Discovery Workshop

Homelessness to Health:

Improving healthcare equity for people experiencing homelessness

21 February 2025

IMAGINATION AT WORK

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Government of South Australia

Commission on Excellence and Innovation in Health

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List of Abbreviations/Definitions

A3HN	Australian Health, Housing & Homelessness Network
AAEH	Australian Alliance to End Homelessness
ACAT	Aged Care Assessment Team
ACF	Australian Childhood Foundation
ACP	Advance Care Planning
AACHO	Aboriginal Community Controlled Health Organisations
AOD	Alcohol and Other Drug
APHN	Adelaide Primary Health Network (PHN Primary Health Network)
ARVL	Andrew Russell Veteran Living
BNL	By-Name List - real time person specific database for homelessness
CALHN	Central Adelaide Local Health Network
CBIS	Community Based Information Systems - for Mental Health in SA
CBD	Central Business District
CHIA	Community Housing Industry Association of South Australia
CICC	CALHN Integrated Care Coordinator
CME	Database used by DASSA (Drug and Alcohol Services SA)
CRM	Consumer Relationship Management
CRN	Centrelink (Customer Reference Number)
CEIH	Commission on Excellence and Innovation in Health
CEO	Chief Executive Office
CRM	Customer Relationship Management
DASSA	Drug and Alcohol Services South Australia
DCP	Department for Child Protection
DCS	Department for Correctional Services
DFV	Domestic and Family Violence
DHS	Department of Human Services
DHW	Department of Health and Wellbeing
DV	Domestic Violence
DVA	Department of Veterans' Affairs
ED	Emergency Department
EMR	Electronic Medical Record
EMAT	Emergency Multi-Disciplinary Assessment Team
GP	General Practitioner
H2H	Homelessness to Home
H@H	Hospital at Home (aka Hospital in The Home) - SA Health hospitals
HYPA	Helping Young People Achieve Housing
ID	Identification
MAC	My Aged Care
MH	Mental Health
MyHR	My Health Record
MHT	Mental health Triage
MOU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO	Non-Government Organisation
NDIS	National Disability Insurance Scheme
NFP	Not For Profit organisation
OACIS	OACIS is a system used by SA Health for Pathology, Imaging and Other
PRODA	Provider Digital Access - online ID verification and authentication system
RAH	Royal Adelaide Hospital

RDNS	Royal District Nursing Services
SA	South Australia or South Australian
SAAS	South Australian Ambulance Service
SAHA	South Australian Housing Authority
SALHN	South Australian Local Health Network
SAPOL	South Australian Police
SHINE	Sexual Health Information Networking & Education
SIL	NDIS – Supported Independent Living
SUU	Sobering Up Unit
SYC	Service to Youth Council
SRF	Support Residential Facility
THA	Transitional Housing Accommodation
UTI	Urinary Tract Infection
VI	Vulnerability Index
VIC	Victoria

1 Introduction

This document provides a report on the Commission on Excellence and Innovation in Health (CEIH) design workshop on identifying opportunities to improve healthcare outcomes, equity and experiences for people who are currently experiencing homelessness. The workshop was held on 21 February 2025 at the Hindmarsh Education Centre.

2 Background

People experiencing homelessness and other vulnerabilities often face high levels of hospital re-presentation due to gaps in the effective management of their care needs. This leads to poorer health outcomes and inefficient use of healthcare resources.

A lack of integration across hospitals, primary care, housing, and social services results in fragmented service delivery. This failure to provide coordinated care creates poor outcomes and experiences for people experiencing homelessness, as well as significant challenges for workers across the system.

The fundamental question remains: How can we ensure that people experiencing homelessness have access to holistic, person-centred healthcare that meets their needs?

Through the Urgent and Emergent Care Statewide Clinical Network, concerns were raised regarding the volume and nature of presentations to metropolitan emergency departments (EDs) by a vulnerable cohort. Preliminary data highlighting these trends was initially provided. In response, CEIH undertook further data analysis and engaged in stakeholder consultation to better understand the underlying issues, identify key challenges, and explore opportunities for system-wide improvement in care delivery for this group.

In February 2025, CEIH brought together a range of stakeholders to undertake a Design Workshop.

3 Purpose

This workshop brought together stakeholders from the homelessness and healthcare sectors to explore opportunities to improve the health journeys, experiences and outcomes for people experiencing homelessness. Although primarily focused on the metropolitan area, the findings and discussions will inform future work including opportunities for scalability and sustainability across South Australia.

3.1 Workshop Participation

The workshop was held in person, with invitations extended to over 60 stakeholders from healthcare, primary (general practice, Adelaide Primary Health Network, hospital, specialist services i.e. mental health, alcohol and other drugs, SA Ambulance Service), housing (Department of Human Services, Towards Home Alliance), community housing providers, community service providers, and organisations. There was also representation from policy and advocacy bodies including Shelter SA, The Australian Alliance to End Homelessness, and the Australian Health, Housing and Homelessness Network.

CEIH would particularly like to thank the five individuals with lived experience of homelessness who generously shared their time, knowledge, and insights to support this workshop. We also extend our gratitude to LELAN and the Lived Experience & Engagement Service for facilitating this valuable opportunity.

A total of 52 participants attended the workshop (see Appendix A for the full list of attendees). Tables were intentionally arranged with a mix of disciplines to ensure a diversity of perspectives and to encourage broad, collaborative discussions.

3.2 Workshop Agenda

	Item
	Coffee & Tea & Networking Online recorded Presentation A3HN
1	**Welcome** Acknowledgement of Country
2	**CEIH Overview**
3	**Purpose of today** & how we got here
4	**Presentations: *New initiatives*** Kerbside Care Adelaide PHN – Pilot Projects
5	**Activity 1**: Service Landscape
6	**Presentation:** A3HN Recorded
7	**Activity 2:** Case Studies
8	**Activity 3:** Gaps, Challenges and Opportunities
9	**Presentations:** Streetside Medics Royal Perth Hospital Homelessness Team Lived Experience
10	**Activity 4**: What does good look like?
11	**Next Steps**
	Close

4 Workshop Activities & Outputs

4.1 Activity 1 – Understanding the Landscape

Objective:
To gain a clear view of the current service landscape and identify any gaps or emerging initiatives.

