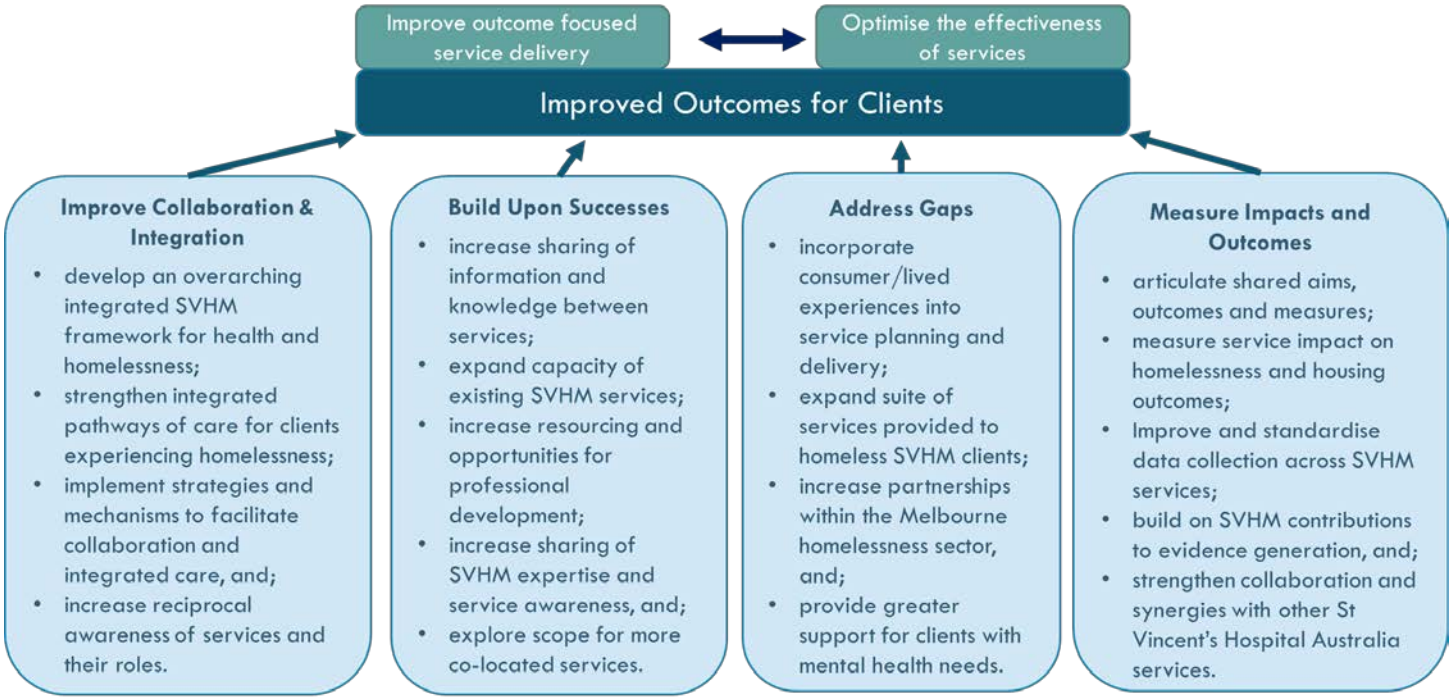

Figure 40: Implications and Recommendations Themes

8.1 IMPROVE COLLABORATION AND INTEGRATION

8.1.1 DEVELOP AN OVERARCHING SVHM FRAMEWORK FOR HEALTH AND HOMELESSNESS

Emphatically, there was strong support for the development of an overarching framework that articulates the shared vision and breadth of activity within SVHM that is contributing to improving the health and wellbeing of people experiencing homelessness. In many ways this would capture what already exists informally, but in a more consolidated form with shared objectives. Further strengthening collaboration between existing services, and enabling more integrated pathway of care for clients are two key drivers for developing an overarching homeless-health framework for SVHM. A third driver stems from the mushrooming of activity around homelessness over time, both within SVHM and in the wider Melbourne community. This has precipitated a heavy reliance on informal or incidental knowledge of the role of other services and the pathways for collaboration.

An overarching framework could serve to provide a more coherent and intentional model of collaboration among a range of SVHM teams that together have enormous potential for impact. The framework should delineate not only '*what is*' but also '*what could be*'; i.e. what might a comprehensive model of homeless healthcare at SVMH look like in the future.

Our recommendation for the development of an overarching SVHM framework for health and homelessness is congruent with the views of many internal and external stakeholders. In addition to the perceived benefits for SVHM, its work in the homelessness arena is often referred to as a valuable exemplar for other hospitals.

> *"… it could become a seamless package because here you are, you've got this ethos and you've got this series of initiatives that have persisted over a long period of time that work together more or less well just depending. But what an opportunity for St Vincent's to position itself internationally in the western world as how to do homelessness in a tertiary hospital."* – ***External stakeholder***

> *"It's important to get the model written up, perhaps starting with when homeless people present in ED, because in a sense it's driven from the ED through - whether it goes to mental health or whether it goes to The Cottage or whether it goes into [gen. med] or wherever. It tends to keep coming back to the ED and they set the tone I think and it needs to be written up, but it hasn't been."* **– *Internal stakeholder***

The is no ready-made best practice template for a hospital based framework for homelessness, but pertinent examples to draw upon include the United Kingdom (UK) Pathway model, which has now expanded to 11 hospitals throughout the UK and has been shown to produce improved patient outcomes, an increased number of care plans for complex, frequently attending patients, and reduce homelessness among discharged patients[77,78]. The UK Pathway model is discussed further under Section 8.1.2.

Additionally, key principles for collective impact (Figure 41) are highly relevant to SVHM's overall work around homelessness, and are useful in distilling key elements of an overarching integrated framework for homeless healthcare at SVHM. In doing so this framework would

provide a platform for articulating common purpose, aims, and the roles of different services and teams in contributing to shared measurable outcomes and collective impact.

Achieving Change through Collective Impact – Key Conditions for Success

Common Agenda: Participants have a shared vision for change, including a common understanding of the problem and collaborative approach to solutions;

Shared Measurement: Participants collect data and outcomes using shared measures across services to ensure consistency and accountability;

Mutually Reinforcing Activities: Participants operate in their areas of expertise while still coordinating with other collaborators;

Continuous Communication: Open and regular communication builds strong collaborative relationships and reinforces shared objectives;

Backbone Support: The creation and management of a collective impact requires a dedicated backbone role with sufficient skills and resourcing to support the entire collective impact efforts and measurement of this.

Figure 41: Key Conditions for Collective Impact
Source: Kania and Kramer[88]

8.1.2 STRENGTHEN INTEGRATED PATHWAYS OF CARE FOR CLIENTS EXPERIENCING HOMELESSNESS

To support the development of an overarching framework, the development of a '*clinical pathway*' approach for clients experiencing homelessness across all of SVHM is recommended. This model has been pioneered in the UK Pathway model of care coordination for homeless people admitted to hospital (see Figure 42 for its key objectives), that has been taken up in 11 hospitals in the UK. Application of the model is producing some compelling results in relation to improved health and housing outcomes [77,78], adding weight to the organisational benefits of more coordinated client focused models of care.

The Pathway model encompasses:

Vertical integration: specialist primary care reaching in to the hospital to coordinate care;
Horizontal integration: care coordinated across physical ill health, mental ill health, substance misuse, social care, housing & voluntary sector within the hospital and out into the community.

Emphasis is placed on both vertical and horizontal care, and service integration within the Pathway model is an important trait that SVHM could further consolidate and articulate as part of its overarching approach.

In many ways the Pathway model is not dissimilar to the care coordination that ALERT provides for homeless patients presenting to ED at SVHM. Like ALERT, Pathway services have a focus on

integrated care with a philosophy based on supporting the most disadvantaged members of the community. There is a dedicated Homeless Health team, comprising a specialist GP, nurse specialists, mental health and housing staff and care navigators; aiming to provide an integrated response to the complex needs of patients experiencing homelessness[78]. The role of specialist homelessness GPs is to conduct ward rounds for homeless patients, providing medical advice that takes into consideration the patients' medical condition in relation to their psychosocial needs and advocating on their behalf with external agencies where required[77,78]. The weekly multidisciplinary team meetings (MDT) that occur as part of Pathway's process are similar to the multidisciplinary clinical review meetings that occur at SVHM, although the processes of the MDT are more structured, with all complex patients referred to the meeting[78].

Figure 42: Key Objectives of the UK Pathway Model

Source: Hewett[1]

Of particular relevance to the provision of more integrated care pathways for clients experiencing homelessness at SVHM, the Pathway model extends beyond the ED with formalised structures and clinical guidelines in place when referring patients to internal departments within hospitals, or for when hospital wards identify a patient who is homeless. A model like this at SVHM would capture much of what already occurs, but in a coherent way reducing the degree of fragmentation and increasing pathways and channels for collaboration, and integrated care.

Many other areas of SVHM currently have contact with, and provide care to people experiencing homelessness, but there is lack of clarity across the hospital around clinical pathways and collaborative care, particularly for clients beyond the remit of ALERT. The UK experience suggests that other hospital departments value greater clarity around their roles in relation to homeless patients and that this has fostered improved collaboration and client outcomes[5].

Within the concept of an overarching model of care and clinical pathways for clients, there is scope to clearly define and implement organisational support processes surrounding patient journeys. Where multiple services are involved in supporting a patient, decisions of which services to involve and in what sequence, should ideally be guided by evidence based and agreed procedures, rather than for example relying on personal connections.

8.1.3 IMPLEMENT STRATEGIES AND MECHANISMS TO FACILITATE COLLABORATION AND INTEGRATED CARE

"Working across the sector between agencies is not a new idea… many service providers already have informal networks with colleagues working in other organisations. Integrated care seeks to build upon these relationships by making them more formal and standardised[4]."

The effectiveness of any overarching framework and articulated models for more integrated care relies ultimately on the implementation of these in practice. Fortunately, SVHM is in a good position to leverage the existing and embedded culture of support for improving the healthcare for people experiencing homelessness to introduce the concept of an integrated framework. Collective acknowledgment of scope to improve the current fragmentation of services can also be harnessed. It was apparent in the interviews with the four services and other internal staff that SVHM staff are highly capable of identifying and addressing the existing gaps in service provision and processes; with many of the suggestions in this chapter stemming from staff themselves.

