STREET TO HOME HEALTH

EVALUATION SNAPSHOT 1

BACKGROUND

Homeless Healthcare's **Street to Home Health** initiative commenced in late April 2020, in response to the heightened vulnerability to COVID-19 and its repercussions for people experiencing homelessness in Perth. Homeless Healthcare has observed an increase in rough sleeping in Perth since March 2020, with many people anxious about COVID-19. It is very difficult for people sleeping rough to follow the recommended COVID-19 hygiene and social distancing precautions when they don't have a safe place to live. The COVID-19 pandemic has also limited the capacity of homelessness services that street sleeping homeless populations rely on for food, support, and safe places to shelter.

Since 2016, Homeless Healthcare (HHC) has provided a Street Health outreach service in the Perth CBD, consisting of a nurse from Homeless Healthcare working alongside outreach workers from local homelessness services. The Street Health service has relied solely on philanthropic funding until recently. In April 2020, additional funding was provided by the WA Department of Health, enabling this service to be expanded to include a General Practitioner (GP) and to operate 8 hours a day, 4 days a week in Perth and 3 days a week in Fremantle.

The new **Street to Home Health** initiative also includes home visits by a GP and support worker to people who have been recently housed, but who are isolated or unable to get to clinic locations. When people have been homeless for a long period of time, the health and social challenges they face continue once housed. COVID-19 restrictions have also made it more difficult or anxiety inducing for some people to leave their homes.

WHO HAS BEEN SUPPORTED?

	ON STREET	IN HOMES
Aboriginal and/or Torres Strait Islander	36%	28%
Age Range	16-73 Y/O	16-65 Y/O
Male	65%	55%
Female	35%	44%
Gender Fluid	0%	1%

392 **103**
Number of individuals supported

1,300+
Total number of engagements

WHERE DOES STREET TO HOME HEALTH SEE PEOPLE?

The street team goes out on foot to see people on the streets and footpaths of inner-city Perth and Fremantle. This includes laneways, malls, and shop doorways as well as those in parks, or camped out in tents.

A significant majority of the home visits occur in public housing locations, including houses, flats, and units across the Perth metropolitan area

The **Street to Home Health** initiative has become an integral part of the wider work of Homeless Healthcare, that includes GP in-reach and case-workers at RPH, GP and nurse-led clinics in a range of drop-in centres and transitional accommodation, After Hours Support Service for people housed through 50 Lives, and a fixed-site clinic.

Evaluation snapshot 1: based on Street to Home Health data from 19th April to 31st August 2020

HOME 2 HEALTH
School of Population & Global Health
The University of Western Australia

THE UNIVERSITY OF WESTERN AUSTRALIA

WHAT DOES THE STREET HEALTH OUTREACH ENTAIL?

FINDING & BUILDING RAPPORT WITH PEOPLE NOT ENGAGED WITH SERVICES

This has included people who:

- Have had past distressing experiences in health system
- Are new to homelessness (including since COVID-19)
- Are reluctant to engage with homelessness or other health services
- Struggle to communicate their needs (e.g. due to trauma, psychosis, brain injury)

MENTAL HEALTH AND AOD SUPPORT

- Gently building trust and unobtrusively assessing mental health &/or AOD issues
- Informal counselling for people experiencing situation crisis and anxiety
- Referrals to mental health/AOD services, and follow up to help people navigate this
- Mental health treatment (e.g. monthly depot injections for psychosis, prescriptions)

'ON THE SPOT' PRIMARY CARE

- Wound assessment and dressings
- Diagnosis &/or treatment for asthma & respiratory conditions, infections, diabetes
- Flu vaccinations
- Checking with people how they are managing with existing conditions (e.g. epilepsy, emphysema, high blood pressure)
- Antenatal /pregnancy care

STRENGTHENING CONTINUITY OF CONNECTIONS TO OTHER SERVICES

- Input to case management with other services for people with complex needs
- Assisting people to access accommodation, get on public housing waitlist etc
- Linking/referring people to other services (eg alcohol and drug or mental health services, Aboriginal health services) and supporting this with follow up
- Locating people that other health services are concerned about (e.g. people who have self-discharged from hospital)
- Arranging GP follow-up via Homeless Healthcare clinics

STREEET OUTREACH CASE STUDY

Rory* is in his mid-thirties and has been homeless for six years. He has schizophrenia that has only been sporadically treated in the past. When he first came into contact with Street Health, Rory was very disordered in his speech, and was reluctant to acknowledge any mental health issues. He was regularly using meth and his psychosis potentially drug-induced. Outreach workers from Uniting WA often accompany the HHC nurses on street outreach in the Perth CBD, and together they have built trust and rapport with Rory over the last year. To date he has been reluctant to accept assistance with accommodation or housing, indicating he *'prefers to be outdoors'*.