Activity Details:

- **Task 1:** Participants reviewed a provided table categorising existing embedded funded services and identified any missing services.
- **Task 2:** Groups examined a spreadsheet of current and known initiatives to CEIH, adding any additional new or emerging initiatives known to them.

See Appendix B and C for a copy of the outputs from this activity.

4.2 Activity 2 – Homelessness Case Studies

Objective:
To explore the client journey through real-life case studies.

Activity Details:
Each table was assigned a case study representing a different social scenario and health issue (e.g., rough sleeping, temporary accommodation, recently homeless, SAHA accommodation). Participants worked together to document the flow of actions they would take to support the client while considering their professional roles (e.g., social worker, nurse, case manager).

Discussion Prompts:

- Initial Contact and Identification
- Assessment & Screening
- Service Providers, Referrals, Coordination & Follow-up
- Data Capture
- Patient Journey, Outcomes & Experience
- Time & Resource Allocation
- Additional Considerations, Issues & Challenges

See Appendix D for a copy of the outputs from this activity.

4.3 Activity 3 – Identification of Gaps, Challenges, and Opportunities

Objective:
To determine where services may be falling short, identify potential overlaps or duplications, and highlight opportunities to improve connected, patient-focused care.

Activity Details:
Groups reflected on insights from the case studies and identified the **"pebbles," "rocks," and "boulders"** that interfere with delivering patient-centered care.

- **Pebbles:** Small barriers that can be addressed with minor adjustments.
- **Rocks:** Moderate challenges requiring structured intervention.
- **Boulders:** Major systemic barriers that need significant policy or service changes.

Findings were recorded on labelled butcher paper under these three categories.

See Appendix E for a copy of the outputs from this activity.

4.4 Activity 4 - Developing a Shared Vision: What Does Good Look Like?

Objective:
To create a collective vision for a successful, integrated healthcare system supporting people experiencing homelessness and to identify **Short, Medium, and Long-term** strategies to establish a cohesive, connected service network.

Activity Details:
Participants engaged in a discussion and documented essential features of an ideal system, including:

- **Interoperable Systems:** Seamless communication and data sharing.
- **Individualised Care Approaches:** Tailored to each client's needs.
- **Cross-Sector Collaboration:** Coordination among healthcare, housing, and social services.
- **Immediate Access to Care:** Minimising barriers and adopting a "no wrong door" policy.

Attendees contributed ideas on labelled butcher paper under Short-Term, Medium-Term, and Long-Term categories.

Each participant was then given three sticky dots per category (nine in total) to **place on their top three priorities** for each timeframe. While this is not a definitive decision-making tool, it provides valuable insight into where the collective group perceives the most pressing needs:

4.5 Activity Identified Short Medium and Long-Term Priorities

4.5.1 Short-Term Priorities:

- **Better Coordination & Communication**
  - Improved communication between ED, healthcare teams, and homelessness services to prevent repeat ED visits (17 votes).
- Shared resources and directories to know who to contact (2 votes).
- **Improved Access & Immediate Support**
  - No closed-door policy: Provide service wherever the person presents (2 votes).
  - Single assessment point for homeless individuals (2 votes).
  - More staff, phone lines, and specialist nurses in ED for better support (5 votes).
- **Accommodation & Housing Support**
  - Increased access to crisis, short-term, and long-term accommodation (11 votes).
- **Increased Awareness & Service Integration**
  - Increase community awareness of homelessness (2 votes).
  - Break down of silos and movement towards integrated services (2 votes).
- **Enhanced Care Delivery**
  - Homelessness staff embedded in hospitals to reduce discharge delays (2 votes).
- **Additional Priorities Raised (**No Votes):
  - No discharging patients into homelessness.
  - Lived experience co-design/input with all initiatives
  - Research into available services avoiding parallel pathways
  - Women's Shelter
  - Abstract Program
  - More empathetic, trained staff with a strong understanding of homelessness
  - Numbers for services – not one number for everyone – not helpful

4.5.2 Medium-Term Priorities:

- **Housing & Crisis Accommodation Expansion**
  - Access to short-stay accommodation for those discharged from hospitals (14 votes)

  - No waitlists – support available during intake and while waiting (9 votes)
  - Easier access to ID (Identification) for homeless individuals to access health services (5)
- **Better Healthcare Access & Case Management**
  - Homeless liaison in all EDs (13 votes).
  - Prescription data stored in EMR for continuity of care (3 votes).
  - Equitable access to primary care (3 votes).
- **Data Sharing & Service Coordination**
  - Shared data systems or key contacts across services to provide consistent support (14 votes).
  - Improved service integration between homelessness, mental health, and employment services (6 votes).
- **Peer Support & Trauma-Informed Care**
  - Increase the number of peer workers with lived experience in hospitals (Victorian example) (2 votes).
  - Increase trauma-informed housing services and case managers (11 votes).
- **Governance & Oversight Improvements**
  - Address EMR alert biases (2 votes).
- **Additional Priorities Raised** (No Votes):
  - Outreach for intakes at hospital
  - Critical health and social information accessible to outreach staff to ensure safety appropriate referrals made
  - Resources/services information database
  - Client escalation/highlighting pathways
  - Salaried GPs in this area
  - Consumers having easy access to mobile phones with data plans
  - Community paramedic model
  - Effective/comprehensive care management service
  - Broader intake criteria
  - More interim facilities
  - Better link between primary care (federal) and state-based services
  - Easy sign-up process and affordable – Better Life Mobile – specialist service for people in homelessness
  - Corrections to plan release – link with services → Judges – released without a system in place
  - Service integration – Homelessness – CMH/Admitted Services –

Employment
- Implement oversight for corrections and service linkage upon prison release.