Moving forward, it is paramount to recognise where services and staff have already been working to improve coordination and communication, often aimed at reducing fragmentation and improving care provision. This was illustrated by various examples of collaboration between staff in SVHM services to improve communication, engagement, manage workflow and together tackle complex client needs, such as poor physical health, substance use, mental health, and homelessness. The clinical review meetings coordinated by ALERT were often mentioned as a positive example of a mechanism for bringing different teams and disciplines together and facilitating communication and collaboration. A more one off, but commended initiative was the forum organised by the Social Work Department to bring together internal and external services to discuss their roles in relation to hypothetical homeless client scenarios. The general view was that 'more of this type of thing' would benefit services and clients, and potentially result in some more efficient and effective solutions. The highly regarded ED Clinical Review weekly meetings could also instigate a follow-up mechanism to track and share the outcomes of discussed clients' interventions, which would promote and share accountability.

Notwithstanding the more formalised examples of collaboration above, it remained clear that communication and collaboration around homeless clients and their care typically occurs more informally and at the level of individual staff relationships, or between two individual services. This contrasts to the more overarching integrated framework and articulation of care pathways across the hospital proposed here.

An effective integrated SVHM homelessness service structure also requires strong collaborative relationships with SHSs as well as community mental health and AoD services working in the vicinity of SVHM, to enhance intake procedures as well as exit strategies. Many SVHM clients experiencing homelessness have tri-morbidities that span physical health, mental health and AoD and the sectors responsible for these have often been siloed in both the funding and service delivery landscape of Australia. This was illustrated in the findings of an AHURI study into the degree of integration between mental health, AoD and homelessness services, where clients of

these service systems often referred to poor care coordination and a constant repeating of information to different services, leading to ineffective and inefficient service delivery[89].

There were also examples given of past mechanisms that promoted collaboration between SVHM services in relation to homeless clients that could be valuably reinvigorated. Depaul House described how in the past ALERT staff had previously attended their service on a regular basis to assess if any clients could benefit from ALERT involvement. This routine cross-service approach to client identification and referral was seen as highly successfully and could be expanded in the future.

Services generally expressed their intentions to further develop collaborative partnerships around care for people experiencing homelessness, with some having already developed or commenced protocols for more effective collaboration, or mapping service gaps and areas of duplication. It makes sense, therefore, to further encourage and expand these types of collaborative strategies where they are already underway, whilst also providing some guidance and example approaches congruent with the overarching framework.

Process mapping and 'customer journeys' are both tools that are gaining traction in health and other sectors[90,91], and could be a useful vehicle for facilitating collaboration and more integrated models of care between SVHM services and external homelessness services they work with. This could be trialled in particular areas or for a certain subcategory of clients (e.g. homeless clients with long term alcohol or drug use), and the learnings applied to other areas.

SVHM may well have some mechanisms for client journey mapping, referral flow charts and so on that can be adapted to the homelessness context, but the need for these to reflect both vertical and horizontal service pathways, and the wider interface with homelessness service providers outside of SVHM is critical.

8.1.4 INCREASE RECIPROCAL AWARENESS OF SERVICES AND THEIR ROLES

Whilst overall, there is a generally good awareness of the four services amongst each other and SVHM more widely, a recurring theme in SVHM staff interviews related to the need to increase awareness and understanding of each other's services, including eligibility criteria and referral processes. This was similarly observed in many of the interviews with external stakeholders. Increasingly this clarity would assist all services to quickly establish the suitability of a service for a given client and enhance information sharing and continuity of client care.

In terms of the four services, there has, to date, been considerable reliance on informal and historical understandings of each other's services, and good initiatives such as orientation visits to other services, joint case meetings, and documented pathways; which appear to be valued but ad hoc. Further, building a familiarity and understanding of each service is important as it opens up greater opportunities to connect and collaborate. Ideas proffered in interviews included staff rotations as a form of professional development, and staff periodically attending meetings of other services to raise awareness of what they do, discussing how they can support each other.

Greater voids in awareness about the services were observed for CHOPS and to a lesser extent for Prague House. Whilst this in part may relate to their more targeted clientele group and offsite location, there was a sense that services wanted to have better understanding of the role of CHOPS, and what the mechanisms would be for engaging with them. Similarly, several services were pleasantly surprised to learn that Prague House can accommodate older people experiencing homelessness if they have a mental health or AoD issue, suggesting that greater awareness raising about Prague House would be beneficial.

> *"I think whenever people are aware of one another and how we work and how all bits of the service work it has better outcomes for clients because the collaboration is key in people's wellbeing where the services are talking to each other, particularly with homeless clients usually have quite complex needs. So when people are talking to each other and not doubling up on something and something is not getting missed - you often hold different understanding and information about clients so we're having the same information and shared is having a much better understanding of the client overall."* ***– Service staff***

Due to lack of awareness (or understanding) of the CHOPS service specifically, it would be valuable to improve the visibility of the service i.e. regular multidisciplinary meeting with CHOPS were suggested to better understand their clients, what they are doing in their role, how other services can utilise CHOPS, and the referral process.

There was some lack of understanding of The Cottage mentioned in external interviews and how referrals occur. Staff turnover at external services can be a factor in this, hence the merit of orienting new staff (both in SVHM and external stakeholders) to each other, as well as the merit of exploring some more documented pathways for homeless clients. These could include the UK Pathway model, or flow charts developed for the Eastern Health mental health program [92] which provide guidance and a visual flow chart for different client scenarios (e.g. if the client has a case manager or housing support worker (or not), or whether a client is rough sleeping versus in transitional housing).

There is both scope and appetite to increase awareness of and the mechanisms for collaboration with other internal services seeing high numbers of patients experiencing homelessness. Depaul House, DOAM, Social Work, ED Mental Health and HARP Mental Health were among the most frequently mentioned areas within SVHM where it would be beneficial to have greater contact and mechanisms for information sharing and collaboration around responses to homelessness. Across the board, the merits of orienting and educating both new and existing staff to the role and ways of working of other homelessness services was strongly supported.

8.2 BUILD UPON SUCCESSES

8.2.1 INCREASE SHARING OF INFORMATION AND KNOWLEDGE BETWEEN SERVICES

SVHM has a long history of commitment to improving the health and wellbeing of individuals experiencing homelessness, and as a result has built up a wealth of knowledge, contacts,

information and networks within the homelessness, social services and wider health sector. However, multiple services within SVHM currently build and maintain independent relationships with other SVHM services and external stakeholders, often compiling their own resource list or system for identifying external support organisations to engage with. It would be beneficial to streamline some of these information gathering and networking practices, both to harness the synergies of each other's knowledge, as well as potentially reducing staff time spent sourcing appropriate services externally.

"There's a lot of stakeholders or services in this space. But they kind of - how do you know what they're actually doing? How do you know if the particular person is accessing these and sort of falling between the cracks." ***– Internal stakeholder***

In recommending that SVHM develop a mechanism for collective information sharing, we attempted to identify templates for SVHM to draw about (e.g. referral pathways, models of care for different client scenarios, new community services). Unfortunately we were unable to locate one that was an ideal fit, but a homelessness resource guide developed for the Eastern Health mental health program [92] serves as an example; in addition to referral prompts for different client needs, it compiles collated information about local homelessness and other support services. During the course of our evaluation we found that many teams within SVHM had developed their own lists of referral options and their own working knowledge of services that may be more or less likely to be able to assist particular clients. It would be invaluable and potentially time saving across the hospital to collate this wisdom, ideally in a digital portal or repository where 'live updates' can be made and key words searched.

Improving mechanisms for greater information sharing around the continuity and coordination of care for people experiencing homelessness is also warranted. It is acknowledged, however, that the current way patient data and records are captured does not make this easy (see discussion in Section 8.4.3), and legitimate time pressures on services and staff also constraint the degree of information sharing that might ideally occur around particular client pathways and outcomes.

Shared protocols regarding the identification and recording of homelessness status, current support received by client and specific referral pathways depending on the client circumstances could be developed. Shared protocols would increase the consistency in client information collected, suitability of referrals to homelessness services and ensure that all support available to clients is utilised. Some examples are provided in Box 24.

Box 24: Areas where Shared Protocols Regarding Clients Experiencing Homelessness could be Developed

- Recording of housing/homelessness status (agreed system of identifying and documenting)
- Capturing current supports client has in place – for example do they have a case manager (and if so with what service), do they have a housing support worker already?
- Support and referral pathways for different client scenarios, for example:
  - Patient admitted to a general medicine ward, identified as homeless, currently has no housing support worker and no previous contact with any of the four services;
  - Patient admitted to mental health unit, has a community mental health worker but has not been connected to housing support services;
  - Client attends outpatient clinic, identified as homeless, has not been connected to support services relating to homelessness.

8.2.2 EXPAND CAPACITY OF EXISTING SERVICES

The constraints on resourcing within SVHM and in the Australian and Victorian health system more broadly; are a pragmatic reality, but nonetheless there were some pertinent suggestions about how the good work of the four services could have greater impact if provided with greater capacity. Interestingly however, rarely were these suggestions couched in terms of a bald 'we need more funding', but rather came from a place of wanting to either improve services for clients, or to meet unmet needs by expanding the number of clients that can be supported.

With The Cottage and Prague House, it was noted by both internal and external services that there are occasionally clients who would greatly benefit from the service, but who cannot be referred or placed due to a lack of beds at the time of need. However, it should be noted that both of these services are valued for their current size and 'feel', and it was noted that additional but similar services within the SVHM network or elsewhere in Melbourne would be a preferred solution than upping bed capacity at either of these existing premises (not that this appears feasible in any case).

The Cottage's limited capacity to take on clients with acute mental health issues was also raised in a couple of interviews with internal and external services. This again points to a gap in the system in Victoria more widely. Whilst some argued for The Cottage to consider less restrictive admission criteria, there are some very valid reasons for these as articulated by Cottage staff, and it may be that alternative options need to be explored for pre and post medical care for homeless people with more serious mental health issues.

The lack of long term accommodation for people with an ABI, and the high confluence of ABI among people experiencing homelessness were raised as a gap in the system by a number of interviewees. Prague House has been able to accommodate several ABI clients who are strictly too young to qualify for aged care residency, as they are homeless, meet eligibility requirements according to ACAS, and there is no alternative options in Melbourne catering for this cohort. However Prague House staff recognises that this is an interim solution as an aged care residency is not the ideal place for someone in their 30s or 40s.

ALERT and CHOPS both have a strong community based roles, and work with clients with complex needs that often require extensive and ongoing support. As such, the number of staff within both these teams inevitably limits the number of clients that can be supported at any one time. Given the upward trajectory of homelessness in Melbourne, and the clustering of mental health, alcohol and drug issues, poor physical health and other social issues in the lives of many of Melbourne's homeless[41] there is a case to be made for expanding the capacity of both ALERT and CHOPS to work with a greater number of clients (subject to funding of course). The findings of this evaluation in terms of some demonstrated reductions in other more costly forms of health care (such as ED presentations and LOS) when hospital utilisation data was compared six months before and after support commencement from a SVHM service, suggests also that there is an economic argument that can also be made for greater investment in these services and expansion of their capacity.