In April his mental health was observed to have deteriorated, and a case conference with MCOT and Inner-City Mental Health was held. Rory re-appeared on the streets in late July, and it transpired that he had been in a mental health unit for 2 months. The Street Health team explained that they can find him on the street and provide his monthly antipsychotic depot and he has been happy for this to occur. The team continues to look out for him as they walk around the CBD. They have informed Rory of food and accommodation options, and gently broached moderating the frequency of his drug use. The collaboration between Homeless Healthcare and the Uniting WA outreach team is vital, as this further expands the network of people who are looking out for and supporting Rory while he continues to rough sleep.

*pseudonym- real names not used in case studies

Street Health nurse during outreach

"As an assertive outreach nurse for HHC I am grateful to now have GP colleagues as part of our outreach to people who are street homeless. The nurses are often seen as the 'hands on carer', showing empathy and compassion, assessing health needs and attending to immediate issues such as wounds. We can introduce people to the GP, who listens with compassion, shares medical knowledge and prescribes medication or arranges referrals to other specialist services. Together we combine our experience and knowledge to provide patient centred care to improve the health and wellbeing of people who have often fallen through the cracks of health and homelessness systems"

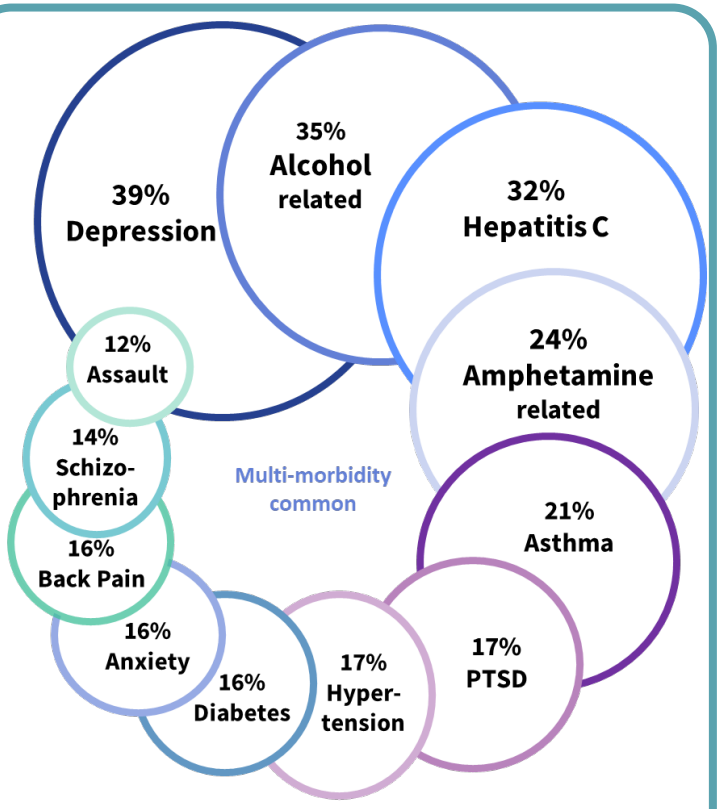
- Homeless Healthcare Nurse

HOME VISITS

While HHC nurses have previously been able to conduct after-hours home visits to patients who are part of Perth's 50 Lives 50 Homes project, the additional WA Health funding has enabled home visits for the first time by a GP and accompanied by a support worker.

MOST COMMON HEALTH CONDITIONS

among people seen on home visits



BENEFITS OF HOME VISITS

- Assist individuals who are unable to visit clinics (e.g. have young children, don't have transport, or anxious to leave their home)
- Follow up and engage patients who have missed GP or hospital appointments
- Checking on patients who are experiencing mental distress, or who have recently been discharged from hospital or commenced mental health or AOD treatment
- Avoids 'clinical setting' for people who have had traumatic experiences in the health system
- Presence of a support worker and GP allows social determinants of health to be addressed, with support worker able to provide complimentary care
- Prevents hospital presentations by timely addressing of health issues in the home

"Being able to provide home visits has been key to responding quickly to health issues thus reducing hospital presentations. Now, when patients start to become unwell they are able to receive a home visit and to get help before their condition worsens to the point of requiring hospitalisation".