4.5.3 Long-Term Priorities:

- **Systemic Healthcare & Housing Solutions**
  - Health services and homelessness support available 24/7 (20 votes).
  - Free primary healthcare for vulnerable people (5 votes).
- **Sustainable Housing Models & Flexibility**
  - Diversity in housing options (High/Medium/Low Density).
  - SAHA lease flexibility and long-term affordable housing models (multiple mentions).
  - Culturally appropriate housing with integrated resources (3 votes).
- **Better Funding & Workforce Development**
  - Establish Peer Work **Lived-Experience** Workforce with structured training and career pathways (6 votes).
  - Sustainable long-term funding for homelessness service providers.
- **Improved Coordination Across Agencies**
  - Unified **MOU** across service groups, SAPOL, DHS, SA Health, PHNs, and Commonwealth-funded services (7 votes).
- A **joined-up funding system** where different funding streams don't create barriers.
- **Employment & Social Integration**
  - Programs for skill development and career transition for people at risk of homelessness.
  - Integrated employment support within homelessness services.
- **Additional Priorities Raised** (No Votes):
  - Healthcare that is not profit driven
  - Build more Common Grounds – appropriate funding
  - Permanent supported housing support
  - More shelters
  - Homeless safety framework
  - Standardise housing standards – e.g. boarding houses
  - Walk-in clinic CBD – LHN (federally funded)
  - Integrated homelessness/employment (individualised approach)
  - Prescriptions provided post-incarceration

- Ageing population strategy
- Drug & alcohol issues to be treated as a health issue, not a criminal one.

5 Findings

The following key areas were identified as core recurring themes and challenges impacting service delivery and integration across sectors:

- **Barriers to Data Sharing:** Multiple systems (e.g., Sunrise, H2H, CBIS, BNL) exist but are not integrated, making cross-agency collaboration difficult.
- **Lack of Coordinated Discharge Planning:** Patients often leave hospitals without clear connections to primary care or homelessness support services.
- **Eligibility Inconsistencies:** Housing and healthcare services use different criteria, creating confusion and exclusion for some individuals.
- **Limited After-Hours Support:** Many critical services operate only during business hours, leaving gaps in crisis response.
- **System Navigation Challenges:** Individuals experiencing homelessness struggle to access services due to complex processes and requirements.
- **Gaps in Mental Health and Substance Use Support:** Many individuals with dual diagnoses fall between service areas, as some homelessness services do not accept people with acute mental health needs.
- **Limited Housing and Accommodation Options:** A shortage of crisis, short-term, and long-term accommodation exacerbates homelessness. Increasing access to appropriate housing, particularly for individuals being discharged from hospitals, is a key issue in preventing people from returning to the streets.
- **Workforce Capability Gaps**: Greater emphasis is needed on trauma-informed, empathetic, and culturally safe service delivery.

6 Next Steps

Based on the outcomes of this workshop, CEIH will undertake further analysis of the information gained, including additional analysis of data to better understand opportunities.

Stakeholders participating in the workshop and other stakeholders interested in this area who were identified through the initial engagement processes have

expressed their interest in particular aspects of the work as well as opportunities within their own organisational or service context. CEIH, pending internal governance approvals, intends to establish a project working group to facilitate and inform the next phase of activity.

CEIH is mindful of the opportunity to harness shorter term improvement strategies to support the health system with managing winter demand and has commenced further data investigation to explore frequent representations to the Central Adelaide Local Health Network ED's.

The next phase of activity will build on the outputs of the workshop to develop a prioritised approach for action across the short, medium, and long term. This work will be grounded in the guiding principles established through stakeholder engagement. CEIH proposes to establish a 'brains trust' (a 'coalition of the willing') to act as an ongoing vehicle to explore and advance opportunities and ideas for improving healthcare equity, outcomes and experiences.

The principles, collected at the workshop from participants, will be considered by the project working group and utilised to inform practice:

- Housing First
- No Wrong Door
- Adelaide Zero Possible
- Respect, Kindness, Empathy, Accessibility
- Trauma Informed
- Strengths based
- Collaborative 'with' not 'to'
- Recovery focus
- Social Determinants of Health
- All of Government
- Each experience is unique
- Agreement best practice care for those who are not successful in housing
- Don't re-invent the wheel - use previous successful models

CEIH will keep stakeholders informed through the following mechanisms:

- Regular updates to the Manager, Adelaide Zero Project and the SAAEH Service and System Integration Network
- Direct stakeholder engagement with key partners
- CEIH website and newsletter

To stay informed you can subscribe to our email list to receive our newsletter and check out our website including the Urgent and Emergent Care Statewide Clinical Network page and our Homelessness to Health project page.

7 Appendices

7.1 List of Attendees

CEIH Staff:

Katie Maiolo (Facilitator)
Monica Novick (Facilitator)
Tina Hardin (Support)
Sofia Tsoukalas (Support)
Tony Stravrou (Support)
Amanda Forbes (Support)
Van Luong (Support)

Attendance List:

