



Homelessness and Human Services – a Health Service Response

March 2000

South East Health



South East Health

Good Health Care

Better Health

**Homelessness and Human
Services – a Health Service
Response**

March 2000

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Foreword

There has been a prevailing belief that homeless people are older men who are down and out because of alcohol abuse. The reality is that the homeless population is quite diverse—incorporating young men with drug and alcohol-related problems, women who are victims of chaotic family situations, their young children, adolescents unable to live at home because of untenable family situations, and people of all ages with intellectual disability from traumatic brain injury and chronic brain damage, alcohol or progressive disease. There are also people of all ages with chronic impairments from mental disorders. Poverty is a feature of all their lives.

South East Health is committed to partnerships, both within our programs and with outside agencies dedicated to the care of homeless people, which identify health and illness issues for homeless people, which provide treatment and rehabilitative services for individuals' needs and which assist in improving and maintaining health status and purposeful activity for people in brokered accommodation.

We are partners with the Department of Housing and the Department of Community Services as well as a large number of government and Non Government Organisations in a wider social strategy for homelessness. We are pleased to provide this position statement on improving health services for homeless people which will guide health practitioners and administrators on our agreed future directions for this population.



Deborah Green
Chief Executive Officer

March 2000

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Executive Summary

While nearly 75% of the enumerated homeless people in South Eastern Sydney (4,000) “live” in the inner city area, an increasing number are presenting in the eastern suburbs, the St George Area and in Sutherland.

Experience in South East Health (SEH) suggests that homeless people are subject to illness problems at a rate significantly higher than the general population, and that their access to services is variable, both because of inflexibility of service provision and because of a reluctance by homeless people themselves to access services.

Health staff, voluntary agencies, Council, Police and Senior Officers in NSW Health, Community Services and Housing and the Premier’s Department have been consulted in the preparation of this Position Statement. *Homelessness and Human Services – a health service response* is an initiative of the Homelessness and Health Working Party of SEH.

This Health framework for homeless people has been developed to outline our priorities and our place in the overall strategy of collaboration by Human Services in South Eastern Sydney. The key areas of commitment addressed in this position statement within Section 11 titled, Future Directions include:

Our Mission

- To contribute to the prevention and reduction of homelessness in South Eastern Sydney and to minimise the health problems of homeless people by collaborating in providing support to affordable, safe housing.

Our Principles of service

- Healthier people
- Fairer access
- Quality Health care
- Better value

Our Organisational capacity for homelessness health

- We will appoint an Area Coordinator and Council for homelessness health;
- We will identify homeless people as a distinct client group with special needs in our community and hospital services;
- We will incorporate our principles of service to homeless people in all our facilities and programs;
- We will develop specific policies and protocols so that homeless people discharged from hospital receive appropriate after care;
- We will identify staff who will give priority in their service provision, to homeless people;
- We will develop an information system with indicators of success of care for homeless people;
- We will continue to auspice Non Government Organisations (NGOs) who provide health care to homeless people.

Our Goals of Care

- We will continue our strategies for prevention and treatment of illness among homeless people;
- We will engage homeless people with improving their continuity of care within South East Health;
- We will enhance support for primary health care clinics for homeless people;
- We will use case conferencing and intersectoral liaison for improving collaboration with partners in outside agencies;
- We will improve our evaluation techniques with database development and research projects.

1 Introduction

The Australian Bureau of Census and Statistics¹ enumerated 3600 people in various degree of homelessness in SEH in 1996. They included people living in hotels, rooming houses and refuges as well as those sleeping rough. 73% were in the Inner City Sector. In addition 456 young people aged 16-24 years received the homeless youth allowance in SEH in May 1999 but were not enumerated in the Census - perhaps because they were staying in someone else's home.

Demand for refuge places is increasing annually. High proportions of people who stay in refuges or sleep rough have mental disorders and alcohol or drug use disorders in addition to other acute and chronic conditions, particularly challenging behaviour. They lack amenities taken for granted by the rest of the community. They usually lack not only a home, but money, safety and a support network. This group includes homeless men, women with and without children, and adolescents. There are special issues for homeless Aboriginal and Torres Strait Islander people.

Factors that have increased the visibility of homeless people's issues recently include

- Devolution of NSW Health funded voluntary organisations to Area Health Services in 1996,
- Voluntary agencies' submissions to SEH on a range of matters, including the distribution of mental health resources,²
- Interest in public health issues concerning homeless people eg. infectious diseases such as hepatitis B, C and tuberculosis, as well as nutritional issues and dental caries,
- Research and service initiatives originating in Community Health which identified health care access and quality of care issues for homeless people; and
- Government initiatives around consumer concern about homeless people in the context of the Olympics,³
- Recognition that the numbers of homeless refuge 'crisis accommodation places' in the inner city has dropped from over 1000 in 1990 to approximately 400 in 1999; and
- Recent strategies to address homelessness amongst human service organisations in the inner city area

A number of NSW Department of Health policies,^{4,5,6} their locally implemented corollaries and existing South East strategies on social, emotional and behavioural health

¹ Australian Bureau of Census and Statistics(1996): Custom Tables from the 1996 Census of Population and Housing.

² Sydney City Mission, Society of St Vincent de Paul, Salvation Army, Wesley Mission and the Haymarket Foundation (1997): *Shifting the deck chairs. Homeless people and mental health services in inner city Sydney.*

³ Cox, G. (1999): *Ready! Set! Go! One year to go. It's time for action on housing and homelessness for the 2000 Olympics.* A report to the NSW State Government. Shelter New South Wales .

⁴ St Vincent's Hospital, City East Police, South Eastern and Central Ambulance (1999): *Memorandum of Understanding between Police and Health concerning people with a Mental Illness.*

⁵ Memorandum of Understanding between Commonwealth Department of Health and Aged Services / NSW Department of Health concerning provision of mental health support to homeless people in receipt or eligible for Community Aged Care Packages.

of younger people,⁷ on child protection,⁸ on mental health,⁹ mental health rehabilitation,¹⁰ mental health and accommodation,¹¹ on alcohol and other drugs¹² and the management of people with mental health and other comorbid disorders have been reviewed to establish their effectiveness for homeless people.

In developing a position on homeless people in SEH a social model has been adopted. The World Health Organisation (WHO) has defined health as not just a lack of illness or disease but a state of physical, mental and social wellbeing. Health services cannot solve the problems of homeless people but they can maximise the opportunities for homeless people to seek their assistance and can be 'welfare-oriented' enough to provide advice and advocacy in a case monitoring role.

The reasons homeless people need to be considered separately from other SEH residents in terms of their health are closely related to the reasons that they are homeless. Two of the common reasons for initial homelessness are family violence or conflict and alcohol or drug abuse. Others reasons include loss of affordable accommodation, mental illness, a term in prison, migration to the city from a country area, seeking work or pursuit of seasonal employment, and poverty. Most homeless people in South Eastern Sydney are single, or women with children; however, rarely, there are complete family groups.

Partnerships against Homelessness, auspiced by the Department of Housing; the Inner City Masterplan for Homelessness, auspiced by Department of Community Services; the Kings Cross Placement strategy, auspiced by the Premiers Department and the Case Support Management Project auspiced by the Ageing and Disability Department have all included Health representation.

The 'social strategy' for homelessness is a broad brush approach which sees the Department of Housing developing policies which increase the capacity (either by physical supply or by brokerage) for crisis accommodation, medium term accommodation and long term housing; the Department of Community Services funding NGOs to provide crisis and medium term accommodation under the Supported Accommodation Assistance Program (SAAP) and the NSW Department of Health providing services which target the health and illness needs of homeless people. All Human Services are committed to their contribution to primary and secondary prevention strategies against homelessness but their main aim is to respond to the homelessness.

John's Story

Aged in his 30's, he has slept rough and had one leg amputated. His history showed an alcohol and intravenous drug dependence, together with cirrhosis. There was an infection in his stump and he had no crutches. He was supplied with crutches and admission arrangements made for him to enter an NGO hostel with nursing

⁶ NSW Housing Department and NSW Department of Health (1999): *Joint Guarantee of Service For People With A Mental Illness.*

⁷ SEH (2000): *Strategy for the Management of the Social, Emotional, Behavioural Health of Younger People*

⁸ SEH (1999): *Towards a Child Protecting Culture.*

⁹ SEH (1998): *Mental Health Strategic Plan 1991-2004*

¹⁰ SEH (2000): *Strategic Plan for Mental Health Rehabilitation Services*

¹¹ SEH (1999): *Strategic Directions for Housing and Accommodation Support 1999-2001 (Area Mental Health Program)*

¹² SESAHS (1997): *Alcohol and Other Drugs Strategic Plan*

2 Definitions of Homelessness

Homelessness is a socially determined and relative concept and is consequently difficult to define and therefore difficult to measure. Homeless people are often taken to be people who live on the street or spend the night in a refuge, but in a society where home ownership and home rental are the norms, less secure forms of tenure are frequently regarded as equivalent in many social respects to absolute homelessness.

2.1 The Australian Bureau of Statistics 's definition

The Australian Bureau of Statistics defines levels of homelessness in *Counting the Homeless: Implications for Policy Development*:¹³:

Primary homelessness: People without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter.

Secondary homelessness: People who move frequently from one form of temporary shelter to another. It covers people using emergency accommodation (such as hostels for the homeless or night shelters); teenagers staying in youth refuges; women and children escaping domestic violence (staying in women's refuges); people residing temporarily with other families (because they have no accommodation of their own); and those using boarding houses on an occasional or intermittent basis.

Tertiary homelessness: People who live in boarding houses on a medium to long term basis. Residents of private boarding houses do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; their accommodation is not self-contained; and they do not have the security of tenure provided by a lease.

Marginally housed: People in housing situations close to the minimum standard.

Culturally recognised exceptions: where it is inappropriate to apply the minimum standard-e.g. gaols, student halls or residence, nursing homes etc.

The Australian Bureau of Statistics advised that at the 1996 Census in SEH the numbers of homeless people were:

Primary homeless :	125 persons
Secondary homeless :	745 persons
Tertiary homeless:	2756 persons
TOTAL:	3625 persons

2.2 Demographics

There were 2826 men and 799 women counted as homeless on Census night 1996 in SEH. They were distributed across all local government areas of SEH^{14 15}

TABLE 1: SUMMARY OF HOMELESS PERSONS BY SECTOR

SEH Sectors	Males	Females	Persons	Percent
Eastern Sector	561	160	721	20%
Inner Sector	2067	568	2635	73%
St. George Sector	134	46	180	5%
Sutherland Sector	63	26	89	2%
SEH	2826	799	3625	100%

There were 1206 (33.3%) homeless people aged 50 years or more, of whom 656 (18.1% of the total) were aged at least 60 years.

There were 76 (5.2%) homeless children enumerated under 15 years and 111 homeless people aged 15-19 years, of whom 49 (44%) were women. There were 53 homeless children under 15 years of age counted in Sydney and South Sydney LGAs and 11 in Sutherland LGA.

The Census enumeration practices included travelling with a van that provided free food to inner city homeless people, filling out 97 short forms from people they could approach and another 60 for people they could not approach. Northwood¹⁶ concluded that the overall coverage of homeless people across the country was uneven on Census night, resulting on the whole in under enumeration of street people in some locations (suburban locations for instance), in squats and places where it may have been unsafe to venture.

Demographic detail can be found in Appendix A.

2.3 Density

A Victorian document¹⁷ describes different strategies for homeless people based on high, medium and low density areas. Consistent with this document the Inner City sector would

¹³ Butterfield, M. (1999): *Defining the homeless* Draft strategy for enumeration of homeless people in the 1996 census ABS Canberra

¹⁴ The inner city sector comprises the SEH parts of Sydney and South Sydney LGAs, Woollahra municipality and half of Waverley. The eastern sector comprises half of Waverley, Randwick and Botany LGAs. St. George comprises Rockdale, Kogarah and Hurstville LGAs. Sutherland sector is Sutherland LGA.