– HHC Support Worker

Home visits case study

Renee is a 30-year-old female who moved to Perth in 2019 and ended up homeless and intermittently couch surfing. An extensive history of childhood trauma and family domestic violence underlies her complex mental health issues and subsequent drug use. In the 10 months prior to accommodation, Renee had 30 ED presentations and accumulated 27 inpatient days, mostly related to self-harm, suicidality and mental health. The total cost of her hospital use over this 10 month period was nearly $89,000. Hospitalisation for mental health issues is in and of itself distressing for Renee, who has said that she feels anxious in hospital settings due to past experiences of being involuntarily admitted.

Support provided through home visits

When Renee recently went through a major depressive episode, the HHC GP and support workers were able to visit her and provide supportive counselling and medication promptly, avoiding the type of hospital ED presentation that had been common the previous year. Renee has expressed that she feels more comfortable dealing with the now familiar HHC GP and support worker as she *"doesn't have to repeat her story each time".*

These home visits have been a circuit breaker for Renee and since being in accommodation and supported by HHC and the AHSS, she has had only one ED presentation (in the last 9 months). She recently moved into her own rental property, and continues to be supported by the 50 Lives After-Hours Support Service (AHSS) along with home visits from a HHC GP & support worker as needed.

SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS DURING COVID-19
FROM STREET TO HOME

HHC GP and nurse talking with one of > 500 people sleeping rough in Perth during pandemic

"The social determinants of health underlie so many medical issues we see, and this has been exacerbated during the COVID-19 pandemic. Without addressing these social issues, they perpetuate the medical problems. By using an integrated model of a GP and support worker for home visits, and a team of GP, nurse and outreach worker on the streets, we are better able to address both the medical and social aspects of people's health, enabling better outcomes than if we addressed either separately."

– Dr. Andrew Davies, Homeless Healthcare

Supporting Street Homeless During COVID-19

Whilst the general Australian population is saturated with information and advice about COVID-19 and how to protect ourselves from it, this does not necessarily reach people who don't have homes or internet/media access, or may have cognitive or literacy difficulties. As part of its street outreach, HHC has:

- Explained to people how to protect against COVIID-19 and symptoms to watch out for
- Provided advice and reassurance to people anxious about COVID-19, many who feel highly vulnerable without a home to stay safe in
- Identified and supported people to get treatment for COVID related risk factors (e.g. respiratory problems, hypertension)
- Provided tailored health education and COVID-19 fact/tips sheets especially developed for people living on the streets
- Connected people to accommodation and support options
- Administered flu vaccinations

COVID-19 Case Study – Home Visits

Fi* is in her mid-twenties and was homeless with two young children. She has had a troubled life and has several mental health issues including PTSD. Fi was recently housed but COVID-19 restrictions impacted on the availability of some of her regular support services and networks. Fi contacted Homeless Healthcare as she was feeling extremely isolated and alone during this period, exacerbated by not having a car or other means to get to places with her two young children, and no working phone.

Support Provided:

After several weeks without support, Fi's mental health and wellbeing had declined and her depression and anxiety were escalating. HHC was able to quickly put in place home visits by a GP and support worker. The option for home visits has been extremely beneficial for people like Fi. She had no car to get to a clinic, and has the added logistical challenges of doing so with two children under the age of 3 years.

As a single parent on minimal income, Fi is not in a position to pay for mental health services, and the HHC GP has been able to support her and helped her access emergency relief funds to see a psychiatrist. The rapport HHC has built up with Fi via the home visits has also meant that she feels comfortable contacting HHC when issues arise. For example, Fi was recently assaulted by someone visiting her home, resulting in an ED presentation. Worried about her children, Fi discharged as soon as she could, but requested a home visit to check on her assault wound, and this provided the GP and support worker with a valuable opportunity to provide clinical & broader care.

This is the first UWA snapshot evaluation report for the Homeless Healthcare **Street to Home Health** initiative.

For further information about:

The wider work of Homeless Healthcare see: homelesshealthcare.org.au/research/

UWA research and evaluation of Homeless Healthcare, see: www.home2health.org