Alice Clark (Shelter SA)	Lauren Moulds (DHS)
Alison Hallion (SA Housing Authority)	Lee Tong (Consumer)
Andrea Wilksch (Consumer)	Liz Sutton (CALHN)
Anna Kleinig (SALHN, Health)	Lucas Milne (SALHN, Health)
Anna Pedulla (Service to Youth Council)	Michael Traynor (Sonder)
Anna Tree (DHW, Health)	Niamh Wade (APHN)
Arieta Papadelos (DASSA, Health)	Nicholas Cowling (DHS)
Brenton Chivell (Housing)	Nicholas Mark (SA Ambulance, Health)
Carman Wilson (AAEH)	Patricia Pearson (Consumer)
Cassie Hutchison (NALHN)	Rema Alsaiedy (Sonder)
Casey Hull (CALHN)	Robb Smart (DHS)
Chris Seyfang (SALHN)	Shaun Whales (SAAS, Health)
Daniel Rowe (RDNS)	Sofia Kennedy (Nunkunwarrin Yunti)
David Holmes (SA Housing Authority	Sonia Masciantonio (So You Can)
Debbie McCarthy (SALHN)	Stephen Byrne (GP)
Duncan Bainbridge (Consumer)	Tania Sharp (Salvation Army)
Elaine Helps (NALHN)	Timothy McMahon (CALHN)
Elene Knowler-Pook (NALHN)	Trudy Gilligan (CALHN, Health)
Ezara Schell (CALHN)	Wendy Rowe (CALHN, Health)
Fiona Hopper (Housing Choices)	Andrew Denton (Salvo's Resolve Program)
Gemma Beaconsfield (Sonder)	Tarun Bastiampillai (SA Health)
Jacqueline Costanzo (DHS)	Simone Trowbridge (SA Health SALHN)
Jess Ellis (DHS)	Tameka Thompson (Hutt Street Centre)
Karen Aistrope (Carrington Cottages)	Carolyn McInarlin (Hutt Street Centre)
Kirstine Restell (CALHN, Health	Josie Crowley (DHW)
Lauren Martin (DHS)	Andrea Wilksch (Consumer)

7.2 Activity 1 – Task 1 - Existing & Missing Services

Names and Types of Services Listed by Participants		
Health Services	**NGO-NFP & Social Services**	**Housing - Policy & Advocacy**
Adult Safeguarding Unit Hutt St Centre Adelaide Zero Project Sobering Up Unit Australian National Wellbeing and Health Agency WestCare Centre - Baptist Care Department of Social Services: Disability Employment + Workforce Australia Allied Health Multi-D Team Nunkuwarrin Yunti of South Australia Inc. - Aboriginal Community Controlled Health Organisation (ACCHO) EMAT RAH ED - Emergency Multi-D Team (Time & Kirstine) - Mental Health & Emergency Assessment - Discharge Liaison Nurse (Wendy & Lisa) Virtual Care Services - SALHN DVA - Veteran's Homelessness (ARVL) Andrew Russell Veteran Living Program Regional Services DASSA (Drug and Alcohol Services South Australia) Community Mental Health Team RDNS	Council Community Services incl. Library Services Orange Sky Home in Mind (VIC Based) One Voice Street Kitchens Carrington Cottages - Independent living - transitional - stabilisation period - permanent housing Thorne Harbour SHINE DCP **Sonder:** Northern Adelaide Head to Health & Safe Haven Café **Service to Youth Council (SYC):** The Foundry, RentRight - early intervention, Independent Housing Solutions (HYPA - Helping Young People Achieve Housing), Homeless Connect SA	Homelessness SA Community Housing Industry Association of South Australia (CHIA SA)

As part of the Response for Activity 1, participants also took the opportunity to start contributing ideas on other types of **services** the system requires. Although this was not the intention of the activity to capture this data, the information gathered is invaluable and has been summarise in the following Table:

What's Missing – Ideas & Potential Solutions

Health Services	NGO-NFP & Social Services	Housing - Policy & Advocacy	Other
• Ease of access to GP's: • Appointment Booking • hard to coordinate unwell or life is chaotic • Transport • Finance • Health Co-ordination between physical & mental health • Hospital "Step-Down" for homeless consumers for access to: • Prescription access - more repeats • Medication storage and temperature control - otherwise will represent to ED's • Outreach (Assertive) Proactive • Outpatient Clinics • Aboriginal Liaison Officer - Homelessness Liaison Officer - Funded 24 hours • 24 hours Mental Health Crisis Services in all LHN's • Safe Space that is accessible • Trauma Informed Care - Holistic care • No wrong door policy • Reduce waiting times for Service Engagement Allied health Access - Podiatry, Dental etc. • Drug Rehab Facility • Options for the most vulnerable • Trauma not social issue • Virtual Care Services • Streamlined referral process from ED to essential services Common, Defined & Direct referral and working pathways • Robust Discharge Practices • Post discharge follow up	• Data-base - inclusive of all services across health and homelessness • Service Linkage - how each can link or contact each other - especially out of hours • More response from homeless connect i.e. someone on the other end of the phone • More flexibility to refer from ED Departments i.e. referrals to Kualana Temporarily • Day Centre Model in all areas • Modelling and Epidemiology • Lack of Youth Services • Lack of Rehabilitation Programs • Data: • Clinical Information Sharing within Health and across sectors • Community Resources	• Core Funding • Increased and sustainable • There is available accommodation but cannot be accessed due to a lack of funding. • Diverse & Sustainable Housing Solutions • Increase stock of risk housing accommodation. • Longer-term housing options plan • Permanent Support Housing – more common ground/housing-first models. • Expansion of Community Housing and Supported Residential Facilities. • Purpose-built housing based on clinical significance (e.g., Domestic Violence (DV) vs Drug Overdose vs Mental Health (MH)) – like the Terrace Boarding House model. • Women's Accommodation to address gender-specific housing needs. • Specialist & Transitional Housing • Immediate Housing (or Step-Down Facility) to support patient's post-discharge 24/7. • Wrap-around care and support and living skills training – learning to live in a house, social integration, ongoing case management, and increased support when transitioning into stable accommodation.	• Funding of the Services • Co-funding opportunities • Partnership between Health, Housing & Social Services i.e. health coordination and management with DHS • NDIS - Barriers are diagnosis - assessment for this cohort to then access NDIS • Corrections discharge and release from court or prison - to include the judges and judiciary - without support they will ultimately present to ED • No MOU for Health + Housing • Sharing Data with politicians and Health/Social CEO's & Leads • Frequent presenter collaboration - Understanding of who, what, where & share • Criteria Silo's – Accessibility Criteria • People Skills, Kindness • Trust in the health system • Remove costs of transferring medical records • Access support from NDIS • Specialist Homelessness Service Across the board • Flexible response