¹⁵ Students are excluded from these tables if they are living in boarding houses or hotels. In the eastern sector 259 students were in this type of accommodation, in the inner sector 482 and in the St George and Sutherland sectors 6 students and 17 students respectively.

¹⁶ Northwood, K.(1997): *Census Enumeration Strategy*, Canberra Australian Bureau of Statistics, Canberra.

¹⁷ Royal District Nursing Service (1999): *A framework for improving health outcomes for people experiencing homelessness in Victoria*

be high density, the Eastern sector would be medium density and the St George and Sutherland sectors would be low density areas.

2.4 Supported Accommodation Assistance Act 1994

The Supported Accommodation Assistance Act 1994 (SAAP) states that a person is homeless if s/he has inadequate access to safe/secure housing i.e. that the only housing to which s/he has access:

- Damages or is likely to damage, the person's health, or
- Threatens the person's safety, or marginalises the person through failing to provide access to
 - (a). Adequate personal amenities, or
 - (b). The economic and social supports a home normally affords; or
- Places the person in circumstances that threaten or adversely affect the adequacy, safety, security and affordability of that housing.^{18,19}

Using this definition, women in a situation of domestic violence or emotional abuse, a person living in a caravan park and the occupants of many single rooms, boarding houses and private hotels could all be described as homeless. Based on both clinical experience and research, the level of disability and disadvantage among tertiary homeless people may be equivalent in most cases to that of people with primary and secondary homelessness.^{20,21, 22}

Estimates of homeless persons originate mainly from the records of accommodation facilities used by them. Estimating the numbers and locations of homeless persons has therefore been heavily dependent on the availability and distribution of such accommodation.

The Department of Urban Affairs and Planning (DUAP) surveyed privately owned low income accommodation in South Sydney²³ in 1998 and found 134 boarding or lodging houses with an estimated resident population of about 1600 people. A further 47 boarding houses with 486 rooms are in the City of Sydney.²⁴

SAAP funded places (auspiced by the Department of Community Services) numbered 990 in South Eastern Sydney in 1997.

¹⁸ Department of Family and Community Services at <http://www.facs.gov.au>

¹⁹ Millsom, A.(1998): Defining Homelessness in the Aboriginal and Torres Strait Islander Context. *Parity* 11(4) May, pp5-6

²⁰ Russell, C., Hill, B. and Basser, M. (1996): Identifying needs among 'at risk' older people: does anybody here speak health promotion? In Michiello, V., Chappell, N., Kendig, H., Walker, A. (ed) *Sociology of Ageing: international perspectives*. Melbourne, International Sociological Association Research Committee on Ageing:

²¹ Kavanagh, K.(1997): *The Battlers Elderly people residing in insecure housing*. Mercy Family Care

²² Hodder, T., Teeson, M. and Buhrich, N. (1998): *Down and Out in Sydney. Prevalence of mental disorder, disability and health service use among homeless people in inner Sydney* Research Group in Mental Health and Homelessness

²³ Davidson, A., Phibbs, & P., Cox, G. (1998): *Inner Sydney Boarding Houses survey draft report*, Department of Urban Affairs and Planning

²⁴ Sydney City Council (1996): *Sydney City housing strategy: draft report*. pp44-46

2.5 Youth allowance

There are a large number of young people in South Eastern Sydney who are homeless and in receipt of the independent rate of the youth allowance because it is unreasonable for them to live at home (domestic violence or abuse etc).

TABLE 2: DISTRIBUTION OF YOUNG PEOPLE RECEIVING THE INDEPENDENT RATE OF YOUTH ALLOWANCE

Area	Males	Females	Persons
Inner Sector * Postcodes	80	136	216
Eastern Sector * Postcodes	124	164	288
St George Postcodes	116	133	249
Sutherland Postcodes	62	89	151
Total youth allowance	380	526	906
Total additional to Census 1996 estimate	77	379	456

** Data have been proportionately allocated to sectors for eastern and inner city sectors*

Numbers of young people in SEH who were unsupported by family and not at home because of domestic violence were: 38 (25 girls and 13 boys); because of sexual abuse: 8 girls; because of serious family breakdown: 539 (232 males and 307 females); because of the family being homeless 29 (14 males and 15 females). There were also 132 transfers from the Austudy Homeless rate, of whom 82 were female and 50 male. Conditions of eligibility for the Youth Allowance –“independent rate because unreasonable to live at home” are included in Appendix B.

2.6 “Living in unstable family circumstances”

The Australian Bureau of Statistics conducted a representative survey of women in Australia (1996)²⁵ that yielded estimates of 2.6% of women having experienced physical violence in the last year and 9% having experienced current emotional violence. Lifetime prevalence of physical violence was 23% and 23.9 % reported that they lived in fear. The application of these estimates to the families of SEH would yield 1,400 families where the woman was subject to physical abuse and 4,800 where she was subject to emotional violence; thus an estimated 1400-4800 families in “unstable family circumstances”.

²⁵ McLennan, W. (1996): *Women’s Safety Australia*

3 Causes of Homelessness

The NHMRC report on the *Health Needs of Homeless Youth*²⁶ includes amongst the physical and psychosocial health problems contributing to homelessness:

- Difficulties in communication and interaction within families, including family breakdown;
- Personality factors, (mental illness is less commonly causative than in later life);
- Physical, sexual and emotional abuse, reported in 30 - 60% of young homeless people; and
- Low self esteem that may be an antecedent to homelessness, but is commonly a consequence of it.

The report states that poverty and unemployment are both causally and consequentially related to homelessness.

Of 104 adolescent interviewees in a Salvation Army Report, *No Place That's Home*,²⁷ 22% said their own alcohol or drug usage contributed to their becoming homeless and 19% also cited their parents' alcohol / drug usage as a factor.

The City of Sydney Homeless Persons Information Centre (HPIC) records the primary reasons for homelessness given by callers as financial difficulty, domestic violence, family breakdown, interpersonal conflict, crisis evictions, overcrowding and substance abuse. Long term homeless people, people travelling from interstate or intrastate and itinerants comprise 20-25% of people contacting the Centre. (Table 3)

The fluctuations in the private housing market, national economic policies, the decline in rural communities and possibly the worldwide reduction in demand for unskilled labour are all factors contributing to homelessness. Legalised gambling and breweries, in taking financial advantage of patrons' weaknesses, also contribute indirectly to the causation and maintenance of homelessness among those homeless people whose drinking or gambling is out of control and amongst those women and young people who become homeless in a response to drunken violence.

In Sydney there is a lack of affordable housing. The wait for public housing is approximately 8 years, with upwards of 100,000 people on waiting lists.

²⁶ National Health and Medical Research Council (NHMRC), (1992) *Health Needs of Homeless Youth*; a summary of the key health issues for those developing policies or services for homeless young people. Cat No 9210829 Canberra

²⁷ Salvation Army Oasis Youth Support Network and Community Relations Department (1998): *The Salvation Army Response to Youth Homelessness*. Salvation Army Eastern Territory, Sydney

**TABLE 3: PRIMARY REASONS FOR HOMELESSNESS IN SOUTH EASTERN SYDNEY
ACCORDING TO THE HOMELESS PERSONS' INFORMATION CENTRE
RECORDS 1998**

Primary Reasons	Number of persons	Percent
Financial difficulty (not due to unemployment or gambling)	1702	22.6%
Crisis eviction	680	9.0%
Family breakdown	605	8.0%
Domestic violence	652	11.5%
Long term homeless	397	5.3%
Inter-personal conflict	512	6.7%
Substance abuse	535	7.1%
Arrived from interstate	505	6.7%
Arrived from intrastate	299	4.0%
Previous SAAP accommodation ended	174	2.3%
Medical condition	126	1.7%
Psych illness	216	2.9%
Recently released from prison	111	1.5%
Itinerant	225	3.0%
At imminent risk of homelessness	36	0.5%
Overcrowding	184	2.4%
Physical /emotional abuse	69	0.9%
Unemployment	59	0.8%
Gambling	61	0.8%
Other	214	2.8%
Total	7526	100%

Source: Homeless Persons Information Centre

Implication

For preventative health reasons more research will be conducted on the factors contributing to homelessness, both in the outer metropolitan and inner city areas of South Eastern Sydney

4 Some Consequences of Homelessness

4.1 Adults

Consequences of homelessness for adults include difficulty recuperating from illness,²⁸ exposure to gratuitous violence, theft of possessions, social isolation, exposure to extremes of weather, malnutrition, low self esteem, poverty and poor continuity of needed health care because of difficulty locating the person or their failure to keep appointments. They may nevertheless feel less mental distress unconfined in this way, and for this reason actively pursue an outdoor lifestyle. In other circumstances, absolute homelessness reflects either a lack of any acceptable accommodation options or any affordable ones. Additionally, lack of income is usual among people who are homeless.

Implication

Homeless people are poor, isolated and generally unwell.

4.2 Young people

For youth, the consequences of homelessness include lost educational opportunities, unemployment and additional barriers to gaining a job.²⁹ There is greater risk of suicide because there are fewer people around them who are alert to a young person with suicidal tendencies and able or willing to help⁷. Mental illness occurs at three times the rate among other young people, particularly related to past trauma history, self-mutilation, and unrecognised depression.³⁰

Lowered self esteem, feelings of lack of control, social isolation, feelings of hopelessness, sleeping problems and exposure to sexually transmitted diseases from multiple sexual partners are common.⁷

Also common are physical and sexual abuse with their sequelae of anger and felt powerlessness, physical injury and disease. Other consequences of homelessness can include pregnancies, with apparently higher miscarriage and prematurity rates and a high risk to surviving children of abuse and neglect.

Young people are likely to have left home because of family conflict or abuse, and they are at high risk of sexual abuse, prostitution, drug use, suicide, developmental issues and gender problems. Mood disorders are likely. Child protection is a particular issue with homeless youths both as victims and as high risk parents⁸.

²⁸ Posenelli, S. (1998): The Cottage Project – a Safety Net. *Health Issues* :27-31

²⁹ Burdekin, B., Carter, J., Dethlefs, W.A. (1989): *Our Homeless Children*. Report of the National Inquiry into Homeless Children by the Human Rights and Equal Opportunity Commission. AGPS, Canberra

³⁰ Background to youth homelessness <http://www.interchange.net.au/hhb/hhb52.htm>

Fewer accommodation and detoxification places cater for homeless people under 21 years of age. If under 16 years old, fewer still find shelter. At the Matthew Talbot Hostel the average age is 27 years.

The Drift Project in Sutherland is seeking to reduce the incidence of youth homelessness by intervening with high risk young people.

As Einfeld and Dean note in the *Strategy on Emotional, Behavioural and Social Health Services for Younger People*,³¹ clinic-based child and adolescent mental health services are unlikely to reach most homeless youths, even if they need the service. Outreach work with young people and consultation with voluntary agency staff such as those in the city's street work based youth services can make mental health assistance more accessible.

Implication

The profiling for this position statement has highlighted the large numbers of young people who are now 'down and out' in Sydney. This has implications for health services in our social health programs and priority is being given in policy development and advocacy for homeless young people.

4.3 People with cognitive difficulties

People with cognitive difficulties may lack the capacity to sustain normal work practices and self-protective behaviours and are therefore, if homeless, exposed to theft, isolation and often violence. Their cognitive status may preclude regular attendance for attention to infections or wounds and they are unable to manage chronic conditions such as diabetes or hypertension themselves.

Implication

People with cognitive difficulties are a major challenge for human services and a priority for intersectoral activities for both social welfare and health reasons.