At the more micro level of resourcing, there were some suggestions about aspects such as increased vehicle access that could assist ALERT staff in the community outreach side of their roles.

8.2.3 INCREASE RESOURCING AND OPPORTUNITIES FOR PROFESSIONAL DEVELOPMENT

Services identified the need to increase knowledge of the needs and treatment of specific client groups. For example, carers at The Cottage would benefit from more training around homelessness, complex psychosocial issues and personality disorders, with the manager stating that "*that's something that everyone could attend as one*". Currently only nursing staff receive regular training, it would therefore be beneficial to increase the capacity for care staff in develop in these realms.

Whilst the professional development needs will vary from service to service, there are also areas that it would be beneficial to build capacity across all SVHM staff working in this homelessness space. Trauma informed and aware care is one such area that is gaining increasing attention in health and homeless services. There is now compelling data on the high prevalence of trauma among people experiencing homelessness, and growing acknowledgment in the health and social services sectors of the need to upskill staff in how to incorporate this into practice[93]. Trauma not only has adverse impacts on health and wellbeing in its own right, but can impede how people engage with and respond to other interventions[93]. Facilitating a sound understanding of trauma and trauma informed approaches to service delivery among SVHM staff working with people who are homeless is important and requires professional development, whether through training, consultation or supervision[94].

However, with resourcing and staffing issues, the ability for services to implement professional development was noted to be difficult.

> *"We've got eight carers that work on different shifts throughout the week, so it's really hard to get people together. That's a real gap for us in terms of getting rapport and teamwork, and getting staff to education sessions."* ***–Service staff***

8.2.4 INCREASE SHARING OF SVHM EXPERTISE AND SERVICE AWARENESS

Many interviewees highlighted the uniqueness of the SVHM approach to assisting those who were, or at risk of becoming homeless. It was recommended that this facet of SVHM, that staff expertise and the effective strategies used, to be shared more widely.

> *"why is St V's not hosting big homeless network forums and saying we are proud that this is the work we do and we want you, you, you, you to be here. Which then improves integration across all services that are involved with - these are pretty achievable things to do and that have probably some big benefits." –* ***External stakeholder***

More broadly, SVHM was seen by a number of external services having the potential to be a significant thought leader around improved health care for those experiencing homelessness, both within Victoria, nationally and internationally. This occurs already to some extent via SVHM's strong reputation for its work in this space, papers and presentations around homelessness, and the diffusion of its insights via staff contributions to partnerships with other agencies. However, interviewees reported they felt that SVHM could do more to share its

experiences, insights on best practice and lessons learnt, both with other hospitals and healthcare providers in Victoria and Australia, and with the wider homelessness sector. Several external interviewees also commended SVHM for instigating this evaluation and indicated that they hoped that some of the findings would be made available in the public domain.

Raising awareness of SVHM services is also relevant to service utilisation and demand. For instance, both The Cottage and Prague House observed that their demand for beds, and where referrals are received from vary from year to year, and it is sometimes speculated that there could be greater awareness among external and internal stakeholders of what their services can provide for potential clients. While there is a place for individual homelessness services within SVHM to be raising and maintaining awareness, there are potential synergies that could be harnessed by some joint awareness raising strategies across the array of SVHM services working in the homelessness space.

Some internal stakeholders also suggested that SVHM could play a more proactive role in lobbying for the needs of homeless and other complex clients. This aligns with SVHA's overall mission but it would be important not to detract from the core health focus. Recent collaborative work between Salvation Army's Hamodava café and ALERT to provide an outreach service to people at the café is a good example of how this can be fostered collaboratively. This, however, would require an organisation to become more integrated and united along common mission/objectives. Some internal interviewees raised a need to introduce a position dedicated to addressing accommodation needs of clients (i.e., a housing officer).

8.2.5 EXPLORE SCOPE FOR MORE CO-LOCATED SERVICES

Whilst the location of different SVHM services is often based on core function, history or the restrictions of the physical building, benefits of co-location or shared facilities were nonetheless noted in a number of interviewees. This was both in the context of current co-location, as well as suggestions for 'more of this' in the future. The physical location of ALERT team within ED for example was regarded as highly advantageous, both from an ALERT, ED and client perspective.

> *"I think for junior medical and nursing staff, there are enormous benefits from them working with them. They will then get confidence in and the smarts to know how to manage someone . . . they do know that they do have some skills because we can all learn from each other"* – ***Internal stakeholder***

Conversely, there were comments that collaboration and communication between ALERT and ED Mental Health could be enhanced if it were possible for the latter to also have a more physical presence in ED. Clearly this at present is not possible in the current ED space configuration, but it may be that there are alternative ways of increasing interaction between ALERT and ED Mental Health. It was mentioned for example that in the past a staff member from mental health ED would rotate through one of the desks in the vicinity of where the ALERT team was located.

> *"The working environment is not conducive to allow teams to work in a certain way. If ALERT and mental health were sitting [in] a room that had access to the main body of the ED … the collaboration would be on the spot."* – ***Internal stakeholder***

Shared physical presence of staff from different services, even if only episodic, also helps build rapport between services and greater understanding of their respective roles.

The close proximity of The Cottage to ED was also seen as strength, and something quite unique to SVHM. Other hospitals in Australia such as Royal Perth Hospital in Western Australia have looked at The Cottage model, but there is no available premise within the nearby vicinity to Royal Perth Hospital. Close proximity not also facilitates patient transfer and staff movements between the two, but also symbolically serves to reinforce that there are close ties between the two services.

Prague House and CHOPS are both located away from the main SVHM site, and whilst there are sound reasons behind this, it does seem to contribute to lower awareness of 'what they do' by other services within the main campus of SVHM. Again there may be some small scale strategies to overcome this disconnect; for example several services suggested that it would be good to have CHOPS visit or vice versa.

8.3 ADDRESSING GAPS IN SERVICE DELIVERY MODELS AND HOMELESSNESS SECTOR

8.3.1 INCORPORATE CONSUMER/LIVED EXPERIENCES INTO SERVICE PLANNING AND DELIVERY

There is now a strong imperative in healthcare for consumer input into service planning, delivery and research. SVHM, like many hospitals, has a number of mechanisms for consumer participation and has an overarching Consumer and Community Participation and Carer Recognition Plan aiming to "*provide guidance to healthcare staff in achieving appropriate levels of consumer participation across the health service*"[95]. People who are homeless however are typically less likely to participate in more traditional avenues of consumer participation (such as consumer participation committees, forums or provision of formal consumer feedback). Whilst many of the staff of the four services work at the coalface with those experiencing homelessness, and this informally infuses the way in which these services are provided and modified over time, the health sector and consumers are increasingly looking for hospital and other health care providers to substantiate how consumer participation is achieved. To this end, there is merit in SVHM (and more broadly SVHA) in considering more overt strategies to enhance the participation of currently or previously homeless people in service planning and review.

In tandem with growing impetus for consumer participation is the concept of involving people with 'lived experience'. This has been particularly taken up in the mental health sector internationally[96] and in Australia nationally and in Victoria[97]. Ways of acknowledging and incorporating the voice of individuals with lived experience (of any health or social condition) can take a number of forms, and has implications for both the philosophy and culture of health care planning and delivery, as well as implications for consultation mechanisms and for the potential employment of peer workers.

The homelessness sector, and the health sector with regard to people experiencing homelessness has lagged behind areas such as mental and sexual health in its inclusion of consumer

participation and/or lived experience, but this needs to change. SVHM is well placed to help lead the way in this, and a number of ways of advancing this are signposted elsewhere. In some of the UK hospitals with homeless pathway teams, there is a designated care navigator role, undertaken by people with previous lived experience of homelessness[5]. The role of a care navigator is to provide care coordination and psychosocial support to homeless patients under the Pathways teams[5,78].

In the submission made recently by SVHS to the NSW homelessness review, it advocated for the role of Peer Support Workers, both within the hospital and across the NGO/homeless sector "*who can bring their lived experience to service delivery as well as service planning*" [98].

SVHM is encouraged to explore ways of more proactively including the input of lived experience, consumer or peer perspectives in the future. It could do so in collaboration with the Victorian based Council for Homeless Persons, which has one of the only peer 'lived experienced' initiatives in Australia[99]. The resource kit for consumer participation developed by Common Ground in Victoria[100] several years ago also offers suggestions that could be adapted for the SVHM context.

8.3.2 EXPAND SUITE OF SERVICES PROVIDED TO HOMELESS SVHM CLIENTS

There is also scope to consider expanding into other types of care for homeless clients that could complement and support the current work of the four services. For instance, there is growing evidence for the benefits of *GP/primary care hospital in-reach* to complement the medical care provided by the hospital to those experiencing homelessness, and to connect clients to a GP that can provide continuity of care in the community setting. This type of GP role is one of the core planks of the UK pathways model[5], and has recently been established at Royal Perth Hospital through the creation of a homeless in-reach team, in which GPs and nurses from community based Homeless Healthcare in collaboration with a dedicated ED consultant [101]. In addition to the benefits of the primary care ward rounds to individuals identified as homeless, Homeless Healthcare is able to provide follow up GP support in the community. Anecdotally already this has demonstrated an association between improved primary care and reduced repeat ED presentations among the hospitals homeless cohort.

Dual diagnosis clinicians could be another skill set to expand within the suite of SVHM homelessness programs - or this could be pursued in partnership with other organisations such as the Living Room, which has recently appointed a dual diagnosis counsellor.

Whilst it is beyond the scope of this review to be making explicit recommendations about totally new services that could be added to the suite of SVHM homelessness activity, the interviews with staff and stakeholders inevitably touched upon perceived gaps in the homelessness sector that pertain to health. One of these is in the area of alcohol and other drugs. As shown in the morbidity profiles in the client data examined for this evaluation, drug and alcohol use and/or related disease is significant among this cohort. SVHM is fortunate to have DOAM and Depaul house; something that has been identified as an enormous gap in states such as WA, where there are no equivalent services co-located and directly affiliated with a public hospital. SVHM also has a unique facility in Prague House, with its remit to be able to care for people with alcohol issues who have been homeless. Given these existing strengths within SVHM around assisting

homeless clients who have AoD issues, this could be a strategic area for SVHM to look at how it could further address sector gaps in this area. To SVHM's benefit, Nexus (a component of the Victorian Dual Diagnosis Initiative) whose role is around enhancing the dual diagnosis capability across sectors is physically located at SVHM. Interestingly, this service (while not a clinical provider) was not mentioned during any staff interviews.