What's Missing – Ideas & Potential Solutions

Health Services	NGO-NFP & Social Services	Housing - Policy & Advocacy	Other
• Referral Processes Pathways • Discharge Letters		• Oversight reporting to the government on housing and homelessness services. • Policy development for the Housing & NGO sectors to improve integration and service coordination. • Office of Public Advocate - Public Trustee involvement in housing solutions for vulnerable individuals	

7.2.1 Appendix C - Activity 1 - Task 2: Homelessness Services: new(ish) and emerging initiatives

The following table was used to document homelessness services, responsible departments, funding sources, digital platforms for client records, health touchpoints, and any notes. (please no information for Digital platforms and Client records were provided):

Service Type	Service Name	Location	Responsible Department/ Agency	Funding Source (temp / sustainable)	Operating Hours	Criteria for Access	Notes (e.g., gaps, new services)	Status
Transitional Accommodation Program	Kurlana Padnipadninya (New Journey)	CBD	CALHN Mental Health / Salvation Army	Sustainable	24/7	Inpatient at CALHN; 18yrs+; homeless or at risk	Excludes: Individuals on the pathway to NDIS-funded Supported Independent Living (SIL), residing in Supported Residential Facilities (SRFs), Regency Green, or Transition to Home (T2H) programs, as well as those in inpatient rehabilitation or residential aged care settings.	Operational
Primary Care	CBD health outreach for homeless codesign	CBD	Adelaide PHN	APHN	TBD	TBD		Design phase
Primary Care	Enhancing healthcare access for homeless; strategic partnerships	Port Adelaide Enfield	Adelaide PHN	APHN	TBD	TBD	Focus on 20 identified rough sleepers	Design phase
Outreach healthcare	Kerbside Care Mobile Healthcare	CBD	CALHN	CALHN, donation	Pilot half day clinics	Homeless; CBD	• Research project • Volunteer service • Fitted out Ambulance as service vehicle	Design phase
Outreach healthcare	Aboriginal Connect - mobile outreach	CBD	DASSA (Drug and Alcohol Services South Australia)		Once a week	Aboriginal, homeless, CBD; will see non-Aboriginal	AOD focused but do primary care/ health intervention/screening	Operational
Alcohol	Integrated Supervised Alcohol Provision Program	TBD	DASSA (Drug and Alcohol Services South Australia)	Not funded	TBD	TBD	Model of Care	Unfunded concept
Outreach healthcare	City Paramedic	CBD	SAAS (South Australian Ambulance Services)	Not funded	TBD	TBD	Business case in draft for pilot	Scoping
Hutt Street & Sonder	Allied Health Program & Integrated Care Program	CBD	Hutt St Centre	Temp/Private Donation				

7.3 Appendix D - Activity 2 - Homelessness Case Studies

Case Study 1 – SAAS

Scenario: 45-year-old Caucasian male

Presentation: Increased sedation (drowsy), offensive-smelling urine.

Background: Sobering up unit contacted SAAS (South Australian Ambulance Services) due to concerns with sedation. Accommodation status unknown. Known frequent presenter to the emergency department. Not known to be linked to case management.

Initial Contact & Identification	Assessment & Screening	Service Providers, Referrals, Coordination & Follow-up	Data	Patient Journey (Outcomes & Experiences)	Time & Resource Allocation

• Call 000
  ○ SAAS to attend SUU (Sobering Up Unit)
  ○ Take to ED (Emergency Department)
• Safety
• Capacity for decision making
• Concerns
• Needs now vs. Future needs (Housing)
	• Possible UTI (Urinary Tract Infection)
	• Drug interaction stabilisation
	• Homeless issue not considered until medical issue/s sorted
	• Discharge considerations
	• Get History from SUU (Sobering Up Unit)
	• When in ED
	  ○ Use Sunrise history
	  ○ Ring Police for information
	  ○ Psycho-social actions
	• If medically cleared, then ready for discharge
	• Medical Action
	  ○ Screen Medical
	  ○ In-tox
	  ○ Mental health review
	• Explore/learn increase regarding Consciousness, Intoxication
	• Look at previous management plan?
		• Often disclosed at discharge time
		• Management Plan
		• Multi-D Team
		• DASSA (Drug and Alcohol Services South Australia) - Including self-referral
		• Permission to connect with:
		  ○ Homeless Connect
		  ○ DASSA
		  ○ Housing
		  ○ Other services
		• Homelessness to Alliance DCS (Department for Correction Services)
		  ○ Allocate case
			• H2H (Homelessness to Home) Access
			• Sunrise
			• dashboard required for known patients
			• SAAS Priority # how long on scene @ hospital
			• SAAS Lacks Patient Data
			• Sunrise
			• CBIS (Community Based Information Systems – Mental Health)
				• Basic medical likely to be resolved
				• Client may or may not get connected to services
				• Admitted/not admitted
				  ○ relevant Social Worker (ED or in Ward)
				• Discharge for further follow-up
				• If frequent at ED - Management Plan
				• With consent of consumer - shared data with other services
				• If (Inpatient Discharge), will have a discharge Summary
					• Depends on how well connected to the homeless sector

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Case Study 2 - Community Health

Scenario: 61-year-old Caucasian female

Presentation: Poorly controlled type 2 diabetes, insulin-dependent, non-compliant with medication. Presents with a toe wound from poorly fitted shoes.

Background: Recently homeless due to rental crisis. Not linked to case management.