³¹ Einfeld, S. and Dean, C. (2000): *South East Health Strategy for the social , emotional and behavioural health of younger people*.

4.4 Women victims of violence

Initially many women become homeless as a result of domestic violence or family breakdown. Health problems include a high prevalence include mood and other psychiatric disorders. Child management difficulties can also be expected to be prevalent. It needs to be remembered that where a woman is homeless because of domestic violence, any children of the household have also been victims of the violence. Community health services in other states provide programs to assist women to manage the effects of domestic violence, promote help-seeking by the men and to assist behaviour change among motivated men.^{32,33}

All women, with or without children, who are homeless because of an untenable domestic situation are likely to have a post-traumatic stress disorder and to have been victims of assault. Behavioural and developmental problems such as stress reactions and conduct disorders with their children are also likely. The high exposure to abuse and violence among homeless women is probably both prior to and subsequent to their homelessness. Homeless women are especially vulnerable to being sexually assaulted, however few of them access Sexual Assault Services.

Focus groups with homeless women in the Homeless Women's Speakout Against Violence in October 1998³⁴ raised the following safety issues:

- Women identified a need for places where they could "hang out, just be". They also identified a need equivalent to a Proclaimed Place for women where mentally ill, intoxicated or drug affected women could safely stay.
- Working girls" often are spat on when working the Cross, while others felt safe in the Cross.
- On occasion even refuges or hostels reported that refuges could be violent places. Security video surveillance and all-women hostels made some feel safer. Safety for women in hostels meant having their own lockable room.
- Communications by women who were sex workers or "junkies," when they were threatened or injured, were often discounted by police. Several women expressed a need for outreach women's health, and women's mental health workers.

A second Speakout held in October 1999 identified the following factors as assisting homeless women in the inner city to feel safer: safe houses for women, companionship from other women in similar circumstances, police on the beat, women's own skills and abilities and physical improvements in the urban environment.

³² Moorhead, S.(1997): Melton Family Violence Program 1997 Awards for Innovation and Excellence in Primary Health Care-Community Support. *Australian Journal of Primary Health Interchange* (2&3): 67-69.

³³ Northern Metropolitan Community Health Service.(1999): *Stopping Violence Groups*. Salisbury SA presented at Primary Health Care Evaluation Conference 30 June –1st July 1999 Adelaide.

³⁴ Attorney General's Department, Violence Against Women Specialist Unit (1999): *Homeless Women SPEAKOUT against Violence*.

Both the 1998 and the 1999 Speakouts indicated the everyday prevalence of violence for homeless women as well as past experiences of domestic violence. Domestic violence was often the precipitating cause of homelessness.

Health service providers report that homeless women are unlikely to make use of sexual and reproductive health services. Consequently they have low participation rates in cervical and breast screening services and do not have access to contraceptive advice.

Malnutrition and drug use may result in irregular menstruation and contribute to unplanned pregnancy, poor maternal and neonatal outcomes and disease in later life eg osteoporosis.

4.5 Women with children

Local observations have suggested that secondary and tertiary homeless women with children do not access early childhood health services or play groups. These mothers in the Inner Sector are often on methadone or may be intravenous drug users and may have comorbid mental disorders. Single homeless women in the Inner Sector commonly have a substance use disorder and/or a mental disorder, and are likely to have been victims of assault.

Lisa and Ollie's story

She is on methadone as is the father of the child. She is unusual amongst homeless women because she still has custody of her child. She is a highly anxious, even hysterical woman in her teens or early twenties. Until recently they were absolutely homeless. She now rents a room in an inner city rooming house. There is no separate space for her 2 year old son. Since there is nowhere to socialise where she lives nor that she can go with her child and feel comfortable, she visits the day centre of an NGO for homeless people that offers free meals at lunchtime.

The child does not obtain suitable food at the day centre. There are no toys; sometimes there are other small children. If he runs around he annoys the other adults. His mother worries he may eat the cigarette butts littering the floor, so he is commonly restrained in a stroller in the centre. Mum's partner and his friends are there daily - she sometimes has another similarly situated girl or two with whom she can talk.

Outside the centre is the footpath and a busy road. One day Ollie slipped away and disappeared down steep stairs in the centre, pulling the self-locking door shut behind him. He fell down the stairs and was hurt. No-one saw him go.

This child was allegedly sexually abused by a homeless resident of the refuge, a man with a currently unmedicated mental illness. They were all at a function at another NGO's city premises. The Joint Investigation Team were involved in the investigation of this incident- the woman still attends the day centre.

Studies of homeless women^{35,36} have reported high levels of previous abuse and current psychiatric morbidity as well as poor social networks when compared to housed controls. Children of these women are more likely to have histories of abuse, of living in foster care, having been notified for child abuse and having disrupted schooling. Children have marked psychosocial problems best predicted by the mother's psychiatric problems.

The high rate of child neglect among drug dependent mothers is relevant to women who are both drug dependent and homeless.³⁷

Post traumatic stress disorders have been found to be common among women domestic violence victims presenting at Emergency Departments.^{38,39}

4.6 Men

Men are seen as the "typical" homeless people and are predominant. Perhaps more at risk from family breakdown, unemployment and substance use disorders than women, men's greater prevalence among homeless people has also to do with their problems with interpersonal and domestic skills.

Their rehabilitative needs, if to be effective, have to cover these concerns. Research completed with older second degree relatively homeless men showed they had pride in how they coped and were inured to hardships. They expressed little dissatisfaction with their substandard living conditions, much attachment to the locality in which they lived and little awareness of support services that could assist them.^{40,41}

³⁵ Efron, D., Sewell, J.R., Horn, M., Jewell, F. (1996): Children in homeless families in Melbourne: health status and use of health services. *Med J Aust* 165(11-12): 630-633

³⁶ Vostanis, P., Grattan, E., Cumella, S., Winchester, C. (1997): Psychosocial functioning of homeless children. *J American Academy of Child and Adolescent Psychiatry* 36(7): 881-889

³⁷ Kermode, M., Crofts, N., Miller, P., Speed, B., Streeton, J. (1997): Health indicators and risks among people experiencing homelessness in Melbourne 1995-96. *AustNZ J Pub Health* 22(4) 464-470

³⁸ Roberts, G., Lawrence, J.M., Williams, G.M., Raphael, B. (1998): The impact of domestic violence on women's mental health. *Aust & NZ J Public Health* 22(7): 796-801.

³⁹ Soloman, S. D. (1999): Interventions for acute trauma response. *Current Opinions in Psychiatry* 12(2) March 1999 175-180

⁴⁰ Russell, C., Hill, B.J., Basser, M.L. (1996): Identifying needs among 'at risk' older people: does anybody here speak health promotion? In: Miichiello, V., Chappell, N., Kendig, H., Waler, A., (ed) *Sociology of Aging: international perspectives*. Melbourne, International Sociological Association Research Committee on Ageing: 378-93

⁴¹ Russell, C., Hill, B.J., Basser, M.L. (1998): Older People's Lives in the Inner City: Hazardous or rewarding? *Aust and NZ J Public Health* 22(1): 98-106

Joe's story

In his 60's or 70's, he was a resident of the medium term hostel section of an NGO when welfare staff first referred him to the community nurse. There was a history of alcohol abuse. The nurse in turn asked the physiotherapist to assess him because the man complained of pain in his leg and had difficulty walking. The physiotherapist referred him to Rheumatology Outpatients. The rheumatologist found no arthritis and discharged him.

He was lost to view after a bout in one hospital, from where he was admitted to a nursing home. Six months later he was on the street. He had absconded from the nursing home and visited a familiar GP, after sleeping on the floor of a mate's house for a night. This GP contacted the community nurse, who went to assess the man. His presentation was scruffy and undernourished; his leg pain now had a diagnosis of advanced spinal cancer.

Joe was unwillingly discharged after several weeks of hospice care, with an aged hostel placement arranged for the next day at 4pm. He presented to a hospital emergency department again which called the community nurse – please find him accommodation. There was none available for the one night until the aged hostel care became available for him. The hospital would not admit him. The hospice was full. The only place available was a proclaimed place for intoxicated persons- 5pm to 9 am - and it was very rough. It was arranged for him to attend a frail aged day centre to shower and he received food and supervision until the hostel bed for indigent persons became free in the afternoon. His last home.

4.7 Aboriginal People and Torres Strait Islanders

“Homelessness was not a concept in Aboriginal belief. This belief is a sense of belonging, of land and country, so homelessness is not always (about) a roof and four walls.”⁴² Persons of Aboriginal origin constitute 8% of the National SAAP client group but are only 2% of the Australian population. They are one group where homeless intact families can be found. Nationally, in services catering for women experiencing family violence they constitute 19% of the client group.

They are often transient in their accommodation, within an extended family group, although this imposes housing stress on family and friends. Interstate movement of itinerant ATSI families has been known, to take advantage of seasonal work or a more hospitable climate. Some Aboriginal persons camp out even in the centre of Sydney. Young Aboriginal men can be observed among homeless people in the Kings Cross area. Interstate stories show that not all such campers-out regard themselves as homeless.^{43,44,45}

⁴² Tom Slokee, Chairperson, NSW Aboriginal Housing Office, cited in *Homelessness: The Unfinished Agenda*. Sydney City Mission, 1999

⁴³ Day, B. (1998): *Gojok's Dream of Home*. Indigenous Homelessness Issue *Parity* 11(4):22-23

⁴⁴ Langton, M., Morris, L., Palmer, L. (1998): *The Long Grass People of Darwin*. Indigenous Homelessness Issue: *The Land is Our Home. Parity*, 11(4):24

Implication

Specifically identified workers in all human services will continue to work together to assist this groups of homeless people with special needs.

4.8 Illegal immigrants and asylum seekers

Illegal migrants and asylum seekers are a hidden group. Illegal immigrants may be found in Sydney amongst garment outworkers, sex industry workers and restaurant employees. Asylum seekers may be unable to seek employment because they did not register their intention of seeking refugee status within 45 days of arrival.

Issues for them include access to health care, counselling and employment and access to the services of interpreters. Always the fear of disclosure to authorities is present. In addition, they have limited rights of appeal for permanent settlement and ability to support themselves, especially if they have no working visa. Voluntary agencies sometimes harbor asylum seekers in refuges.

Isolation, depression and post-traumatic stress syndrome are particular mental health issues for asylum seekers, where general practitioner access and mental health services provision are needed but often unavailable. Language specific services are a particular problem for the Non-English speakers among them, along with access to the Health Care Interpreter Service.

The demand for health care associated with illegal immigrants and asylum seekers is not large. The Asylum Seekers Centre in Surry Hills has 6-10 people per month for whom medical assessment is warranted, frequently to assess the effects of possible torture and trauma.

As most asylum seekers are of reproductive age, there are 15-20 pregnant women a year requiring antenatal care, of whom perhaps 2-3 would be local to SEH. Without Medicare, access to obstetric and antenatal care is particularly difficult, and some of the pregnancies, as a result of the women's previous history, are high risk. Some antenatal care is offered through the Aboriginal Medical Service but it is common for women to be seen by the nurse at Asylum Seekers Centre in advanced pregnancy without any previous antenatal care. Hospitals, general practitioners and NGOs have difficulty providing medical care for them as they lack money and are not eligible for Medicare when tests or treatments are required.⁴⁶

⁴⁵ Keys Young (1999): *Homelessness in the ATSI context and its possible implications for the Supported Accommodation Assistance Program (SAAP) 1998*. Final Report prepared for the Department of Family and Community Services. Commonwealth Australia

⁴⁶ Sinnerbrink, I., Silove, D.M., Manicavassagar, V.L., Steel, Z. and Field, A. (1996): Asylum seekers: general health status and problems with access to health care. *MJA* 165: 634-637

5 Trends in homelessness

5.1 School children

According to Chamberlain and Mackenzie, the rate of homelessness for young people (school children) in two parent nuclear families during 1994 was 3.4 per 1000 of population.⁴⁷ For students in alternative family settings it was 25.1 per 1000. They concluded that the risk level for children in 'blended', divorced and single parent families is 7 times higher than for teenagers in two parent nuclear families.