As illustrated by a number of the case studies undertaken for this evaluation, and by the empirical morbidity data, traditional homelessness services or accommodation options are often not well equipped to meet the needs of individuals experiencing homelessness with significant and entrenched drug and alcohol addictions; a gap that has also been identified in NSW[102]. The managed alcohol program that has been recently piloted by SVHS[102] is one example of an approach to addressing sector gaps in another state and in countries such as Canada[103,104]. This particular model may or may not be needed in Melbourne, but the enormity of drug and alcohol use among this demographic, and the flow on of this to alcohol related morbidities and recurrent homelessness, flags it as a high priority issue for the sector, and potentially SVHM in the decade ahead.

8.3.3 INCREASE PARTNERSHIPS WITHIN THE MELBOURNE HOMELESSNESS SECTOR

Partnerships and consortiums are prominent in current discourse in both the health sector and homelessness sectors in Australia at present. Funding models increasingly drive collaborative models of service delivery, with partnerships between public, private and not-for profit sectors often actively encouraged. SVHM has several current partnerships with external organisations including Launch Housing, Ozanam House and NRCH. It has also had a long standing working relationship with RDNS, and during the course of this evaluation, ALERT had begun to explore the potential for an in-reach initiative with the Salvation Army's Hamodava café. Further developing relationships with other inner Melbourne SHSs, alcohol and other drug services and community mental health services also merits attention, as these sectors have often operated in funding and service delivery silos in the past[89], and SVHM is well placed to be a valuable conduit for leveraging and encouraging collaborations across these sectors.

Given increasing emphasis on partnered models of care, and the imperative for more 'joined up solutions' around homelessness, there is scope for SVHM to further expand in this regard, and to potentially tap into external funding sources or existing infrastructure (outside of SVHM itself) to enable this. In a SVHA submission to the 'Homelessness in NSW Discussion Paper' the merits of embedding clinical expertise within homeless services were articulated[98].

The partnership between SVHS and Wesley Mission, where a hospital clinician is embedded in a homelessness service run by the Wesley, was cited as an example that had fostered collaboration between the hospital and community based homelessness services[98]. The Pathway project[105] delivered through a partnership between St Vincent's Brisbane, Micah, and range of other organisations has some parallels to ALERT in terms of case management services provided but is predominately outreached based and does not have a permanent hospital presence. The Pathway project has leveraged funding from the Queensland government for this partnership model, with a particular focus on providing outreach mental health services to people experiencing homelessness.

External organisations can sometimes leverage or apply for funding from other sources. Hence SVHM would not necessarily have to underwrite the costs of forging new partnerships for the coupling of health with other services for vulnerable homeless people within its catchment. Philanthropy and government, particularly through NPAH projects in recent years have supported innovative collaborative projects that seek to end the cycle of homelessness. These projects have included support for those leaving hospital, residential psychiatric care and rehabilitation to access housing where homelessness was the only exit path available and assist them in their new homes. Governments around Australia, including the Victorian Government, have also supported impact investing as a new form of finance for innovative projects into homelessness. Impact investing involves impact investors providing funding for new projects and receiving an income return from government if the projects they fund meet threshold impact target returns. The Victorian Government has provided funding to pilot two Social Impact Bonds, one of which is to reduce harmful use of alcohol and other drugs. There is merit in SVHM considering conveying to others in the homelessness sector its willingness to potentially partner with other organisations in these types of innovations.

8.3.4 PROVIDE GREATER SUPPORT FOR CLIENTS WITH MENTAL HEALTH NEEDS

A recurring theme from the interviews was the high prevalence of mental health needs of the cohort, and the limited capacity of existing services to meet this demand. This is an issue being echoed around Australia, and mental health services in Victoria are clearly strained. For people experiencing homelessness, mental health is often a co- or tri- morbidity, hence service needs are complex. This is regularly observed by CHOPS where clientele can be distrusting of mainstream mental health services due to past negative experiences. Many of these issues lie outside of the scope of this review, and speak to systemic policy and funding issues for the health sector more broadly. What may be more doable however, is a clearer articulation of the mental health support options and care pathways for homeless clients at SVHM. For example, clarity around how CHOPS can become involved with a client, or around where ED Mental Health and ALERT could facilitate joint assessment or care planning, or around what flexibility The Cottage has to take referrals for patients with particular mental health needs.

> *"A more integrated approach I think particularly with the mental health. If you're dealing with homelessness we know mental health and drug and substance abuse, dual diagnosis. That stuff is just one of the precursors. It's just so prevalent that you have mental health so separate"– **External stakeholder***

Another suggestion provided by interviewees was the extension of dual and multiple diagnoses for clients so the services supporting and providing medical care were more comprehensive. This would align with the mental health reforms recently instigated by the Federal government that have called for a more stepped care approach to service delivery for those with greatest needs[106], and furthermore has implications for people experiencing chronic homelessness; which often clusters with mental and physical health issues.

8.4 MEASURING OUTCOMES AND COLLECTIVE IMPACT

8.4.1 ARTICULATE SHARED OUTCOMES (AIMS AND MEASURES)

At present, each of the four services has their own key performance indicators (KPIs), and when asked to prepare a program logic just prior to the commencement of this evaluation, each has its own set of desired outcomes. Whilst each service has a unique role, providing people who are homeless with access to quality health care and support and treating them with dignity and respect is in effect a shared mission, but not one that has ever been articulated in a shared form that we could ascertain. Moreover, each service described its desired outcomes in a different way, but there were clearly many commonalities beneath the differences in wording and emphasis. There is a clear need for an integrated program logic framework to be developed covering all of SVHM homelessness services.

From our discussions with SVHM staff, there was an appetite for a more clearly articulated shared vision and outcomes for SVHM pertaining to the care for people currently or at risk of homelessness. To test the feasibility of this we therefore conducted an activity during the joint focus group with service managers to compare the program logics and outcomes of each of the four services and come up with a set of shared outcomes and desired impacts that each individual service could relate to. The potential outcomes resulting from this activity are shown in Box 25. This exercise demonstrated that it was feasible for the staff present to identify areas of commonality and to come up with ideas on wording of outcomes in a way that can suit any of the four services. Interestingly, the exercise also highlighted outcomes that some services felt in hindsight mattered to them also, but that they had not thought to articulate on their original program logic.

Box 25: Shared Outcomes Across the Four Services

- Achieve client-directed goals;
- Care coordination;
- Coordinated linkages with other services;
- **Identification of clients' underlying physical, mental and psychosocial needs;**
- Improve health outcomes;
- Improved attendance at follow up appointments;
- Improved engagement with services (internal and external);
- **Improved self-care and hygiene for clients;**
- Involve clients in decisions (resulting in increased trust of services);
- **Link clients to appropriate and stable housing or accommodation;**
- Maintaining an appropriate level of contact;
- Reduce the need for involuntary treatment and intensive support.

The three **bolded** items indicate what the service managers perceived to be the three most important/relevant impacts that their services could have overall. Interestingly, it was implicit in this group discussion that equitable access to high quality clinical care for this vulnerable population group is a fundamental tenet at SVHM, hence the three outcomes and impacts identified as most important related more to the psychosocial domain. Moving forward however, it is important that any shared statements around desired impacts also refer explicitly to the central role of clinical health care, as this distinguishes SVHM from other homelessness sector agencies, and underscores the unique contributions it can make to the wellbeing of people who are homeless because of its health care remit.

Additionally, all services identified that they would ideally have a more formal focus on prevention but that a lack of resourcing, in particular a lack of timely access to long term secure housing, mental health services and alcohol and other drug services, means that this has to be a secondary focus, behind addressing clients' immediate health and housing needs.

Whilst this list of shared outcomes is by no means polished nor definitive, it illustrates that there is scope and willingness to have an overarching mission and set of outcomes relating to homelessness and health care at SVHM. Establishing a suite of shared outcomes across SVHM services would greatly facilitate any future composite evaluation of homelessness services and the associated collective impact. It also shines a spotlight on outcomes that are difficult to measure with the type of data currently collected, as discussed shortly.

In developing the outcomes framework of SVHM homelessness services, regard should be given to incorporating existing outcomes and indicators used in the national SHS system particularly as they relate to non-health objectives such as housing. Correspondingly, including a small set of questions on entry and exit from SVHM services used in the national SHS reporting framework is suggested.

8.4.2 MEASURE SERVICE IMPACT ON HOMELESSNESS AND HOUSING OUTCOMES

One of the objectives of this review was to assess the impact of SVHM services on homelessness and housing outcomes, which was also articulated as a desired outcome in the joint focus group with the four services' managers. Moreover, the social determinants of health ethos of all four services embrace the fundamental importance of assisting homeless clients where possible to connect to housing support and accommodation services. Whilst some very positive examples of this being achieved emerged in the interviews and case studies, we were largely unable to evaluate SVHM's impact in this domain due to the limited data collected specifically in relation to housing and homelessness outcomes.

> *I don't know how you capture that sort of data that suggests that you've made 18 phone calls. You went to three different site visits or you know even linking homeless people in with drop in centres. I don't know how you would capture that.* ***– Service staff***

Prague House is an exception to this in the sense that once people are residing there, their homelessness has in effect ended (unless they discharge themselves back into homelessness which is exceedingly rare). But the other three services at best have anecdotal information on housing and homelessness outcomes, and while there is homelessness and housing history documented in text in patient clinical records on PAS and MRO, there is no easy way to search for or distil this information. As we found in compiling the case studies for this evaluation, records need to be manually reviewed to glean information about journeys into and out of homelessness, and it seems there is no routine prompt or method for how or whether such data is recorded. Similarly, the numerous proactive collaborations and contacts between SVHM services and external agencies that may then provide complementary support and care for clients is not routinely

documented – staff are busy doing this all the time, but it is not currently captured in data, and again this impedes being able to assess outcomes for clients beyond discharge.

> *Our funding is purely based on the contact with the clients, its activity based funding, whereas - for us the quality of the service is very much about how well we interface with services - how well we work together consistently with the client. That's not something that's recorded and the reality is that activity based funding and direct contacts with clients is only a small small portion of what [we do].* – ***Service staff***

The danger in not having a comprehensive set of clear outcome measures that reflect the breadth of service delivery by CHOPS, ALERT, The Cottage and Prague House and other SVHM services providing care to homeless patients, is that the required KPIs of funders or hospital administrators may be defaulted to (e.g. number of episodes of care, LOS) and these do not do justice to SVHM services impact on the health and lives of people experiencing homelessness.

Additionally and as noted in Chapter 7, standard health system outputs and metrics may inadvertently infer a negative outcome, for example if long term neglected chronic disease or mental health is finally being regularly managed, then some forms of health care utilisation may increase rather than decrease.