Initial Contact & Identification	Assessment & Screening	Service Providers, Referrals, Coordination & Follow-up	Data	Patient Journey (Outcomes & Experiences)

• ED
  ○ Time constraints to organise
• THA (Transitional Housing Accommodation) Outreach
• Questions:
  ○ What is your address?
  ○ Links with Support?
• Hutt Street
• RDNS Nurse
• Care Finder to connect with MAC (My Aged Care)
• Meal & Shower:
• Intake (Identification) + Assessment + Referral
  ○ Health - If person doesn't identify as experiencing homelessness it won't be picked up - maybe at discharge it will be mentioned
	• Not consistent process + criteria not clear
	• Repeat information
	• Funding impact
	• No linked information
	• Good case worker - better outcomes
	• Inequitable
	• Proforma needed - housing
	• Need someone to advocate for you for housing - careful to say house available
	• Co-support between case worker + lived experience - working together to help connect - E.g. Update information
	• Knowing what rebates are available to help things happen quicker
	• Ask
	• Database/CRM
	• My Health Record
	• Barriers - Info Sharing
		• Continued level of support needed e.g. Ending Driver length of time
		  ○ Not driven by individual needs
		• Connected with: Email, Phone Call, Favour, Paper
		• Online services NOT linked
		• SA Housing - over 200 emails per day
		• No unified referral process for Housing
		• Case management needed: Multi-Agency E.g. Family Safety Framework
		• Consumer not an 'Open Book' willingness to share data/information
		  ○ People don't generally like to share
		  ○ Shame factor, trust, lost faith in system
		  ○ Connection is important to build trust
		• Sonder - Govt housing – Silo
		• Connect system for housing:
		• BNL (By-Name List – real time person specific database for homelessness) + Zero projects, Rough Sleeper – H2H (Homelessness to Home)
		• Limited Access to Data Systems - cannot see current homeless
		  ○ Temp housing
		  ○ Brief snapshot
		• Not every system is linked
		• Eligibility not always known
		• Funding checks
		• EMR
			• Privacy & Consent - Sonder
			• Repeat of background story
			• Consumer - Frustrating
			• Not consumer by choice
			  ○ Just want to get out
			• Housing SA - needs to be better accommodation e.g. air-conditioners
			• Some people unable to self-advocate and verbalise health needs
			• Majority of the patients will not adhere to the discharge plan due to the lack of access to:
			  ○ Fridge
			  ○ Medication storage
			  ○ No regular GP for follow-Up
			  ○ Compliance to self-care plan
			• Patient will most likely avoid the hospital
				• Can be up to 4 months to get the clients trust and understanding of how you as a health professional will advocate for them as an individual who is going through life crisis and unwell physically and emotionally
				• From a Diabetes Education perspective, to help that patient a referral to the 'high-risk' foot clinic at the RAH was done in the past for clients presented to Hutt St, but the patient refused to attend the appointments due to fear on consequences + stigma of homelessness ED's time constraint to organise things adequately & presenting when bad weather

Initial Contact & Identification	Assessment & Screening	Service Providers, Referrals, Coordination & Follow-up	Data	Patient Journey (Outcomes & Experiences)
	• More systems collaboration needed • Place based	• Categorisation/Criteria not consistent for acceptance for housing - mental health • WestCare Centre • Hutt Street ○ Wellbeing, Aspire, THA (Transitional Housing Accommodation), ACF (Australian Childhood Foundation) • Hospital Avoidance • Outreach > wellbeing > divert > resolve > access etc. • DASSA (Drug and Alcohol Services South Australian), • DFV (Domestic and Family Violence) Homeless Connect • Urgent 'Mental Health' care • CBIS (Community Based Information Systems for Mental Health) • EMR (Electronic Medication Records – Sunrise) • H2H (Homelessness to Home) • MHR (My Health Record) • Advance to Zero Database • BNL (By-Name List) • Penelope (Cloud based management software) • Care Connect • Sonder • MAC (My Aged Care) • RDNS (Royal District Nursing Service) system • Mental health Triage • Consent and information sharing	visits or any outpatient clinic because they are not treated by a holistic approach • Patient will most likely avoid the hospital visits or any outpatient clinic because they are not treated by a holistic approach • Patient will talk to case managers about their diabetes complications but will not do anything about it until it is too late • Mentoring, connection, emotional support, helping to find quicker ways for resolution • Confusing • Frustrating • Dis-jointed • Demoralising • Transport	

** No 'Time and Resource Allocation' points recorded by participants

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Case Study 3 - Mental Health

Scenario: 19-year-old trans woman

Presentation: Suicide ideation following a recent assault.

Background: Long-term history of rough sleeping with unstable accommodation.

Initial Contact & Identification	Assessment & Screening	Service Providers, Referrals, Coordination & Follow-up	Data	Patient Journey (Outcomes & Experiences)	Time & Resource Allocation