Poverty, domestic violence, child abuse, mental disorder, alcohol and drug use disorders can contribute to family breakdown and youth homelessness,^{48,49} and are higher in the families of children who are blended, single parent or divorced families. The numbers of these types of family are rising.

5.2 Trends in accommodation demand

SAAP data shows the primary support groups to be single men, women escaping domestic violence and young people.

South East Sydney had four times the SAAP support periods of any other area in the last year reported. Most unmet demand for SAAP accommodation was for those who needed Alcohol or Other Drug services and medical /health services. This constituted more than 50% of total unmet demand and 60% of male demand. This suggests, of the men who slept rough on Census night the majority probably had an alcohol or other drug problem and/or a psychiatric condition.⁵⁰

Between 1997 and 1998 demand from South East Sydney, as measured by people calling the Homeless Persons Information Service (HPIC), increased by 38%, mainly among single men, single women and women with children. Demand by youths under 18 years did not increase. The greatest growth occurred among people with financial difficulty, people with substance abuse problems, people in family breakdown and from crisis evictions. Total calls have risen from South Eastern Sydney 'residents' from about 2500 in 1996 to more than 5000 in 1998.

The number of men's crisis beds in inner Sydney has decreased from 808 beds in 1991 to 370 beds in 1997 through the Inner City Hostels Redevelopment Program (previous crisis beds have become maintenance beds). Demand as measured by calls has increased; the number of people without shelter each night has also increased.

⁴⁷ Chamberlain C, Mackenzie D. *Youth Homelessness: Early Intervention And Prevention*, Australian Centre for Equity Through Education. Sydney, 1998.

⁴⁸ SESAHS (1998): *Towards a child protecting culture*.

⁴⁹ Einfeld, S. & Dean, C. (2000): *Strategy for the social, emotional, behavioural health of younger people*.

⁵⁰ AIHW (1999): *SAAP National Data Collection Annual Report 1997-1998* New South Wales. AIHW Cat No HOU 25 (SAAP NOCA report series 3) Canberra.

TABLE 4: TIME TRENDS IN DEMAND FOR SAAP ACCOMMODATION FROM SOUTH EASTERN SYDNEY 1997-1998

Group	1997 Persons %		1998 Persons %		Size of change
Adult males	1620	30	2776	37	+1156
Adult females	987	18	1199	16	+202
Male youth 12-17 years	51	1	42	>1	-9
Female youth 12-17 years	49	1	48	>1	-1
Woman and children	1431	26	1665	22	+234
Man and children	125	2.	186	3	+61
Adult male and female	355	7	541	7	+186
Couple and children	518	10	704	9	+186
2 Adult males	70	1.	92	1	+12
2 Adult females	34	<1	55	0.7%	+21
2 youths (m or f)	10	0.0	20	>1	+20
Other	170	3.	163	2	-7

Source: Homeless Persons' Information Service custom tables, 1997 &1998.

6 Health Status

6.1 Health disorders

Homeless people are more likely than other people to have a variety of health problems, many of which are listed in Table 5, grouped as mental and behavioural disorders and other health issues.

TABLE 5: DISORDERS AND HEALTH ISSUES FOR HOMELESS PEOPLE

Group	Prevalent mental, behavioural disorders	Physical & Health issues
Single men	Mental , substance use disorders	Injury ⁵¹ ,dental decay and toothlessness, ^{52,53} blood borne infections ¹³ ,malnutrition, ⁵⁴ gastrointestinal, respiratory and cardiovascular disorders, ⁵⁵ suicide risk, self poisoning, poor access to preventive services such as podiatry and dietitians
Single women	Mental , substance use disorders	Injury, victim of assault, especially sexual violence, blood borne infections, poor use of preventive services ²⁵
Women with or without children	Mood disorder, substance use	Victim of violence
Children of homeless women	Behavioural, developmental problems- acute stress reactions and conduct disorders	Dental decay, risk of child abuse from parent and others, possible malnutrition, unsafe environment
Homeless youths	Mood disorders, substance use disorders	Blood borne infections, poor dental health, poor use of preventive services, possible malnutrition, exposure to sexual abuse, suicide risk ^{26,27}

Implication

The focus of health services for homeless people will be on prevention of poor nutrition, prevention of the spread of infectious diseases in the community and maintenance of function for chronically ill or behaviourally disturbed people.

⁵¹ Hodder, T., Teesson, M., Buhrich, N.(1998): Down and Out In Sydney. Prevalence of Mental Disorder, Disability and Health Service Use among Homeless People In Inner Sydney. Research Group in Mental Health and Homelessness.

⁵² Kermode, M.,Crofts, N., Miller, P., Speed, B., Streeton, J.(1997): Health indicators and risks among people experiencing homelessness in Melbourne 1995-96. *Aust &NZ J Public Health* 22(4):464-470.

⁵³ Blackmore, T., Williams, S.A., Prendergast, M.J., Pope, J.E. (1999): The dental health of single male hostel dwellers in Leeds. *Community Dental Health*, 12 (2): 104-109.

⁵⁴ Darnton-Hill, I. Ash, S.(1988): Dietary and alcohol intake patterns of a sample of homeless men in Sydney, Australia *J Human Nutrition and Dietetics* 1:397-408.

⁵⁵ Babidge, N. (1999): *Mortality among the homeless mentally ill in Sydney -a ten year follow up*. A dissertation submitted for the Section II examination, Royal Australian and New Zealand College of Psychiatrists.

6.2 Excess death risk

Amongst homeless people there is more than three times the age adjusted mortality rate for both men and women. Homelessness exacerbates the risks for needle sharing, and for death from overdose. Death from cancer and from cirrhosis through Hepatitis A, B and C as well as alcohol use disorder is more prevalent in this group^{52,55}.

Resistance to infection is likely to be impaired in the many homeless people with alcohol use disorder or heroin use disorder because of the likelihood of malnutrition.

Implications

Improvement in nutritional status of homeless people will reduce their risk of infection.

Concerted efforts to prevent the acquisition and spread of infectious diseases among homeless people will be beneficial for the whole community

6.3 Excess hospitalisation risk

Homeless people may be encountered in many parts of the Area Health Service, particularly emergency medicine, gastroenterology, orthopaedics, cardiac and respiratory medicine, detoxification, mental health services, methadone clinics and needle and syringe exchanges, social work and community health. Women's health, obstetrics, and paediatrics all encounter homeless people occasionally. Some Area Health funded NGOs see homeless people very frequently.

Although homeless people are not at this time reliably identifiable in standard databases and some work needs to be done on defining the conventions for recording 'no fixed abode', some comments can be made about hospitalisation of 'homeless' people in SEH hospitals. Refer to Appendix C.

For the period July 1995- June 1998 there were 1295 admissions of patients with a SAAP address and 1150 with 'no fixed abode' to South East Health hospitals.⁵⁶ There was a decreasing trend from 1200 in 1994/95 to 700 in 1997/98. Most people were aged between 15 and 54 (range 0-100) with the median range at 35-39. Older people are more likely to be hospitalised than younger. No fixed abode patients were younger than SAAP accommodation people. More than 50% of homeless people's admissions come through the Emergency Departments, compared with 23% for the accommodated community.

The three main reasons for admission for over 50% of the separations were 'schizophrenia', 'drug use disorder and dependence' and 'alcohol use disorder and dependence'. 'Homeless' people stayed less than half the number of days in hospital than did their accommodated peers, and may be readmitted more frequently.

⁵⁶ NSW Health (1999): Inpatient Statistics Collection

In terms of SEH Hospitals, in 1997/98, 46% of 'homeless people' admissions were to St Vincent's Hospital (40% of admissions to Caritas – the psychiatry unit – were for homeless people) and 28% to Sydney Hospital.

'Homeless' Aboriginal or Torres Strait Islander people appear to be admitted at 16 times the rate of the accommodated ATSI population, but this difference is at least partly accounted for by high numbers of transient Aboriginal people within the homeless people admitted to hospital.

Implication

That systematic database entries need to be established in South East Health hospitals and community health services to facilitate accountability, evaluation and aggregated research data on homelessness.

6.4 High risk illnesses for inner city homeless people

6.4.1 Mental health problems

Mental disorders have a high prevalence among Sydney absolutely and first degree relatively homeless, and among those sampled of inner city second degree homeless people.²² Schizophrenia affected 23% of the men and 46% of women and mood disorders occurred in 26% in a cross-sectional study.²² Comorbidity with substance use disorders is also prevalent.⁵⁷

6.4.2 Drug and alcohol problems

Approximately 40% of Sydney absolutely and first degree relatively homeless have an alcohol use disorder.²² Half are likely to have another mental disorder. Opiates and other drug use related diseases are problems for 20% of Sydney's absolutely and first degree relatively homeless people. One third may have another mental disorder. Mood disorders such as post traumatic stress disorder are the most common comorbidity, especially in women.

Homelessness, because of alcohol and other drug use disorders is a risk factor for liver diseases, cognitive impairment, cardiovascular diseases and neoplasms (74% are smokers), blood borne and food borne infectious diseases and malnutrition.²² Hepatitis A, Hepatitis C, HIV, sexually transmitted diseases and pediculosis all seem to have higher than usual prevalence among particular subgroups of homeless people, according to local observation for hepatitis and overseas findings for other conditions.

⁵⁷ Hall, W., Farrell, M.(1997): Comorbidity of mental disorders with substance misuse. *The British J Psychiatry* 17(7) 4-11

Risk of assault, including sexual violence, and risk of injury are high for both sexes in Sydney.²⁵ Homeless women have an almost universal history of assault, frequently sexual assault.²⁵ This is confirmed in US and UK findings.

6.4.3 Ageing

The incidence of illness rises as people age. Homeless people who are ageing are particularly vulnerable.

It is difficult for tertiary homeless people to “age in place” both because of accommodation difficulties, and their cognitive and behavioural limitations. Their lack of security of tenure and the shared facilities of their accommodation make modification of their homes to support them very difficult. In addition boarding houses and other low cost accommodation where they live are threatened by redevelopment and availability is sharply reduced.⁵⁸

For frailer homeless people who enter hostel care, there can be issues of affordability, social ‘fit’, inability to provide for clothing and other needs, desire but inability to drink when pension money goes for hostel care, and there is no supplementation by relatives. Working to support the men in their immediate environment when they become frail would fit better with their expressed values than their relocation to residential care.

6.5 Common issues in providing health care to homeless people

Common issues in providing health care to homeless people revolve around their transience, co-morbidities and a failure of health staff in some instances to consider the implications of a patient’s homelessness on his or her capacity to benefit from treatment.

The challenge for hospitals is to understand the obstacles faced by homeless people on discharge and the need to plan care to take their disabilities into account. Adequately following instructions is one example in which the patient’s understanding of the task and his ability to perform the task, given his surroundings, can both be compromised.⁵⁹

⁵⁸ Davidson A, Phibbs P, Cox, G. *Inner Sydney Boarding Houses survey draft report*, Department of Urban Affairs and Planning , 1998. Also Sydney City Council. Sydney City housing strategy: draft report. The Council, Sydney 1996 44-46

⁵⁹ Basser, M.L. (1999): The evaluation of outreach health care to insecurely housed Sydney men. *Journal of Primary Health –Interchange*. 5(3): 82-92

Issues encountered by SEH providers in giving care to homeless people:

- Mobility, lack of fixed abode, unpredictability of attendance
- Clients' poor memory for appointments, instructions
- Complexity of social /health issues to be addressed
- Compliance problems
- Intoxication
- Aggression
- Cognitive impairment as a comorbidity
- Mental illness as a comorbidity
- Alcohol or other drug dependence as a comorbidity

Problems encountered by homeless people with health care providers:

- Some health providers invalidly assuming homeless people's capabilities, so discharge them without regard for support and care needs
- Anxiety, distress around institutions and authority
- Lifestyle makes it difficult to fill prescriptions or use medication effectively
- Lifestyle limits after care re dressings, diet, rest, therapy
- Appearance and behaviour lead to being ignored, discounted or rejected
- Communication and comprehension issues
- Personal distress and mismatched expectations;
- Ignorance of entitlements and health resources.