8.4.3 IMPROVE AND STANDARDISE DATA COLLECTION ACROSS SVHM SERVICES

As noted in Chapter 6, one of the challenges encountered by the evaluation team, and often articulated by SVHM staff was the way in which data relating to homeless clients is currently collected, recorded and accessed. There was strong support therefore for SVHM exploring ways to collect, document and retrieve client data in a more systematic and standardised manner. This is important not only for shorter term client tracking and outcome monitoring, but would also enable a longitudinal evaluation of service impacts. Additionally in reviewing examples of routine data collection implemented by a couple of homeless health services in Western Australia, staff in these services cited the value of having streamlined data collection tools and ways of quickly generating month-by-month or year-to-year graphs of trends in service demand, services provided or patterns of referrals (both into and from their service).

Some of the key areas needing more standardised data collection methods are discussed below.

Who are our Homeless Clients?

Whilst SVHM is more active than many other hospitals working with homeless clientele, like many hospitals it lacks a standardised identifier for this across all hospital records and databases, and with no standardised definition or understanding of homelessness that is applied consistently across the hospital. Thus the process of identifying this cohort of clients for the evaluation was not straightforward. Even within ALERT and The Cottage, there is no routine or systematic way for flagging in the system who is homeless versus a client with other complex needs unrelated to

homelessness. Where homelessness status is recorded, it tends to capture mainly the primary[i] homeless population, and underestimates the true number of patients experiencing homelessness, as it may not capture patients who do not appear 'homeless' or who state that they have a residential address. In 2015 for example, the number of patients flagged with ICD-10-CM diagnosis code Z59~ at SVHM was slightly lower than the number of homeless clients that had contact with the four services alone, suggesting that it underestimates the total number of homeless patients in a given year.

Nonetheless, this ICD code is recognised and part of the SVHM data collection, and perhaps greater advocacy for its use across the hospital might enhance its usefulness as a routinely collected (albeit crude) metric for homelessness. Its usefulness outside of the hospital context is however limited, as ICD code tends to not be widely used by external health services, so comparative data is limited. In an ideal world, there would be a shared definition of homelessness used by health services across Melbourne (or indeed Victoria), to enable not only data comparisons, but also to facilitate the linking of different datasets for research and evaluation purposes in the future.

Standardisation of Measures of Types of Services Provided and Referrals

Much of the great work done by services such as ALERT and The Cottage in terms of connecting clients to external services, referring them to other health or social services and so on is currently not documented other than in individual patient records and case notes. Hence the evaluation team could not compile an empirical picture of the range and number of services and types of care being provided directly by SVHM staff, nor of the number or spread of referrals and links to other services within SVHM or externally. Whilst very conscious of the need to not burden staff with data collection, this is an enormous gap. We have therefore looked for examples of non-onerous data collection by other hospitals or health services working with individuals experiencing homelessness (see Appendix 5). Most of these are implemented via simple spreadsheet tools that can be used by staff during or following client contacts, and then systematically collated.

Should collecting data on client quality of life and housing status prove to be too burdensome on staff time it is possible to collect this information sporadically, on a sample of clients, through audits. This approach of 'snapshot data collection' has been used by the four services in the past, with a 2013 evaluation of The Cottage collecting data on all clients' health and housing status over a month-long period.

Quality of Life

Homelessness services that support clients in addressing their health, housing and psychosocial needs have the potential to significantly improve clients' quality of life. However, clients' quality of life outcomes are not always assessed in a systematic manner. Several recent evaluations of homelessness services have included quality of life measures[78,107]. The Pathways model utilised a short, self-complete questionnaire, the EQ-5D-5L[108], to measure changes in quality of life and

[i] i.e. someone rough sleeping with no fixed address, e.g. sleeping in a park or under a bridge (as stipulated in section 2.4.1)

found that the Pathways approach resulted in improved quality of life compared to the standard care pathway[78]. A recent evaluation of a Housing First approach in Queensland used the more in-depth (AQoL)-8D to measure clients' quality of life[107]. The (AQoL)-8D assesses wellbeing across a range of domains including perceived self-worth, capacity for independent living, mental health, pain and relationships[109].

Client Feedback Data

There were some data gaps identified by internal stakeholders. For example it was mentioned that obtaining client feedback on services only occurs in an ad hoc way currently. Having a mechanism with a shared standardised pool of questions (that can still be tailored to a particular service) would be beneficial and could be administered at point of discharge from a service. With increasing emphasis in the health system on client focused care, consumer input and outcomes, a robust mechanism for gathering client feedback and even follow up client self-reported data on outcome measures is warranted. Whilst individual services could each develop this, a more uniform approach across the suite of services working with people experiencing homelessness would yield far more useful data to inform decision making about the improvement and integration of services.

There also appears to be a lack of data on the proportion of potential clients eligible for a service but who decline to accept it, or who commence with a service but then elect to sever this prematurely. ALERT for instance, has data on those clients who agree to their support, and there is anecdotal evidence to suggest that the uptake among homeless individuals identified in ED by ALERT is reasonably high. However, there are no statistics on the number who decline, nor the reasons for this. For The Cottage we wanted to look at the frequency of client instigated early discharge (which has been shown elsewhere to bear a cost for the health system and impede optimal client wellbeing) but data on this was not readily available, with the exception of a couple of one-off audits (for example one done for the month of July 2013)[52].

8.4.4 BUILD ON SVHM EVIDENCE GENERATION

At the aggregated level, there is a costly revolving door between homelessness and the health system. Thus there is both a fiscal and public health imperative to build evidence for effective interventions that can reduce homelessness and its associated health impacts. In the course of undertaking this evaluation, considerable work has been undertaken (by SVHM staff and the research team) to identify the cohort of 359 clients seen by the four services at SVHM during the 2015 calendar year, and to map their patterns of health service use in the six months pre and post episode commencement date. It is recommended that SVHM build on its investment in the current evaluation to:

- follow up of the current cohort to look at changes in health service use at one and two years, and ideally beyond;
- conduct further economic analysis using follow up data for this cohort;
- access linked administrative data through the Victorian Data Linkage Unit to capture comprehensive history of service use of cohort.

Whilst SVHM is clearly primarily interested in the impact on service and resource demand and associated costs for its own services, there is also considerable merit in building on this evaluation research as the basis of a larger research study capturing the health and economic benefits of the highly regarded SVHM approach to homelessness. Ambulance data included in this evaluation is but one example of other resource demands associated with homelessness that are born by the wider Victorian health system.

The potential for the SVHM suite of services and its partnerships with other services (internally and externally) to contribute to the wider social and wellbeing outcomes for individuals experiencing homelessness (e.g. housing, use of community AoD services, contacts with Police and the justice system, employment etc.) is also significant, and warrants further research. The funding need not come from SVHM with a number of partnership grant schemes available in Australia that encourage partnerships between universities and not for profit organisations, including hospitals. Alternatively philanthropic funding has been obtained elsewhere to expand the Australian evidence base for efficacious intervention to address homelessness (such as occurred with the Micah project).

A pertinent and current Melbourne example of expanding an existing evaluation to add additional layers of linked administrative data is the Journey to Social Inclusion Mark II program where the evaluation of the program being undertaken by the Centre for Social Impact sought and received consent from research study participants to obtain their pre-baseline and post-baseline Victorian hospital and other health service use records. The advantage of using whole of Victorian health service use records is that it provides a more accurate picture of an individual's overall health use and of change in health service use before and after support. The Victorian Data Linkage unit has been very supportive of this work and assisted the research team in submitting the application which is presently being reviewed by the unit.

8.4.5 STRENGTHEN COLLABORATION AND SYNERGIES WITH OTHER SVHA SERVICES

Improving healthcare access and wellbeing for people experiencing homelessness is a priority shared by SVHA more broadly, and is a focal area for SVHS in particular. Recent communications from SVHA[72] and the SVHS submission to the NSW Government[110] exemplify the capacity for SVHA and its state based facilities to be significant innovators and drivers for homeless healthcare in Australia, and SVHM has much that it can contribute in this regard. There would be beneficial synergies in greater collaboration and sharing of approaches across the SVHA network. This evaluation of SVHM has shone the spotlight on a number of unique initiatives that could be adapted for other SVHA services, and conversely, there could be learning opportunities for SVHM from the way that other SVHA facilities have responded to gaps in healthcare for people who are homeless. For instance the St Vincent's Hospital Pharmacy in Sydney has instigated a partnership with the Homeless Health Outreach Service which provides free prescription medicines to members of the homeless community. This particular initiative may or may not be needed or viable in Melbourne, but this and other SVHA affiliated initiatives could be considered as SVHM moves forward in mapping out its integrated framework for homeless health for 2017 and beyond.

This evaluation has also elucidated some challenges that are possibly common across SVHS and other SVHA services that work with people who are homeless, and shared approaches to problem solving or trialling of strategies could be advantageous. Within this evaluation, difficulties such as QoL measurements and longitudinal follow up of client outcomes would do well to be spearheaded by a multi-armed approach.

8.5 CONCLUSION

Although the physical delivery of healthcare is the entry point, SVHM recognises that the causes of both homelessness and associated poor health are multifactorial, and that more tailored and multi-pronged solutions are necessary. As this evaluation has brought to light, the intent of SVHM's work with people who are homeless, and the compassion and dignity infused in the SVHM ethos and service delivery, has become highly regarded both within the SVHM network and beyond, into the wider homelessness sector in Melbourne. Through the four services central to the heart of the SVHM homelessness response; ALERT, The Cottage, Prague House and CHOPS have been shown in this evaluation to have had significant impacts at the client, service and organisational level, and have contributed to new innovations in tackling the revolving door between homelessness and health. Through their efforts, they have provided numerous lessons, points for development and a persevering encouragement for other hospitals and services to model and lend from in their own contributions to this difficult issue.

More broadly, as reflected in an editorial in the British Journal of Hospital Medicine, the care of homeless people in a hospital setting is in effect an 'acid test' for the whole system [5]. Homeless patients often have multiple health problems that challenge clinical boundaries, and almost by definition they will bring a whole collection of social problems with them to hospital. This understanding infuses the approach taken by SVHM, and we hope that the findings and recommendations of this evaluation enable SVHM to further amplify the difference it is making.