• Ask them when they present
• Referral received
  ○ Self-referred or not
  ○ Details on whether they are housed or not
• If presented before: No intake assessment if they have previous records
• Consumers:
  ○ First contact with system
  ○ Police if assault
  ○ Limited short-term interaction
  ○ May involve SAAS
• Preferred pronouns
  ○ Safety
  ○ Environment
• ID (3 Identifiers):
  ○ Non-Medicare
  ○ No ID
  ○ Cannot charge or collect data
	• Housing homelessness
	• Safety plan developed if need identified in screening
	• Mental Health clinician:
	  ○ To have conversation if have suicidal ideation
	  ○ Then assess options for further service deliver
	• What do you NEED? WANT?
	• Address & explain limits!
	• De-escalate
	• Safety risk align person to service
	• Start to broaden questions:
	  ○ Health
	  ○ Hormones
	  ○ GP
	  ○ Bio
	  ○ Psycho-Social
	  ▪ Family Friend Services
		• Social NGO's
		• Community nursing
		• Suicide prevention
		• SHINE SA (Sexual Health Agency)
		• Yarrow Place (Confidential Service for over 16yo's who have experiences rape or sexual assault)
		• Thorne Harbour (Health Service supporting LGBTIQ+ community)
		• Female nurse on site
		  ○ Referral out
		  ○ Suicide
		  ○ Mental Health Triage (state-based)
		• If suitable then go to urgent mental health (Grenfell Street) or call ambulance (long wait)
		• Urgent Mental Health:
		  ○ good if in acute crisis
		  ○ not good if not in active crisis
		• Community mental health
			• CALHN-EMR
			  ○ Self-reported by patient (post data fields) has patient history
			• H2H (Homeless to Home) journey:
			  ○ History
			  ○ Contacts
			  ○ Homeless case notes
			• SALHN (South Adelaide Local Health Network)
			  ○ Disclose notes section capture barriers to discharge
			  ○ Only for admission
			• Hutt Street + Penelope (data for all of Hutt Street patients)
			• Sunrise EMR
			• Sonder - Care Connect (Sonder) - internal client database
			• Consumer experience - easier when specific questions asked
			• Does data capture the story (are fields or questions the best to capture) - Need to know what information is for?
			• SAPOL
			• Sunrise
			• Paper
				• Outpatient appointment (Waiting for up to 6 hours)
				• Mental Health
				  ○ Not referred if not acute or at risk
				• Inpatient receives phone call follow-up
				• People not always referred or discharged into homeless services
				• Siloed responsibilities
				• No/little service integration
				• Homeless services always want support if you have acute
					• GP consultation is only 15min (Limitless): multiple visits maybe required
					• Would need 1/52 to make appointments
					• Referrals maybe required
					• Case Management could take 4/52
					• Is there opportunity for Early Assessment?
					• Wardli-ana (Program within Toward Home Alliance supporting the Indigenous population) - 60 people Waiting List

Initial Contact & Identification	Assessment & Screening	Service Providers, Referrals, Coordination & Follow-up	Data	Patient Journey (Outcomes & Experiences)	Time & Resource Allocation

• Introduce self and role:
  ○ LISTEN
  ○ Food and drink offered
• What do you need or want?
  ○ Making observations
  ○ Assessing risks
  ○ Priorities
  ○ Our focus vs their focus
  ○ ENVIRONMENT
	○ Reported assault - want to report? Offer support
	○ Wound
	○ Safety and Planning:
	  • Connections (Health)
	  • MH
	  • Family
	• Barriers:
	  ○ Time & Resources
	  ○ Engagement
	  ○ Right person
		○ via mental health triage manage alone MH pathway
		○ ADMIT or discharge to home(lessness)
		• SAPOL (South Australian Police)
		• Yarrow Place
		• Youth Mental Health
		  ○ Head to Health
		  ○ Head Space
		• Thorne Harbour (Sexual Health)
		• Domestic Violence line
		• Hospital?
		• MHT (Mental Health Triage – S1) 131 465
		• SAAS
		• Homeless Connect
		• Safety Plan future focus empathise
		• Connect to homeless service
			• CICC (Coordinated Intake and Case Coordination)
			• Connect to SAHA (South Australian Housing Authority)
			• NACCHO (National Aboriginal Community Controlled Health Organisation)
			• H@H (Hospital in the Home and My Home Hospital Services)
			• SAAS
			• By-Name List
				Mental Health needs
				• Homeless Services support during hospital stay and try to support post discharge - sometimes aren't aware of discharge
				• Discharge to homelessness
				• Waiting case management from homeless service
				• SAPOL
				• Yarrow Place response
				• Thorne Harbour response - not crisis	

Case Study 4 - Multicultural Support

Scenario: 70-year-old man originally from Afghanistan

Presentation: Shortness of breath and chest pain (clutching chest) at Hutt Street.

Background: Arrived in Australia 10 years ago, couch surfing in Melbourne before arriving in Adelaide 2 weeks ago. Minimal English requires an interpreter. Unable to read and write.

Initial Contact & Identification	Assessment & Screening	Service Providers, Referrals, Coordination & Follow-up	Data	Patient Journey (Outcomes & Experiences)	Time & Resource Allocation

• Contact RDNS nurse @ WestCare or Hutt St - SAAS
• ED for Immediate urgent assessment
  ○ Translator
• CICC (Coordinated Intake and Case Coordination) - Focus on assessment first then address social/alternate pathway
	• Language barrier - needs access to interpreter
	• Proved safe environment
	• Trauma informed
	• My Health Record (Sunrise) - ID Medicare
	• Psycho/Social - Other Databases
	• Functional Assessment:
	  ○ Visa Status
	  ○ Medicare
	  ○ Aged Care
		• Interpreter
		• Who is my contact person or go to person?
		• 2 weeks in Adelaide not eligible for homeless response
		• Refugee Service - for new arrivals
		• Aged city living & Hutt St
		• Admit
		• Interpreter - Cultural Communications
		• Services:
		  ○ Social Work
		  ○ Centrelink
		  ○ ACAT (Aged Care Assessment Team)
		• These services are not 24/7
			• Access Databases:
			  ○ Sunrise
			  ○ OACIS
			  ○ CME (DASSA),
			  ○ CBIS (MH)
			  ○ H2H
			  ○ Medicare (PRODA – Services SA Platform)
			  ○ My Health Record
			• NO INTEGRATION across the databases
			• Information sharing & consent
			• By Name List (Adelaide Zero Project)
				• Very messy
				• Daily access to basic support (Hutt St & WestCare)
				• No IMMEDIATE accommodation
				• Outcomes based on clinician:
				  ○ care factor
				  ○ knowledge
				• Pressure in system
				• Poor co-ordination of transition from primary care to community
				• Not like to be person centered-centric
					• Multi Service +++++ in resources contributed - with poor integration of communication - lots of duplication of work

Case Study 5 – Substance Use Disorder

Scenario: 43-year-old female

Presentation: Pressured speech (stressed), requesting immediate detox.