Implications

There is a need for greater awareness by health workers of homelessness as a health issue, particularly for follow up

There is a need for more workers who 'target' homeless people

7 Current Health Services for Homeless people

7.1 Public Health

The Public Health Unit's surveillance, regulatory and advisory roles involve it, as required, in investigations of communicable diseases such as viral hepatitis among street youth and intravenous drug users, childhood infections among young children in refuges with their mothers, and tuberculosis in homeless men. The Unit convenes an Area Tuberculosis Advisory Committee and participates in Hepatitis C and HIV/AIDS committees which have representation from NGOs.

The Public Health Unit has investigated several foodborne outbreaks related to hostels and has played a role in conjunction with Health Promotion in ensuring that adequate food hygiene and food practices are part of nutritional programs such as Meals on Wheels.

A Public Health Officer trainee is reviewing current data sources to evaluate health issues for homeless people.

7.2 Primary Health Care

7.2.1 General practitioners

Primary health care to homeless people is provided by a small number of general practitioners who bulk bill, by walk-in medical centres, by voluntary agency primary care clinics and by hospital Emergency Departments.

The Haymarket Foundation, a voluntary agency in Darlinghurst, offers nurse-delivered primary care seven days a week and general practitioner services five days per week, with 130 attendances per week. It provides the primary medical care for people with chronic alcoholism who have detoxified at Gorman House (St Vincent's Hospital), and other disadvantaged people in its neighbourhood. There are "house" calls, if required.

The Station, a voluntary agency in the inner city, has a weekly general practice clinic and primary nurse-managed care the rest of the week.

Matthew Talbot Hostel, a facility of the Society of St Vincent de Paul, has a nurse-managed primary care service with a sick bay, and visiting medical services. Foster House (St Vincent de Paul) has medical services for its residents, as does Campbell House (Mission Australia).

7.2.2 Health service primary carers

Kirketon Road Centre, a facility of Sydney Hospital, offers primary medical care to at-risk young people, women and sex workers, amongst its other services. Many clients are homeless.

The following table provides a profile of some health service use by homeless people.

TABLE 6: SOME SERVICE USE BY HOMELESS PEOPLE

Estimated GP visits annually; inner sector primary and secondary homeless persons	7,189 ⁶⁰
Estimated GP visits annually by homeless persons	32,988 ⁶¹
Estimated annual emergency attendances, inner sector primary and secondary homeless	2259 ⁶²
Estimated maximum emergency department attendances SEH by homeless persons – primary, secondary and tertiary	10368 ⁶³
Estimated outpatient attendances inner sector annually by primary and secondary homeless	1849
Maximum estimate outpatient attendances by homeless persons annually SEH	8,483
Separations in SEH by primary and secondary homeless persons 1993/94 to 1995/96	1,969 ⁶⁴

7.2.3 Dental Care

Tooth loss, including toothlessness, gum disease, dental decay and neglect are common among homeless persons world wide. The Victorian homeless persons' study found that only one third of homeless people seen had all their teeth and one third had fewer than half or none of their own teeth. Of their sample, 65% had not seen a dentist in the previous two years.¹⁷

Central Sydney Area Health Service's Dental Health Strategic Plan identified untreated dental decay in a pilot project to homeless youth of 4.9 teeth per person (aged 14-29 years). It identified only 27.5% of youth having seen a dentist in the last 12 months and 37.2% not having seen a dentist in the last 5 years.⁶⁵ This should be compared with decay of 1.3 teeth (ages 14-24) per person in the general population with more than 50% of 14 - 24 year olds having visited a dentist in the last 12 months.⁶⁶

A dental service targets homeless youth in SEH and Central Sydney Area Health Service (CSAHS), operating through youth centres, refuges and other outreach health services. Appointments are made directly by the dental therapist with United Dental Hospital. Administrative requirements and waiting times on the day of appointment are minimised. 37.5% needed urgent treatment because of pain, pathology or trauma.

⁶⁰ extrapolated from cross sectional survey data Hodder et al 1998

⁶¹ extrapolated to all homeless people in SEH from Hodder et al. Assumes homogeneity of characteristics

⁶² extrapolated from cross sectional survey data Hodder et al 1998

⁶³ extrapolated to all homeless people in SEH from Hodder et al. Assumes homogeneity of characteristics

⁶⁴ SESAHS (1997): Area Health Profile

⁶⁵ CSAHS (1995): *Dental Health Strategic Plan*

⁶⁶ National Oral Health Survey 1987-88, cited CSAHS Dental Health Strategic Plan.

A dentist from CSAHS attends Kirketon Road Centre on Fridays and provides a clinical service and there is an outreach dental therapist service utilising the Kirketon Road Centre bus. The clients are predominantly sex workers or intravenous drug users.

Implication

More dental services would be utilised at the NGO hostels and refuges.

7.3 Hospital care

Every hospital Emergency Department provides primary care for homeless people from time to time.

7.3.1 Sydney Hospital

Sydney Hospital has long been a resource for homeless persons and Emergency Department and social work staff maintain regular communication with community agencies which serve homeless people. The Drug and Alcohol Team, with Emergency Staff coordinate the Homeless Persons Networking meeting attended by NGO hostel staff and Homeless Persons agencies. The Director of the Emergency Department is on the Board of the Haymarket Foundation. Kirketon Road Centre, a facility of Sydney Hospital, is focused on primary health care for at-risk youth and the sex industry, providing amongst its services needle and syringe exchanges, primary medical care, prescription of methadone, a sessional dental service and access to a social worker.

7.3.2 St. Vincent's Hospital

St. Vincent's Hospital as a teaching hospital with a major trauma centre and provides services for a large number of homeless people, many on referral from the refuges and hostels.

The presence of an extended hours social work service in the St. Vincent's Hospital Emergency Department enables more homeless people's social needs to be recognised and met than previously. Some homeless people are referred to the Inner City Outreach Service Nurse who works from Darlinghurst Community Health Centre.

7.4 Alcohol and other drug services

SEH has identifiable Drug and Alcohol services, providing primary and secondary prevention support.

The main acute services that are provided for people with alcohol or other drug use disorders are ambulance and emergency assistance in recovery from drug overdoses and detoxification services. Outpatient detoxification is often not a viable option for homeless people.

Sydney Hospital has 6 medically supervised detoxification beds. Medical assessment at the Langton Centre is the entry requirement. There is a mixture of medical and nursing detoxification. The Drug and Alcohol staff coordinate the “homeless network” meeting for people with drug and alcohol problems, with NGOs who also look after these people.

Langton Centre has homeless people on its outpatient detoxification program, its methadone program and using its needle and syringe exchange services. Assistance with accommodation, food and legal issues are provided by the welfare officer.

Gorman House, the 22 bed detoxification service of St. Vincent’s Hospital, is reported to care for many homeless persons over a year but it does not record their accommodation status, so exact figures are not known.

No data are available about the extent to which homeless people use alcohol and other drug services, although the role of alcohol and other drug use disorders in precipitating and maintaining homelessness has been recognised in a variety of studies.⁶⁷

7.5 Dual diagnoses/co-morbidity

Recent collaborative developments between Mental Health and Drug and Alcohol services are aimed at achieving better care and treatment for all persons with comorbidities. The impact of their introduction on services for homeless people cannot be evaluated at this early stage.

Referral options for clients with more than one health issue, particularly homeless ones, are limited.

Implications

That within South East Health patients with dual diagnoses or complex behaviour will be recognised as challenges for coordinated duty of care and protocols for integrated case conferencing and collaborative case support management will be developed. Protocols for interagency collaboration will be developed.

⁶⁷ Darnton-Hill, I., Ash, S. (1988): Dietary and alcohol intake patterns of a sample of homeless men in Sydney, Australia *J Human Nutrition and Dietetics* 1:397-408

7.6 Mental Health Services

Mental Health Services are sector based and there are four in SEH. St. Vincent's Mental Health Service provides clinics at four of the homeless agencies in the inner city sector. Additionally, the Inner City Housing Project, a funded initiative of the Mental Health Service, in partnership with Mission Australia, provides assistance to people affected by mental illness in order to increase their independent living skills and thus reduce the risk of homelessness for these people.

St Vincent's Mental Health Service also provides formal rehabilitation for people disabled by mental disorders, many of whom are homeless. These services are provided within the framework of the *SEH Strategic Plan for Mental Health Rehabilitation Services*. They are individualised and focussed on increasing role functioning. Social support and time structuring activities are offered. A strong consumer-managed model is facilitated through the Mental Health Service Consumer Ideas Forum with ongoing low levels of support as requested.

The following table provides a profile of utilisation of community mental health services by homeless people.

TABLE 7: REGISTRATIONS OF HOMELESS MENTALLY ILL PRIMARY AND SECONDARY HOMELESS PERSONS WITH COMMUNITY MENTAL HEALTH SERVICES AS A PERCENTAGE OF ESTIMATED ELIGIBLE PERSONS IN INNER AND EASTERN SECTORS SEH

Service	Inner sector	Eastern sector
Estimated homeless people (from Table 2)	2635	721
Estimated homeless with schizophrenia	737	152
Estimated homeless with a mental disorder ⁶⁸	1422	390
Homeless people registered with Community Mental Health 1/3/98 to 1/3/99	200	5
Maximum percentage of homeless with schizophrenia registered	27%	3%
Maximum percentage of any homeless mentally ill registered	14%	1%

The St Vincent's mental health service model comprises both acute and rehabilitative components including acute inpatient facilities. Estimates presented in Table 7 suggest that substantial numbers of homeless people who are mentally ill are not in receipt of treatment in this service. These may include some people receiving medication from General Practitioners as well as people who are unwilling to be treated by mental health services. Nonetheless these access figures present a challenge to St Vincent's Mental Health Service.

Other mental health services in the Area (Eastern Suburbs, St George, Sutherland) have lower numbers of homeless people and those who live in refuges, although issues about access to appropriate mental health services are of concern.

⁶⁸ From Hodder Teesson and Buhrich 1998 Rates applied to 23% city homeless men , 46% of city homeless women with schizophrenia, 26% mood and anxiety disorders

7.7 Community Health Services

SEH's Northern Community Health Services and Programs have one Home and Community Care Program (HACC) funded nurse allocated to provide continuity of health care and primary care for homeless persons, with a focus on those who would meet HACC criteria of frailty, age, or disability. (Table 8)

This community nurse works on an outreach basis as part of the multidisciplinary community health team and maintains active contact with hostel and hotel managers, as well as absolutely homeless people. A successful pilot of this service demonstrated its potential for improving liaison between General Practitioners and other agencies in the care of homeless people.

Generalist community health services located at Darlinghurst, Waverley and Zetland all provide a service to 'homeless' clients in boarding and rooming houses referred for nursing, social work, occupational therapy and physiotherapy. Local women's refuges refer to generalist community health social work for counselling services.

TABLE 8: COMMUNITY SERVICES TO HOMELESS PEOPLE BY SECTOR : NUMBER OF REGISTRATIONS

Service	Inner sector	Eastern sector	St George Sector	Sutherland sector
Generalist Community Health 1/3/98-1/3/99	60	16	N/A	N/A
Aged Community health care 1/3/98-1/3/99	32	12	N/A	N/A
Aged Care Assessment (ACAT) 1997/1998	33	23	24	1

7.8 Aged Care Assessment Teams

The Waverley, Randwick–Botany and St George Aged Care Assessment Teams (ACATs) all see some homeless people for aged care assessment as shown in Table 8.