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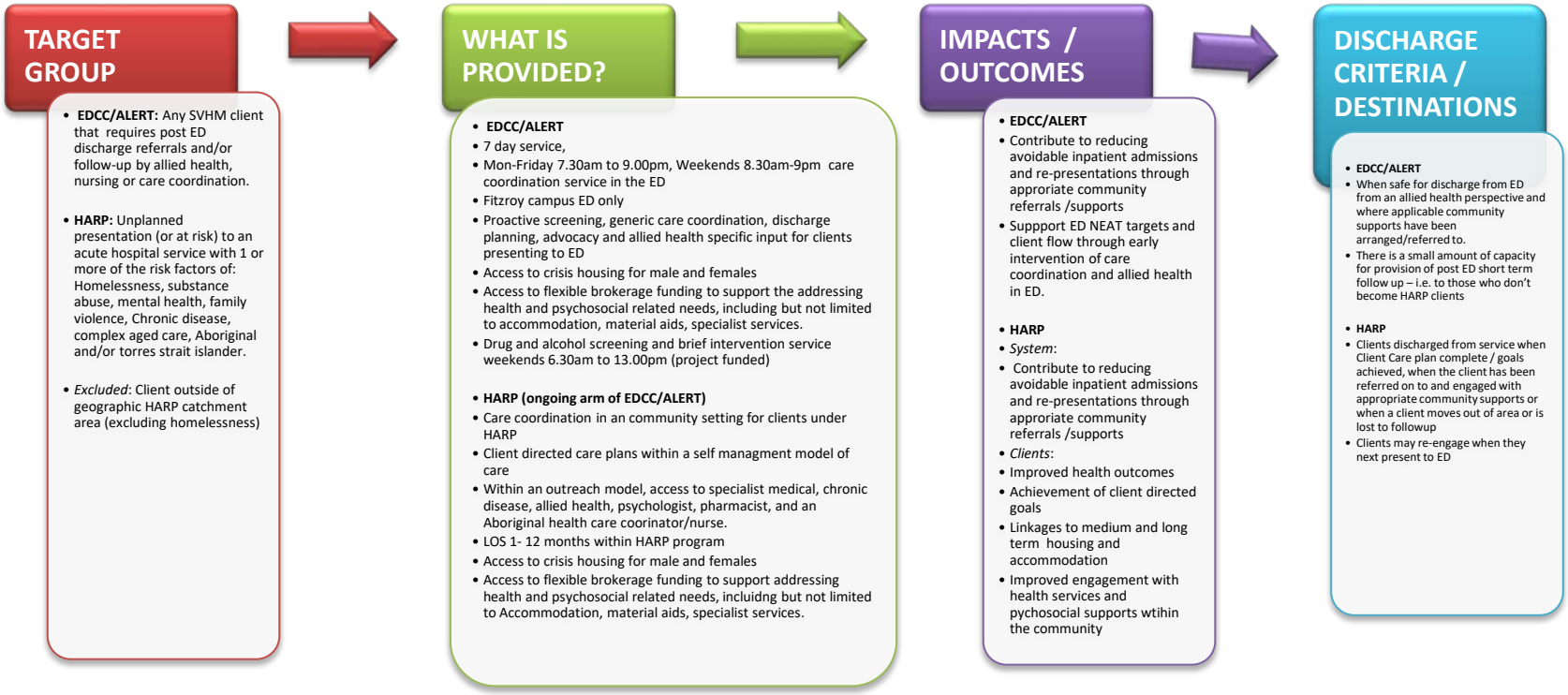
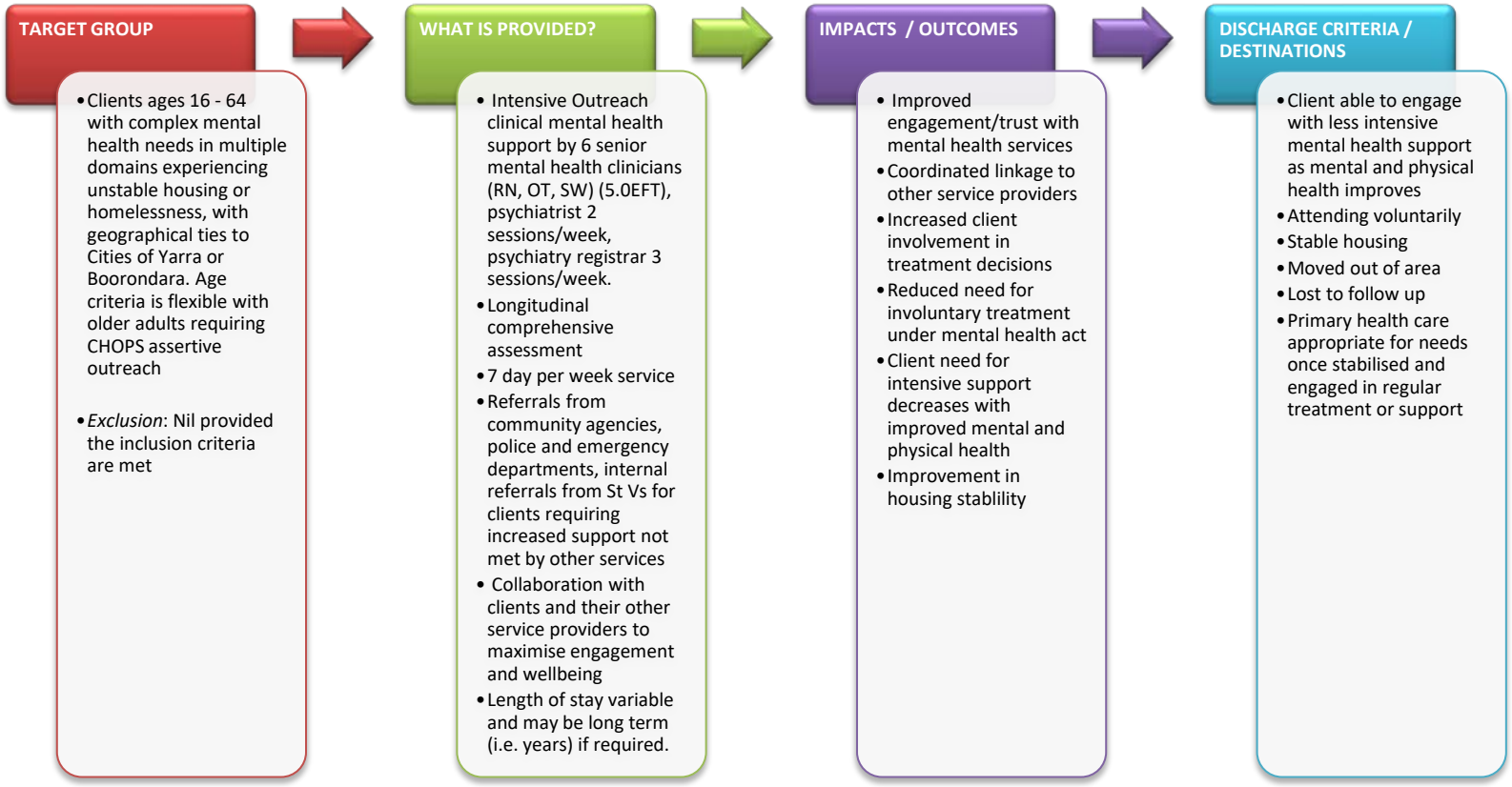
APPENDIX 1: PROGRAM LOGIC MODELS

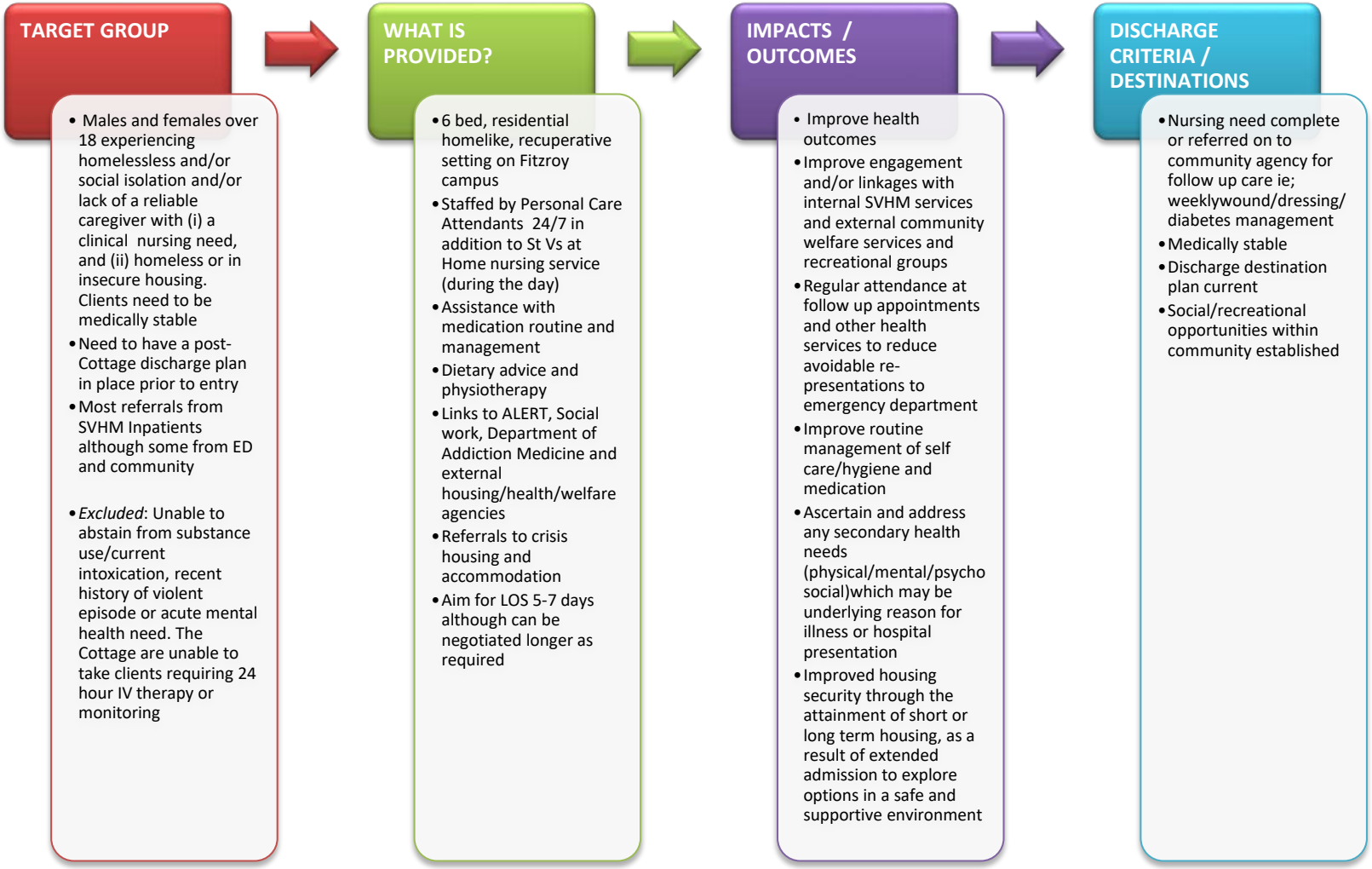
Program Logic Model: ALERT/EDCC (Emergency Dept. Care Coordination) & HARP (Hospital Admission Risk Program)