Background: Two children with DCP. Recently released from incarceration into homelessness. Relapsed with substance use in the last 2 months. Has contacted DCP and wants to reunify with her children.

Initial Contact & Identification	Assessment & Screening	Service Providers, Referrals, Coordination & Follow-up	Data	Patient Journey (Outcomes & Experiences)	Time & Resource Allocation

• ID (Name, Address, CRN, Medicare)
• Risk Management
• Homelessness assessment: rough sleeper, couch surfer, boarding house
• Challenges – does not consider itinerant & transient
• Risk
  ○ Suicidal
  ○ Harm to self or others
	• Drug affected?
	• MH assessment, what services is she connected?
	• Is she safe? DV?
	• Homelessness
	  ○ Ongoing access
	• Building rapport
	• VI (Vulnerability Index)
	• Time - Client always in hurry especially ones that are drug affected
		• DASSA
		• ACP (Advance Care Planning) - Referral
		• GP Referral
		• Urgent Medical Referral
		• Explore Rehab (long term)
		• Disengagement or do not return as planned
			• Name, CRN, Medicare Number
			• Phone, Challenges
			• Medical History, Prescriptions, EMR, Sunrise
			  ○ Forensic - Scripts - Impossible or 2 weeks wait
			• MHT (Mental health triage) - 7 Hr Wait times - Access 2 Minutes
			• H2H
			• CBIS
			• CCME
			• OACIS
			• NONE OF THESE SYSTEMS 'BLEEP BLEEP' TALK
				• Experience
				• Timeliness
				• Long term outcome
				• Waitlist
				• Client resources (no phone, no transport, literacy, no way to follow-up, to address to send letters or correspondence
				• When presenting need a result or immediate response
					• Client unable to wait
					  ○ Re-engagement challenge
					• Only has access to client whilst engaged
					  ○ disengagement
					• Lack of resources everyone has a waitlist
					• Everyone is stretched

7.4 Activity 3 – Gaps, Challenges, and Opportunities (Pebbles, Rocks & Boulders)

Pebbles	Rocks	Boulders

• Education - or Lack of knowledge about systems and resources
• Knowing what is available - understanding eligibility
• Lack of understanding of the housing crisis in general
• Empathy
• Stigma of Homelessness
• Lack of trust in the health system
• Previous example in hospital impacts how you relieve current services
• Communication Issues (language)
• Phone numbers/websites out of date
• Identifying the consumer appropriately
• Lack of mental health support
• AOD, Chronic
• Obtaining ongoing prescriptions
• Cost of medical services
• Better fitted shoes - prevention
• The RIGHT staff (qualifications)
• Burden on staff
• Potential of changing staff – (to support) 2 x person visits
• Have a more holistic approach
• Tighten networks
• The wrong people meet
• How can we interact with the client - outreach - other services
• Community disassociation
	• Appetite for change—personal perspective
	• Homeless situation not flagged
	• Accessing care
	• Transport options
	• Lack of flexibility
	  ○ Personal and cultural beliefs, including human perspectives + religious
	  ○ Gender
	• FDV - Females in Domestic Violence
	• Criteria exclusion—clients who don't fit the boxes
	• Prioritisation of access to service
	• Silo services
	• Poor (Varied) access to data
	• Misinformation across services
	• Lack of information or access
	• Consultant-to-consultant communication gaps
	• Fighting within our services
	• Power imbalances for consumers in services
	• Lack of trust from consumers—not getting the information needed to support them
	• Challenge in client interaction or disengagement
	  ○ Staying in contact
	  ○ Misinformation or poor historian
	  ○ No mobile phone
	• SACAT or Public Trustee barriers
	• Workforce & System Capacity
	  ○ Limited human resources
	  ○ Burnout + loss of knowledge
	• Feedback and service improvements needed at a smaller level
	• Lack of individualised medication regime
	• Total person care gaps—e.g., MH won't look at feet
		• Lack of housing
		• No emergency accommodation
		• NO HOUSING OPTIONS - Funding EA - appropriate - available stock
		• Access to GPs and being charged - prescriptions needed, so appointment required
		• Medications that need to be in a fridge - no housing or accommodation
		• Co-morbidities - treating AOD and Mental Health as the same issue
		• Medicated drugs - turn to street drugs to escape
		• Mental Health Services (Community) - early intervention
		• Social Support
		• Lack of clarity around patient/consumer capacity requirements
		• Months/year's lost trying to organise, assess functioning capacity, neuropsychology, guardian, administration
		• No legal avenues to ensure action takes place
		• Closing of doors is default - lack of clarity on responsibility
		• Overwhelmed homelessness sector
		• Service funding silos
		• Medicare Model - needs alternate funding models
		• Consumers who are not eligible for Medicare
		• Expectation to fund health care
		• No Centrelink
		• Competitive tendering impacts long-term sustainability
		• No Information Database
		  ○ System Disconnect - Databases - Information Lack of access to information
		  ○ Lack of information sharing
		  ○ How to access information - no centralised data access
		  ○ Digital - multi-systems

		• Health EMR - Housing - H2H - system disconnect • Lack of communication with housing providers • Integration (timely) - Data - Services - Clinician Knowledge • Sharing - Collaboration (not consumer-focused) • Journey of the individual similar across the spectrum • Clearer pathways to help if a patient doesn't fit precisely for one service • Linking to regional services • Explore use of Portal such as Family Safety Framework for other services • Follow-up on Discharge - who will do it? • Lost time and money • Cost of inefficient/duplicated responses ○ Starting it ALL again each time • Wait times • Mobile phone access (Better Life Mobile) • Red Alerts on EMR (will this cause bias??) • ID & Medicare Number

8 Contact

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