Community Aged Care Packages, a community based range of support services funded by Commonwealth Health and Aged Services, and accessed on the recommendation of an ACAT have recently been made available to homeless people in the inner city. These packages can provide alternatives to hostel placement for people with self-care and housing difficulties. Commonwealth/State Agreements have been reached about mental health support to these packages as required.

8 Resources assisting homeless people

8.1 South East Health resources

SEH is one of the largest Area Health Services in the state, covering 750,000 residents from the Sydney Harbour in the north, through Botany Bay and Port Hacking to the Royal National park in the south. The Area incorporates the LGAs of Sydney (part), South Sydney (part), Waverley, Woollahra, Randwick, Botany, Rockdale, Hurstville, Kogarah and Sutherland.

The Area Health Service is responsible for a number of hospitals and their associated Community Health Services: Prince of Wales/Prince Henry, the Royal Hospital for Women, Sydney Children's Hospital, Sydney Hospital and Sydney Eye Hospital, St Vincent's, War Memorial Hospital Waverley, St George, Calvary and Sutherland Hospital. It conducts clinical programs across the facilities and community health services such as Mental Health, Drug and Alcohol services, Women's Health, Multicultural Health, Aboriginal Health, Aged Care, Rehabilitation, Men's Health, HIV/AIDS and other related diseases. It has a Public Health Unit and a Health Promotion Unit with responsibilities across the area and it auspices funding for a large number of health related services in NGOs.

There are a number of SEH resources that directly assist homeless people (Table 9).

TABLE 9: RESOURCES PROVIDED BY SEH ASSISTING HOMELESS PEOPLE

Provider	Service	Target group	Other services provided & connections
St. Vincent's Mental Health Service	Voluntary Agencies Clinical Service (VACS)	Homeless mentally ill men and women	Clinics at 4 inner city NGO hostels
Sydney Hospital	Kirketon Road Clinic Needle & syringe exchange, social work, primary health care, outreach to "The Block", Redfern, limited dental service	youth, sex workers	
Community Health Services and Programs	Darlinghurst CHC – Inner City Outreach Service- one nurse pro-active primary health care, generalist community nursing, social work, physiotherapy and occupational therapy	Homeless men and women primarily in HACC target range, mainly 50+	Counselling referrals to social workers from women's refuges
Women's Health	Prevention of Violence against Women	Includes initiatives with homeless women	Funding Attorney General's Dept

There are a number of other SEH services that provide incidental care to homeless people in the course of their work. (Table 10).

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TABLE 10: AREA SERVICES INDIRECTLY ASSISTING HOMELESS PERSONS

Provider	Service & Target group	Other services and linkages
St. Vincent's Hospital Emergency	Acutely ill	Refer to Matthew Talbot Hostel sick bay, social workers and Inner City Outreach Service
St. Vincent's Mental Health Service in cooperation with Sydney City Mission: Inner City Housing Project	22 homeless persons with a mental illness in 6 houses	
St. Vincent's Hospital: nonmedical detoxification at Gorman House	Alcohol dependent	Links AA, Board of "The Station"
Sydney Hospital Emergency	Ambulatory care and acute medicine-	Emergency clothing, social work services, medical clearances for proclaimed places
Sydney Hospital medical and nonmedical detox beds	Alcohol dependent	Assessment through Langton Centre
Sydney Hospital, Sydney Sexual Health Centre	Sexually active persons re sexually transmitted diseases	Has previously been represented on committee on housing needs of persons with HIV
Langton Centre Needle & syringe exchange-D4 location	Injecting drug users	Health education for safer use of drugs
Langton Centre, Outpatients detoxification, methadone program	Alcohol and/or drug dependent persons,	Assess for detoxification at Sydney Hospital, assist with food, accommodation, legal, medical care.

8.2 Health-Funded Non Government Organisations

There are 59 NGO programs funded within SEH, of which six are core homelessness programs (Table 11) and there are some others with a focus on Alcohol and Other Drugs. Seven NGO programs focus on HIV/AIDS with some overlap with the homeless. Three NGOs have some mental health source funding, and through their rehabilitation of mentally ill persons may reduce homelessness.

One core homelessness program, "The Station", has two consumer representatives on the management committee. Although transient people cannot often participate in management, people whose way of life has stabilised, perhaps in transitional housing or medium term hostel places, could contribute.

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TABLE 11: NGOs PROVIDING CORE SERVICES TO HOMELESS PERSONS AND SEH FUNDS RECEIVED

NGOs	Service	Target group	Area funds
Society of St. Vincent de Paul	Matthew Talbot-Accommodation, proclaimed place nursing centre, sick bay, medical clinics, rehabilitation	Homeless men, esp alcohol dependent	NSW health funded since 1992/93, - 1998/99 \$163,800
The Station Limited	Primary care clinic Sessional GP, mental health, welfare, counselling, optometry, day centre	Primary and secondary homeless esp mental and drug use disorders	Funded since 1988/89 1998/99 \$73,500 for 1.5 D&A workers
Haymarket Foundation	Haymarket Clinic Primary nursing clinic 7 days, general practice, 5 days, controlled drinking program, housing related interventions; drug dependence and alcohol rehab houses, proclaimed place	Primary secondary tertiary homeless, dis-advantaged people	Funded since 1988/89, 1998/99 \$84,400 for 2 D&A workers
Mission Australia Campbell House	Campbell House for homeless men, providing medically supervised detox, treatment for alcohol related & associated illnesses	Homeless men with alcohol and drug problems	Funded since 1995/96 In 1998/99 \$583,700
Mission Australia- D&A intervention program	Campbell House- proclaimed place crisis accommodation , assessment and referral	Homeless men with alcohol and drug problems	Funded since 1994/95 In 1998/99 \$91,300
Wayside Chapel	Shepherd of the Streets. Outreach and fixed service providing information assessment and referral in Kings Cross area	At-risk youth at Kings Cross	Funded since 1988/89 In 1998/99 \$91,400
Wayside Chapel-Crisis Centre	A crisis counselling service for anyone in need	Anyone in need	Funded since 94/95, In 1998/99 - \$72,900
Salvation Army Oasis Youth Support Network	Street work / outreach program for homeless youth and young sex industry workers in the inner city	Homeless youth & young sex industry workers	Since Jan 1 1994 (from DOCS) 1998/99 \$218,900
Youth Accommodation Association	Hands on HIV education for youth workers	Youth workers working with homeless youth	In 1998/99 \$136,900
Total funds to core homeless programs			\$1,516,800

There are another 12 NGOs who receive some Health funding (total \$4M) in South Eastern Sydney who provide incidental services to homeless people and these are noted in Appendix D.

Many voluntary agencies that supply core services to homeless people in SEH do not receive Health funds. There at least 48 organisations receiving SAAP funds through the Department of Community Services (DCS) and Supported Accommodation and Assistance Program (SAAP) IV. These are also shown in Appendix C. Some receive funds from both sources, a few from neither.

There are other services that assist homeless and disadvantaged people in South Eastern Sydney that receive no funds from DCS or Health. Some of these are also listed in Appendix D.

9 Issues raised by stakeholders

9.1 General Practitioners

There appear to be poor communications on homelessness between and among General Practitioners, whose interests are diverse. General Practitioners have a varying level of interest in homeless people. There are low levels of awareness among General Practitioners about the issues involved in providing good health care to homeless people, and the general practice representative on the working party believed that both education and support for practices with homeless patients are needed.

Difficult case presentations here are people with brain damage, severe intoxication, severe mental illness and aggressive patients. Complex psychosocial problems need time and resources, communications between agencies, and other General Practitioners. The challenges are greatest with General Practitioners working in non-government agencies such as The Station, Haymarket Foundation and Campbell House, where high volume presentations of complex cases are the norm. A proposal has been made for greater resourcing of these positions by NSW Health in terms of equipment, staff, data entry facilities and education.

The GP representative on the working party advised that a list of key phone numbers and addresses prominently displayed e.g. with large print and bright format would assist appropriate referral of homeless people to the right Mental Health, Aged Care Assessment, Alcohol or Other Drug Service, Community Health Service etc. The identification of the key contacts in each sector, together with the suburbs served by the service could assist in simplifying the case management of homeless people, for General Practitioners.

General practitioners attending homeless people in all settings have unmet information requirements for resources to assist their homeless patients with multiple or complex needs. A resource book for general practitioners called *The Homeless and Institutional Treatment Manual for Primary Health Providers* has been produced by a Melbourne Division of General Practice.⁶⁹ A proposal has been made to develop a similar publication for Sydney.

⁶⁹ Melbourne Division of General Practice *The Homeless and Institutional Treatment Manual for Primary Care Providers*. Melbourne Division of General Practice, 1997.

Implication

Practical assistance to General Practitioners could be provided in the form of subsidised vaccines and treatment resources and in the support of a project to prepare a Manual about Homelessness and Health for General Practitioners.

9.2 Non government agencies

In meetings with Health funded and other non government agencies and lobby groups, the organisations highlighted as their perceptions:

- Difficulties for SAAP-funded agencies in dealing with complex emotional, social and behavioural health issues in homeless people when their staff and volunteers are not appropriately trained for these tasks;
- Inadequacy of discharge planning for homeless people from the health care system and lack of continuity of health care;
- Discrimination against clients with mental health and alcohol and other drugs co-morbidity by either/both services;
- Difficulties for homeless people in accessing services which have defined population catchments. (Some homeless people are assumed ineligible because of their lack of a fixed address. Gorman House is the only detoxification program without geographic eligibility criteria);
- A shortage of affordable accommodation across Sydney.
- A shortage of supported accommodation options across Sydney.
- An inadequate commitment to partnership with the NGO sector by SEH services as a whole (although there are pockets of effective relationship building);
- A shortage of detoxification facilities for younger people in NSW.
- Inadequate health service planning and interventions for homeless people.

Whilst the NGO sector key informants were largely critical of South East Health's initiatives to date, they were able to provide some constructive strategies for the future. These included:

- Developing formal partnerships between SEH, NGOs and housing providers to set up housing with "floating" support and active case management of the health issues.
- Developing and trialling outreach triage teams to NGOs which could comprise allied health, nurse and medical staff. Management by an NGO was suggested as an option.
- Increasing interaction between the SEH clinical staff and NGO workers by provision of more education and support.
- Establishing regular case discussions and shared client meetings between Health and NGOs
- Piloting more outreach models of care delivery.
- Providing greater education to achieve attitude change within SEH clinicians to improve understanding of health and homelessness issues;
- Seeking funds, accommodation and partners for the establishment of a small convalescent care cottage for use by homeless people to assist recuperation.

10 Emergent models

Throughout the Western world there are attempts to develop new initiatives and approaches to health care for homeless people. Some of these could provide direction for South East Health.

Swanborough⁷⁰ proposes a continuum of health care for homeless persons organised on a geographic Service Cluster that brings a variety of providers together. The key components of the continuum include:

- an operational relationship with SAAP and links into the environments where homeless people live and gather;
- a specialist primary health care response that assertively takes health care to homeless people;
- clears pathways into the Aged Care Sector;
- generalist primary health care response;
- a specialist mental health response linked to community and psychiatric in-patient services;
- targeted alcohol and drug services linked to generalist drug and alcohol services;
- a formally articulated Acute Care response linked to a step-down care facility and supported by a community referral process.

This model therefore advocates the development of specific health services for homeless people.