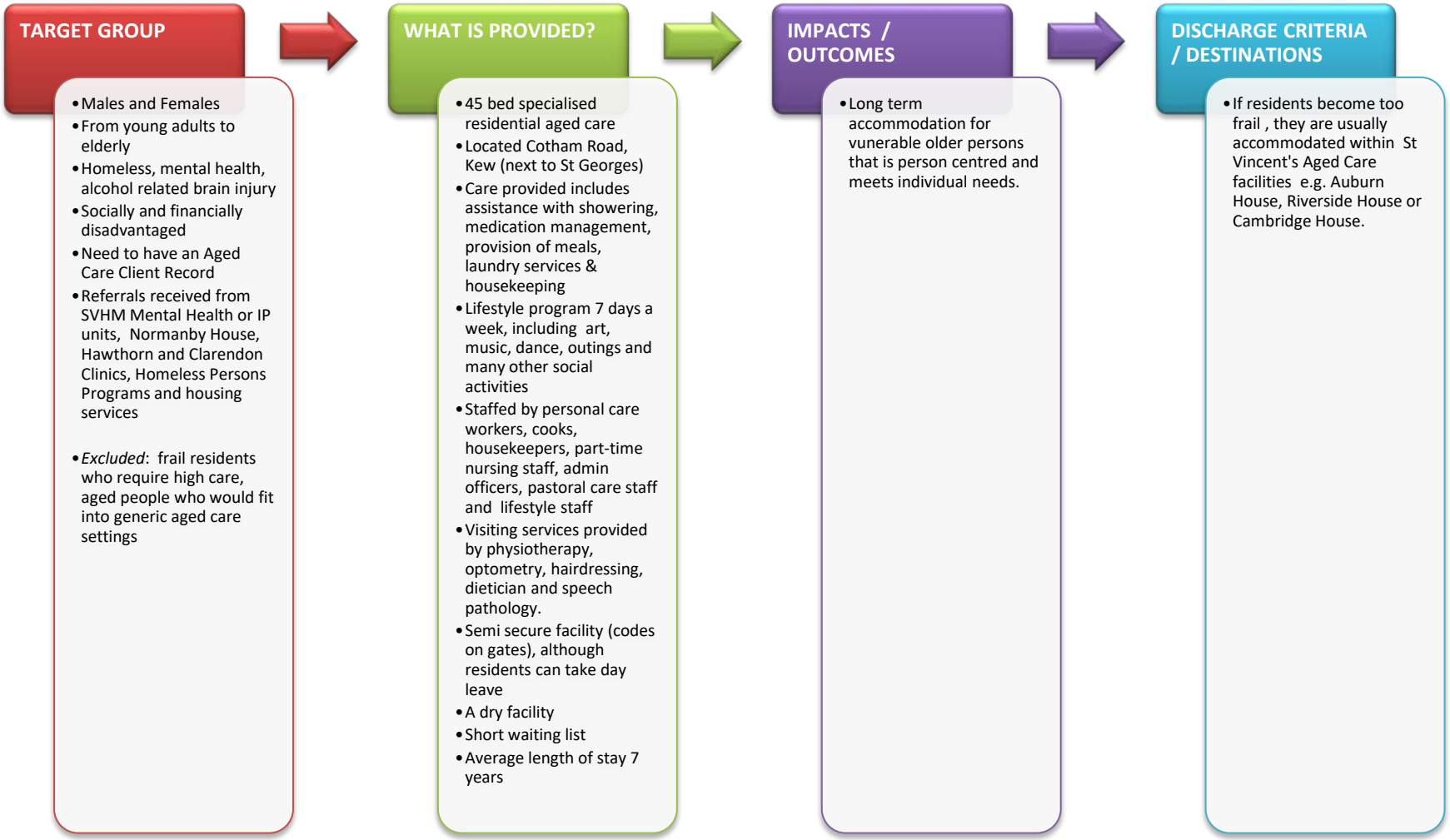
Program Logic Model: CLARENDON HOMELESS OUTREACH PROGRAM (CHOPS)



Program Logic Model: THE COTTAGE



Program Logic Model: PRAGUE HOUSE



APPENDIX 2: INTERNAL AND EXTERNAL SERVICES

Internal Stakeholders	External Stakeholders
• **Aged Care Assessment Service (ACAS)** • *Aged Psychiatry Assessment and Treatment Team (APATT)* • **Clarendon Community Mental Health Centre** • **Consult Liaison Psychiatrist** • **Crisis Assessment and Treatment Service (CATS)** • **Depaul House** • **Department of Addiction Medicine** • *Department of Gastroenterology* • *Department of Nutrition and Dietetics* • **ED Mental Health** • **Emergency Department** • **HARP – Aged Care** • **HARP – Chronic Disease** • ***HARP Physio*** • *Hawthorn Community Mental Health Centre* • **Inpatient Mental Health** • **Koori Liaison Team** • **ED Nurse** • *Respiratory Medicine* • **Social Work Department** • **St Vincent's at Home**	• *Acquired Brain Injury Service (ARBIAS)* • **Ambulance Victoria** • *Anglicare* • **coHealth Community Health – Collingwood** • **coHealth Community Health – Fitzroy** • *Common Ground* • *Community Brain Disorders Assessment &Treatment Service (CBDATS)* • **Council to Homeless Persons** • *Flagstaff Crisis Accommodation* • **Hamodava Café** • **Launch Housing – Collingwood** • **Launch Housing – Southbank** • *Melbourne City Missions' Frontyard* • *Melbourne Streets to Home* • *Multiple and Complex Needs Initiative (MACNI)* • **North Richmond Community Health (NRCH)** • **Office of Public Trustees** • **Ozanam House** • *Peter MacCallum Cancer Centre* • *Royal Dental Hospital* • **Royal District Nurse Service – Homeless Persons Program (RDNS HPP)** • *Safe Steps* • **Salvation Army** • *St Kilda Crisis Centre* • *St Mary's House of Welcome* • *St Peter's Eastern Hill* • **The Living Room** • *Victorian Police* • *Yarra Community Housing* • *Youth Support and Advocacy Service (YSAS)*

Note: **bold** indicates stakeholders spoken to and *italics* indicate stakeholders who were not spoken to for the purposes of this evaluation.

APPENDIX 3: ADDITIONAL DATA TABLES

MODE OF ARRIVAL FOR ED PRESENTATIONS

			ALERT *	The Cottage	ALERT/The Cottage **	CHOPS	Prague House	Total
AMBULANCE	Before	n(%)	177(56.2)	58(56.3)	62(57.5)	37(28.0)	7(77.8)	341(51.1)
		Mean	3.0	1.7	3.1	1.9	1.4	2.5
		Range	1-33	1-5	1-22	1-9	1-2	1-33
	After	n(%)	173(61.8)	40(35.7)	35(33.0)	17(23.0)	7(77.8)	272(46.8)
		Mean	5.1	1.5	2.5	1.2	1.4	2.9
		Range	1-61	1-5	1-7	1-2	1-2	1-61
OWN TRANSPORT	Before	n(%)	54(17.1)	20(19.4)	21(19.4)	27(20.5)	2(22.2)	124(18.6)
		Mean	1.4	1.1	1.5	1.8	1.0	1.4
		Range	1-4	1-2	1-3	1-3	1-1	1-8
	After	n(%)	36(12.9)	29(26.8)	28(26.4)	12(16.2)	1(11.1)	107(18.4)
		Mean	1.3	1.5	2.3	1.3	1.0	1.6
		Range	1-2	1-2	1-7	1-4	1-1	1-7
POLICE VEHICLE	Before	n(%)	8(2.5)	1(1.0)	1(0.9)	21(15.9)	0(0.0)	31(4.6)
		Mean	1.6	1.0	1.0	1.6	-	1.6
		Range	1-4	1-1	1-1	1-5	-	1-5
	After	n(%)	12(4.3)	0(0.0)	3(2.8)	14(18.9)	0(0.0)	29(5)
		Mean	1.3	-	1.5	1.7	-	1.5
		Range	1-3	-	1-2	1-5	-	1-5
PUBLIC TRANSPORT	Before	n(%)	19(6.0)	8(7.8)	9(8.3)	10(7.6)	0(0.0)	46(6.9)
		Mean	1.3	1.1	1.1	1.0	-	1.1
		Range	1-4	1-2	1-2	1-1	-	1-4
	After	n(%)	16(5.7)	10(8.9)	8(7.5)	7(9.5)	0(0.0)	41(7.1)
		Mean	1.1	1.2	1.1	1.7	-	1.2
		Range	1-2	1-2	1-2	1-3	-	1-3
OTHER	Before	n(%)	57(18.1)	16(15.5)	15(13.9)	37(28.0)	0(0.0)	125(18.7)
		Mean	1.4	1.2	1.4	1.8	-	1.5
		Range	1-4	1-2	1-3	1-8	-	1-8
	After	n(%)	43(15.4)	32(28.6)	32(30.2)	24(32.4)	1(11.1)	132(22.7)
		Mean	1.6	1.3	2.7	1.3	1.0	1.6
		Range	1-4	1-6	1-15	1-6	1-1	1-15

Note: N is reflective of the number of occurrences each mode of transport was used

Chi-square *$p<0.05$, **$p<0.01$

Chi-square looks at the changes in proportions over time. The Cottage ($p<0.05$) and ALERT/Cottage ($p<0.01$). So with Cottage ambulance has significantly dropped and other has significantly increased over time.