St Vincent's Hospital Melbourne has demonstrated that improved management of homeless health care can lead to cost benefits and health benefits when the resources are used to provide support to homeless people at an earlier stage of care as in a short stay facility.⁷¹ Step down care and short stay facilities for unwell homeless people are operative in Melbourne in the Sister Francesca Healy Cottage, which is a six bed facility located in Fitzroy beside St Vincent's Hospital. It provides nursing management by the "St Vincent's at Home" Program.

A similar model is also under development at Royal Adelaide Hospital in South Australia.

The Royal District Nursing Service in Melbourne has 16 community nurses in its Homeless Persons Program. The Program promotes an outreach model that works. It follows the principles of "find, engage, get trust....".⁷² They try to be located at places where people experiencing homelessness visit, such as the street, night shelters, crisis and drop in centres and at low cost hotels. Accident and Emergency services at three inner Melbourne hospitals refer people who are experiencing homelessness to their service.

⁷⁰ Swanborough, T. A. (1998): Continuum of care What is the framework? *Health Issues* 54 : 17-19

⁷¹ Pathways Ch11. downloaded 1/9/999 <http://www.health.gov.au:80/pubs/nhs/pathways/pathch11.htm>

⁷² Cameron, J.(1998): Plugging the Holes, but not Fixing the Leak. *Health Issues*: 20-22

In Canada, transitional care beds for the sick-but-not-sick-enough-for-hospital have a strong focus on women, especially those in poverty, severely mentally ill and those with HIV/AIDS, each with a community advisory panel for service planning and monitoring.⁷³

Victoria also has the SHIFT program, a Service for Homeless, Intellectually Disabled, Frail and Transient (SHIFT) people based at Health and Community Services in Footscray. This service provides coordination and support. It assists patients to access services and comply with referrals. The small multi-disciplinary team has experience from a wide range of health and welfare backgrounds. Criteria for eligibility include homelessness and intellectual disability or the presence of a “potential intellectual disability”. The service operates state-wide in recognition of the transient nature of these clients.

The Hawthorn Primary Care Project (also in Victoria) provides outreach support to the marginalised boarding house population of the City of Booroondara (formerly Camberwell, Kew and Hawthorn). The Victorian Government funds this through the Salvation Army. The case workers have experience in housing, mental health, alcohol and drugs services and aged care. The project has a chaplain. Its role is to identify and meet clients’ needs including basic needs, minimising duplication of assessment and referrals, improving client access to information and improving liaison with other services.

Jane's story

This developmentally disabled woman was aged about 40. She was mentally ill, secondarily alcohol dependent, and a dependent gambler. She was highly suspicious and foul mouthed when the community nurse met her. She was a tenant of a Department of Housing owned rooming house, sub-let to a landlord. Referred to community health centre as "not coping". She was known to St Vincent's Mental Health Service, known to (the former) Bourke Street Alcohol and Drug Service, and known to "The Station", an inner city NGO, where she was a regular attendee. The community nurse assessed her as unsuitably accommodated, with greater support needed. ACAT assessment by a doctor was arranged. An aged care hostel placement was organised. Appropriateness?

There are a few innovative programs in Sydney in terms of health care including the clinics funded at Matthew Talbot, the Station and the Haymarket. There are mental Health outreach clinics at several hostels. Specialised acute step down facilities are not available at present. There is a plan to develop an intersectoral initiative in the Kings Cross Masterplan for Homelessness.

Implication

New models of care, incorporating identified staff and collaborative cross government or cross agency resourcing may be beneficial, particularly in the inner city area of Sydney

⁷³ McWilliams, J. (1998): Homelessness: An International Overview of the Relationship to Health. *Health Issues* March: 8-13

11 Future directions

The causes of homelessness are complex and not easily remedied. Poverty, drug dependence, alcohol abuse, domestic violence and mental illness, alone or in combination contribute to homelessness. In collaboration with other agencies we are agreed that the key to both the prevention and amelioration of homelessness is **affordable, safe, supported accommodation**. This document has considered the role of SEH in the provision of appropriate health support to people who need the services.

Discussions with other agencies, the consultations by members of the Working Party, policy documents released by various departments and a literature review have led to the following principles of care for the health of homeless people, which have been adopted in South East Health facilities and programs. They are grouped under the NSW Department of Health's four goals of healthier people, fairer access, quality health care and better value.

11.1 Principles of service

In keeping with its corporate mission of “Good health care, Better Health” South East Health will have a framework for recognising and responding to the special needs of homeless people in recognition of the contribution of safe, stable accommodation to the health of its residents.

Healthier people

- South East Health recognises that provision of safe, supported accommodation is an issue of concern to health workers, because in its absence health needs cannot be adequately met;
- Homeless people will be identified and recognised as having special needs;
- Continuity of care is integral to better health of homeless people and policies and protocols within facilities and programs will ensure continuity of case support management.

Fairer access

- In SEH emergency departments, hospital wards and in community health settings, the identification of people of “no fixed abode”, “single room”, “boarding house” or “hotel accommodation” will:
 - trigger referral to relevant social work, discharge planning, mental health, drug and alcohol or community health staff for case identification and coordinated health service planning; and
 - engage health staff in advocacy to achieve stable sheltered environments with the appropriate levels of support;
- As far as possible, homeless people will be facilitated and supported to access generic health services;
- Generic health services will develop realistic procedures and protocols which maximise engagement and treatment for people who are homeless;

- Where necessary outreach health services to homeless people's agencies and shelters will be available;
- Absolutely or first degree homeless people will be recognised as being at greatest risk;
- Special services will be developed in collaboration with Aboriginal and Torres Strait Islander community controlled medical services to meet the specific needs of homeless people of these backgrounds;
- Gender and Age issues will be promoted to health service providers as requiring special attention;
- Health service providers will be assisted to identify violence, abuse and neglect in the histories of homeless people and will facilitate access to appropriate services to deal with these issues.

Quality Health care

- The principles of effective intersectoral action⁷⁴ will be applied by SEH. Effective intersectoral action requires organisations:
 - to have identified the necessity to work together to achieve their goals
 - to have opportunities for action to occur
 - to have the capacity to take action
 - to have developed a relationship that enables them to take action
 - to have planned the action to the satisfaction of each in order to achieve sustainable outcomes;
- Services and education will be provided collaboratively, both within different components of South East Health programs and in conjunction with external agencies and non government organisations;
- Research into the factors contributing to homelessness, the consequences of homelessness and effective means of improving health in homeless people will be encouraged;
- Services will be evaluated for their effectiveness and progress towards organisational goals;
- Outreach health care for homeless people will always be provided in a safe work practice environment, consistent with relevant occupational health and safety protocols in South East Health.

Better value

- Health services will be provided to individuals or to organisations serving homeless people without consideration of imposing cost recovery on the individuals or the agencies.

⁷⁴ Harris, E., Wise, M., Hawe, P., Finlay, P. and Nutbeam, D. (1995): *Working together: intersectoral action for health* AGPS Canberra

11.2 Organisational capacity for homelessness health

- Responsibility for homelessness as a population health issue will rest with at the Area Executive level;
- A Coordinator for Homelessness Issues will be nominated who will provide an administrative reference point for liaison and coordination concerning homeless people;
- SEH will be represented on the Premier's Department, the Department of Housing, Department of Community Services and Local Human Services Interagencies concerning homelessness by relevant service managers;
- A SEH Homelessness and Health Advisory Committee will be convened to share information, develop new projects and advise senior management. Membership will include Public Health, Mental Health, Drug and Alcohol, Women's Health, Men's Health, Youth Health, Aged Care; Community Health, general practitioners and relevant consumer NGOs;
- The principles of service to homeless people will be incorporated into Area facility and programs' policies and protocols;
- Staff in Community Health, Mental Health, Drug and Alcohol and Emergency Services will meet to develop agreed protocols for the case support management of homeless people with complex needs;
- Outreach staff to facilitate health access by homeless people will be identified from within community health services and programs;
- Indicators of care for homeless people will be developed and reported to the Quality Council of the Board of SEH;
- National definitions of homelessness will be incorporated into databases and there will be a standardisation of accommodation codes;
- South East Health will continue to auspice funds for NGOs assisting in improving the health of homeless people.

11.3 Goals of care

Preventing and treating illnesses among homeless people

- The Public Health Unit will continue to lead health service research into the issues for homeless people;
- The Public Health Unit will continue ongoing surveillance of infectious and other notifiable diseases in homeless people;
- The Public Health Unit will advise on and be involved in the monitoring of food hygiene and practices and environmental health aspects of hostels and refuges.
- Advice on nutritional issues will be provided by the Health Promotion Unit as part of its strategy for improving the health of vulnerable populations;
- Community based health care providers in refuges etc will be supported by providing access to vaccines, take-out medications, harm minimisation techniques and treatment services for infectious diseases such as Hepatitis, Tuberculosis, Tetanus, Influenza, HIV/AIDS etc;

Homelessness and Human Services

- Services such as the Kirketon Road Centre, Sydney Sexual Health Centre and the Langton Clinic will continue to provide for homeless people;
- Access of homeless people to acute treatment services in our hospitals or in clinics in refuges will be continued;
- Where homeless people are identified with complex needs and chaotic lifestyles a collaborative approach to coordinated service provisions will be developed;
- For high risk groups such as women at risk of violence, frail older people etc, special attention will be paid to the development of service responses which are sensitive to their needs.

Engaging homeless people and improving continuity of care within South East Health

- An organisational framework as described above will be developed in SEH;
- South East Health services will develop policies for all staff which facilitate identification of homelessness as a high risk health issue. Care protocols and pathways will be developed to facilitate collaborative coordinated care;
- Policies and protocols will be developed which ensure better communication between providers about health care for homeless people;
- Access of homeless people will be facilitated by the development of appropriate care pathways and protocols. Priority for the development of these will include Mental Health, Alcohol and Other Drug, detoxification and Community Health services;

Improving collaboration with partners in outside agencies

- SEH will continue to demonstrate leadership in intersectoral strategy building for homelessness issues;
- General Practitioners who are interested in health issues of homeless people will be identified and supported by provision of vaccines, issue of complete courses of medications on discharge from hospitals etc
- Existing conjoint “clinic” activities in refuges and hostels will be enhanced with doctors, nurses, dentists, dietitians, pharmacists from Health etc;
- Accountability of health funded projects provided by NGOs, for homeless people will be clarified and strengthened;
- Continuing education of non health providers such as NGOs will be provided with by South East Health as will reciprocal education by NGOs for our staff;
- SEH staff will participate with other agencies in the development and evaluation of interventions that reduce homelessness and redress contributory factors, including illness;
- Service agreements will be developed with Police, Housing and other Departments regarding management of complex health issues including Drug and Alcohol comorbidity, ensuring Child Protection, supporting victims of family violence and managing challenging behaviours. The Joint Guarantee of Service between Health and housing should be examined as a model for such service agreements;
- South East Health will facilitate clinical collaboration such as case conferences for the monitoring of complex and high risk health issues in homeless people (comorbidity of mental illness with drug and alcohol problems, with developmental disability and drug and alcohol morbidity and with other comorbidities such as traumatic brain damage);
- Whilst respecting the rights of individuals, confidentiality codes of practice will not be used as a barrier to service provision;
- Initiative to develop models of accommodation for the long term care of people with health problems complicated by challenging behaviour and/or progressive disability will be encouraged and piloted across health and other provider networks.

Improving evaluation

Evaluation of health services for homeless people will require multiple approaches. These will include:

- Public Health initiatives where population data on health status of homeless people are collected and analysed;
- Systematic reporting of the implementation and evaluation of collaborative protocols, pathways and service agreements. This would utilise a Participative Action Research approach;
- Monitoring of individuals with complex needs for measures of service improvements such as reduced crisis presentation, reduced complications of non-compliance with treatment. This would use a qualitative approach; and
- Research outputs on the causes, contributions and complications of homelessness as they relate to health, an academic approach.