ADMISSIONS TO INPATIENT UNITS AS A RESULT OF AN ED PRESENTATIONS

			ALERT	The Cottage	ALERT/The Cottage	CHOPS	Prague House	Total
Emergency Short stay	Before	n(%)	94(68.1)	32(42.7)	30(56.6)	5(10.9)	1(12.5)	162(50.6)
		Mean	1.6	1.6	2.0	1.0	1.0	1.7
		Range	1-6	1-5	1-7	1-1	1-1	1-7
	After	n(%)	55(65.5)	21(37.5)	36(75.0)	0(0)	0(0)	112(53.3)
		Mean	2.0	1.3	3.3	-	-	2.0
		Range	1-10	1-4	1-10	-	-	1-10
General Medicine	Before	n(%)	27(19.6)	17(22.2)	11(20.8)	1(2.2)	4(50)	60(18.8)
		Mean	1.7	1.2	1.2	1.0	1.0	1.4
		Range	1-4	1-3	1-3	1-1	1-1	1-4
	After	n(%)	12(14.3)	15(26.8)	8(16.7)	1(7.1)	4(50)	40(19.0)
		Mean	1.3	1.1	1.3	1.0	1.0	1.2
		Range	1-2	1-2	1-2	1-1	1-1	1-2
Psychiatry	Before	n(%)	4(2.9)	1(1.3)	0(0)	39(84.8)	2(25.0)	46(14.4)
		Mean	1.3	1.0	-	1.4	1.0	1.3
		Range	1-2	1-1	-	1-4	1-1	1-4
	After	n(%)	4(6.0)	4(7.1)	1(2.1)	12(85.7)	2(25.0)	24(11.4)
		Mean	1.7	1.3	1.0	1.5	1.0	1.4
		Range	1-2	1-2	1-1	1-3	1-1	1-3
Other	Before	n(%)	13(9.4)	25(33.3)	12(22.6)	1(2.2)	1(12.5)	52(16.3)
		Mean	1.4	1.2	1.2	1.0	1.0	1.2
		Range	1-3	1-3	1-3	1-1	1-1	1-3
	After	n(%)	12(14.3)	16(28.6)	3(6.3)	1(7.1)	2(25.0)	34(16.2)
		Mean	1.5	1.3	1.0	1.0	2.0	1.4
		Range	1-4	1-3	1-1	1-1	2-2	1-4

N is the number of admissions to each unit

DISCHARGES TO EACH LOCATION FROM AN ED PRESENTATION

			ALERT	The Cottage	ALERT/The Cottage	CHOPS	Prague House	Total
At own risk	Before	n(%)	13(4.2)	3(3.8)	0(0)	7(5.3)	0(0)	23(3.7)
		Mean	1.6	1.0	-	1.4	-	1.4
		Range	1-6	1-1	-	1-2	-	1-6
	After	n(%)	6(2.1)	3(2.2)	6(4.8)	3(3.9)	0(0)	18(2.9)
		Mean	1.2	1.0	1.2	1.5	-	1.2
		Range	1-2	1-1	1-2	1-2	-	1-2
Home/private accommodation/ hostel	Before	n(%)	245(79.3)	66(83.5)	74(83.1)	82(62.6)	4(44.4)	471(76.3)
		Mean	2.8	1.8	3.5	2.1	1.3	2.5
		Range	1-25	1-6	1-21	1-6	1-2	1-25
	After	n(%)	211(74.0)	102(75.0)	94(75.8)	50(65.8)	6(66.7)	463(73.5)
		Mean	3.7	2.0	3.0	1.7	1.5	2.7
		Range	1-47	1-9	1-25	1-7	1-3	1-47
Left – not seen	Before	n(%)	29(9.4)	4(5.1)	8(9.0)	18(13.7)	0(0)	59(9.6)
		Mean	2.2	1.0	2.0	2.2	-	2.0
		Range	1-10	1-1	1-4	1-7	-	1-10
	After	n(%)	36(12.6)	11(8.1)	15(12.1)	15(19.7)	0(0)	77(12.2)
		Mean	2.1	1.2	1.7	1.9	-	1.8
		Range	1-11	1-3	1-5	1-4	-	1-11
Left - partial treatment	Before	n(%)	12(3.9)	2(2.5)	4(4.5)	10(7.6)	0(0)	28(4.5)
		Mean	1.7	1.0	1.0	1.7	-	1.5
		Range	1-5	1-1	1-1	1-3	-	1-5
	After	n(%)	19(6.7)	2(1.5)	5(4.0)	5(6.6)	0(0)	31(4.9)
		Mean	2.7	1.0	1.0	1.0	-	1.6
		Range	1-10	1-1	1-1	1-1	-	1-10
Transferred to another hospital	Before	n(%)	4(1.3)	0(0)	1(1.1)	2(1.5)	2(22.2)	9(1.5)
		Mean	2.0	-	1.0	1.0	1.0	1.3
		Range	1-3	-	1-1	1-1	1-1	1-3
	After	n(%)	1(0.4)	6(4.4)	0(0)	0(0)	0(0)	7(1.1)
		Mean	1.0	1.5	-	-	-	1.4
		Range	1-1	1-2	-	-	-	1-2
Other	Before	n(%)	6(1.9)	4(5.1)	2(2.2)	12(9.2)	3(33.3)	27(4.4)
		Mean	1.0	1.0	1.0	1.5	1.0	1.2
		Range	1-1	1-1	1-1	1-4	1-1	1-4
	After	n(%)	12(4.2)	12(8.8)	4(3.2)	3(3.9)	3(33.3)	34(5.4)
		Mean	1.3	1.3	2.0	1.0	1.0	1.3
		Range	1-2	1-4	2-2	1-1	1-1	1-4

N is the number of presentations.

Other includes aged care residential, returned to ward, mental health residential facility etc.

APPENDIX 4: ESTIMATED SERVICE EXPENDITURE ASSOCIATED WITH HOMELESSNESS CLIENTS

ALERT:

ALERT has both homelessness and non-homelessness clients and the service has two program components; EDCC and HARP.

Total ALERT expenditure (for homelessness & non-homelessness clients): 51.3% relates to EDCC function and 48.7% relates to HARP function.

ALERT program expenditure relating to homelessness clients is estimated based on proportion of client contacts which relate to homelessness clients. EDCC: 15% of client contacts; HARP: 64% of client contacts. Wages and salaries: EDCC; Clinical staff delivering 7 days per week extended hours multi-disciplinary care in ED, with on call telephone support to senior clinician. HARP; includes program share of administrative support and manager. Clinical staff providing multidisciplinary outreach based coordination, addressing health and psychosocial needs, with access to a range of specialist medical staff and senior clinician.

Patient related expenses: EDCC; includes taxi and Metcard vouchers provided within ED, brokerage within ED. E.g. clothing and footwear, phone and accommodation. HARP; includes purchase of crisis accommodation. Brokered patient expenses including clothing, food, phones and transport.

Direct overheads: EDCC and HARP; includes program share of administrative and team manger cost, stationary, utilities, vehicle.

HIP overheads: EDCC and HARP; Includes the service's share of the complex care services manager, evaluation and data support, program wide administration., facilities fee and software licencing costs.

The Cottage:

Wages and salaries: Personal care supervisor plus personal care workers. Staff available 24 hours a day, with sleepover shift 11pm to 7am. Functions include supervision of household running, client personal support and attendance at appointments.

SVHM nursing/physio staff: Nursing - $224,370 (95.2%). Physiotherapy - $11,400 (4.8%)

> Nursing - staff on duty during the day and on call after hours. HITH funding.
>
> Physiotherapy - physiotherapist, grade 2 mobility and falls assessment, provision of equipment PT advice and referral.

Patient related expenses: Includes internal pharmacy, food supplements

SVHM nursing patient related expenses: Incudes medication, home dressing supplies, consumables, aids and equipment.

Direct overheads: Includes utilities, phone and stationary, repairs and maintenance, laundry, grocery items and cleaning supplies.

HIP overheads: Includes the service's share of the complex care services manager, evaluation and data support, program wide administration, facilities fee and software licencing costs.

CHOPS:

Wages and salaries: Approximately 90% clinicians, and 10% management and administrative staff.

Goods and services: Allocation of Clarendon expenditure to CHOPS based on number of FTE.

Prague House:

Patient related expenses: Includes food, medication, supplies

Direct overheads: Includes professional development, admin, cars, leases, utilities, recruitment, repairs and maintenance.

APPENDIX 5: MEASURES USED TO COLLECT DATA ON HOUSING STATUS, SUPPORT AND REFERRALS FOR HOMELESS CLIENTS IN OTHER HOSPITALS AND HEALTHCARE SERVICES

	Housing status on service entry & discharge/ post intervention interventions	Types of support provided	Referrals to other services	Method of data collection	Quality of Life
Pathways UK	Street homeless (rough sleeping) Access to accommodation	• Medical treatment • Case management/ psychosocial support • Housing officer to facilitate housing access	• Primary health • Community support services • Housing • Community mental health	• Housing status is recorded by the Pathways team on admission, discharge and during future contacts with clients	• Pathways teams used a short self-complete questionnaire, the EQ-5D-5L, to measure changes in clients quality of life
St Vincent's Hospital Sydney	• Primary homelessness (rough sleeping) • Secondary homelessness (frequently move between crisis accommodation • Tertiary homelessness (boarding house etc.) • Housed	• Primary health care (COMET) • Medical treatment (SVHS) • Care coordination (Tierney House) • Short term accommodation (Tierney House)	• Housing/accommodation services • Primary health Community mental health	• All service activity undertaken by COMET is recorded in the Community Health Information Management Enterprise (CHIME). • Data on all Tierney House clients is recorded in a spreadsheet maintained by the Nurse Manager	No information on quality of life routinely collected/ available
Royal Perth Hospital	• Primary, secondary or tertiary homelessness • *Type of accommodation* (street, temporary/crisis accommodation, staying with family or friends, transitional housing) • Length of time in current housing situation • Length of time since secure housing	• Practical • Primary health • Medical treatment • Advocacy (i.e. delaying discharge) • Support (counselling)	• Housing (support priority housing application) • Community health services • Other community services (Centrelink etc.)	• RPH Homeless Team staff enter patient data into a spreadsheet	No information on quality of life routinely collected/ available

	Housing status on service entry & discharge/ post intervention interventions	Types of support provided	Referrals to other services	Method of data collection	Quality of Life
	• Primary, secondary or tertiary homelessness				
Homeless Healthcare, Perth	**Type of accommodation** • Rough sleeping • Temporary (crisis) accommodation • Medium term transitional housing • At risk of homelessness • Previously homeless	• Primary health care • Mental health • Substance use support	• Alcohol and substance use • Emergency department • Mental health • Homelessness services • Other	Homeless Healthcare staff manually enter data into a spreadsheet	No information on quality of life routinely collected/ available
Ruah Community Services: After Hours Support Service	**Type of accommodation** • Rough sleeping • Temporary housing • Transitional housing • Housed	**Basic needs** • Vouchers • Transport • Community engagement • Toiletries • Clothing • Practical support (e.g. household goods) • Medical needs	• Accommodation • Crisis • Family/Domestic Violence service • Mental health support • Health • Housing Authority • Other	Staff record nature of the support/referral provided in spreadsheet	No information on quality of life routinely collected/ available
Pathways QLD	• Rough sleepers • Scattered site public / community housing	• Supportive housing outreach (S2H, Homefront, Common Ground)		• Pathways analysis • Interviews with participants	• The (AQoL)-8D was used to assess wellbeing across a range of domains including perceived self-worth, capacity for independent living, mental health, pain and relationships

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