Appendix A

Tables of demographic analysis of homelessness

TABLE 12: ACCOMMODATION TYPE, ACCOMMODATION RESOURCES AND USE BY GENDER OF USER WHERE ENUMERATED, FOR EACH SECTOR OF SEH

Accommodation and homeless people	Eastern	Inner City	St George	Sutherland	SEH
<u>Primary homelessness</u>					
Male	0	86	0	9	95
Female	3	18	3	6	30
Total	3	104	3	15	126
<u>Secondary homelessness</u>					
Male	13	573	3	10	599
Female	9	113	6	17	145
Total	22	686	9	27	744
<u>Tertiary homelessness</u>					
Male	549	1408	131	44	2132
Female	148	437	37	3	625
Total	697	1845	168	47	2757
<u>Total all forms of homelessness enumerated</u>					
Male	562	2067	134	63	2826
Female	160	568	46	26	800
Total	722	2635	180	89	3626
<u>Refuge places and transitional accommodation as of 1997</u>					
Male adult	0	582	0	0	582
Female	10	42		6	87
HIV		15 refuge	0		15
Medium term	62 (F)	192			
Youth	16	32	8	6	60
<u>Private for profit rooming houses and hotels 1997-98</u>	208	2086 ⁷⁵	158	7	2459

In the Inner Sector 568 women were homeless; 437 women (82%) had insecure tenure in private for profit accommodation. The Eastern Sector had 160 homeless or insecurely housed women, of whom 93% were in private sector accommodation. There were 9 women enumerated in refuges.

The St. George sector had 46 women enumerated among its homeless persons, of whom 3 were sleeping rough, 6 (13%) were in a refuge, and 37 (80%) were in private for profit accommodation. In Sutherland of the 26 women counted as homeless; six (23%) were sleeping rough, 17 (65%) were in a refuge, and three (12%) in a privately accommodated.

Primary homeless men were mainly enumerated in the inner city sector, where 86 men were counted on Census night.

It is not possible to quantify the under-estimation that is likely to be present. The numbers of absolutely homeless persons sleeping in building sites, squats, bus shelters, parks, and

⁷⁵ Davidson A, Phibbs P, Cox G. *Inner City Boarding House draft report* Department of Urban Affairs and Planning, 1998, and Sydney City Council. *Sydney Housing Strategy: draft report*, The Council Sydney 1996. Cited in Johnston C. *Evaluation report on the boarding house pilot project in SAAP New South Wales*. Johnson policy futures, August 1998, pages 2-3.

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cars in the suburbs was almost certainly under-estimated in the Eastern sector and elsewhere, as in the east no men were identified as absolutely homeless on Census Night, but several regulars can be observed on a daily basis by eastern suburbs residents and commuters.

Of the 599 males enumerated in refuges, 573 were counted in the inner sector, where 597 refuge places for men have been listed.

Of the homeless people living in rooming houses and hotels, 1845 were in the inner city sector, but a further 241 were missed by the census collectors. Of the 534 boarding house residents identified in the Eastern sector 427 were men, and again up to 200 more residents could have been in premises not identified by the collector but known to councils, or occupied by students.

TABLE 13: HOMELESS PEOPLE IN SEH ENUMERATED BY AGE AND SEX CENSUS 1996

Age group	Males		Females		Persons	
	Number	% of all ages	Number	% of all ages	Number	% of all ages
0-14	50	1.8	26	3.3	76	2.1
15-19	62	2.2	49	6.1	111	3.1
20-29	505	17.8	219	27.4	724	20.0
30-39	530	18.8	164	20.5	694	19.1
40-49	606	21.5	108	13.5	714	19.7
50-59	432	16.3	79	11.0	550	15.2
60-69	368	13.0	67	8.4	435	12.6
70-79	193	6.8	52	6.6	245	6.8
80 and over	50	1.7	26	3.3	76	2.1
All ages	2826	100.0	799	100.0	3625	100.0

TABLE 14: DISTRIBUTION OF HOMELESS PERSONS ENUMERATED BY ACCOMMODATION TYPE, RELATIVE DEGREE OF HOMELESSNESS AND

Type of accommodation	AGE GROUP FOR SEH						Total
	0-14 yrs	15-19 yrs	20-34 yrs	35-49 yrs	50-69 yrs	70 yrs +	
Sleeping rough / absolutely homeless (primary homelessness)	10	14	44	26	28	3	125
Refuge (secondary homelessness)	29	43	222	209	172	69	744
Private hotel, boarding, rooming house (tertiary)	25	41	501	468	620	170	1701
Public hotel, motel (tertiary)	12	13	320	342	289	79	1055
Total	50	62	1087	1045	1109	321	3625

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TABLE 15: DISTRIBUTION OF HOMELESS MEN AND WOMEN BY LGA AND ACCOMMODATION TYPE, COMPARED WITH PUBLIC AND PRIVATE PROVISION OF ACCOMMODATION

LGA	Sex	slept rough	refuge	private hotel	public hotel	Total	SAAP places funded 1997	Rooming house, hotel from Council records *
Botany	M	0	0	34	31	65		
	F	0	0	0	6	6		
	Total	0	0	34	37	71	0	230
Hurstville	M	0	0	3	13	16		
	F	3	0	0	0	3		
	Total	3	0	3	13	19	0	20
Kogarah	M	0	0	0	21	21		
	F	0	0	0	0	0		
	Total	0	0	0	21	21	4	0
Randwick	M	0	13	293	51	357		
	F	3	3	83	16	105		
	Total	3	16	376	67	462	63	459
Rockdale	M	0	3	35	59	97		
	F	0	6	25	12	43		
	Total	0	9	60	71	140	44	289
Sth Sydney	M	45	509	545	243	1342		
	F	6	89	154	90	339		
	Total	51	598	699	333	1681	747	2086
Sutherland	M	9	10	32	12	63		
	F	6	17	3	0	26		
	Total	15	27	35	12	89	90	54
Sydney	M	41	64	122	227	454		
	F	9	18	9	99	135		
	Total	50	82	131	326	589	See Sth Sydney	See Sth Sydney
Waverley	M	0	0	199	81	280		
	F	0	12	48	37	97		
	Total	0	12	247	118	377	171	431
Woollahra	M	0	0	83	48	131		
	F	3	0	33	9	45		
	Total	3	0	116	57	176	0	0
SEH	M	95	599	1346	786	2826		
	F	30	145	355	269	799		
	Total	125	744	1701	1055	3625	990	3350

*Source for Council figures: Population Health Profile SESAHS 1997

TABLE 16: FORMS OF ACCOMMODATION USED BY HOMELESS PEOPLE IN SOUTH EASTERN SYDNEY ON CENSUS NIGHT 1996

Accommodation type	Males	Females	Persons
Sleeping rough	95	30	125
Hostel/refuge for homeless persons	599	145	744
Rooming house/private hotel	1346	355	1701
Hotel/motel	786	269	1055
Total	2826	799	3625
<u>% of total</u>			
Sleeping rough	3.4	3.8	3.5
Hostel/refuge for homeless persons	21.2	18.2	20.5
Rooming house/private hotel	47.6	44.4	46.9
Hotel/motel	27.8	33.7	29.1
Total	100.0	100.0	100.0

Appendix B

For Youth Allowance purposes, according to Australian Social Security legislation “homeless person” means a person who:

- (a) is not a [member of a couple](#); and
- (b) has no dependent children; and
- (c) either:
 - (i) does not live, and for a continuous period of at least 2 weeks has not lived, at a home of the parents, or of a [parent](#), of the person because the parents are not, or neither parent is, prepared to allow the person to live at such a home; or
 - (ii) does not live at a home of the parents, or of a parent, of the person because domestic violence, incestuous harassment or other exceptional circumstances (eg. Neglect, parental substance abuse, forced marriage) make it unreasonable to expect the person to live at such a home; and
- (d) is not receiving continuous support, whether directly or indirectly and whether pecuniary or otherwise, from a parent of the person or from another person who is acting as the person's [guardian](#) on a long-term basis; and
- (e) is not receiving, on a continuous basis, any payment in the nature of [income](#) support (other than a [social security benefit](#) or a [youth training allowance](#)) from the Commonwealth, a State or a Territory

Appendix C

Inpatient statistics - homelessness and hospitalisation

TABLE 17: NUMBER OF INPATIENT EPISODES BY HOMELESS STATUS AND YEAR OF SEPARATION

	1994/95	1995/96	1996/97	1997/98
NFA [^]	748	464	440	256
SAAP clients*	468	388	456	451
SEH residents	205457	214801	217450	217633
Total	206673	215653	218346	218340
%homeless	0.6	0.4	0.4	0.3

[^] Including NFA patients treated at hospitals within the South East Health boundary only.

* Including patients from SAAP accommodations located within the South East Health boundary only.

Data source: NSW Inpatient Statistics Collection.

TABLE 18: NUMBER OF INPATIENT EPISODES FOR HOMELESS PEOPLE BY POSTCODE OF RESIDENCE, 1995/96-1997/98

	SAAP Clients [*]	No Fixed Abode [^]
2010	890	
2011	337	
2000	17	
2026	14	
2502	8	
2232	6	
2229	5	
Other	18	1150
Total	1295	1150

[^] Including NFA patients treated at hospitals within the South East Health boundary only.

* Including patients from SAAP accommodations located within the South East Health boundary only.

Data source: NSW Inpatient Statistics Collection.

TABLE 19: NUMBER OF INPATIENT EPISODES BY HOMELESS STATUS AND AGE, 1997/98

Age	No Fixed Abode [^]		SAAP Clients [*]		SEH residents	
	No. of episodes	% of all ages	No. of episodes	% of all ages	No. of episodes	% of all ages
Under 15	2	0.8	3	0.7	16155	7.4
15-19	12	4.7	28	6.2	5425	2.5
20-24	41	16.0	13	2.9	9392	4.3
25-29	39	15.2	28	6.2	14208	6.5
30-34	36	14.1	52	11.5	15164	7.0
35-39	42	16.4	85	18.8	13686	6.3
40-44	22	8.6	50	11.1	11890	5.5
45-49	19	7.4	34	7.5	12438	5.7
50-54	21	8.2	23	5.1	13850	6.4
55-59	8	3.1	18	4.0	13728	6.3
60-64	5	2.0	17	3.8	13492	6.2
65 and over	9	3.5	100	22.2	78205	35.9
All ages	256	100.0	451	100.0	217633	100.0

[^] Including NFA patients treated at hospitals within the South East Health boundary only.

* Including patients from SAAP accommodations located within the South East Health boundary only.

Data source: NSW Inpatient Statistics Collection.

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TABLE 20: NUMBER OF INPATIENT EPISODES BY HOMELESS STATUS AND ABORIGINALITY, 1997/98

	No Fixed Abode [^]		SAAP Clients [*]		SEH residents	
	No. of episodes	% of total	No. of episodes	% of total	No. of episodes	% of total
Aboriginal or TIS people	4	1.6	17	3.8	720	0.3
Neither	252	98.4	434	96.2	216913	99.7
Total	256	100.0	451	100.0	217633	100.0

[^] Including NFA patients treated at hospitals within the South East Health boundary only.

^{*} Including patients from SAAP accommodations located within the South East Health boundary only.

Data source: NSW Inpatient Statistics Collection.

TABLE 21: NUMBER OF INPATIENT EPISODES BY HOMELESS STATUS AND ADMISSION SOURCE, 1997/98

	No Fixed Abode [^]		SAAP Clients [*]		SEH residents	
	No. of episodes	% of total	No. of episodes	% of total	No. of episodes	% of total
Admitted via ED	128	50.0	260	57.6	50836	23.4
Planned admissions	128	50.0	191	42.4	166796	76.6
Total	256	100.0	451	100.0	217632	100.0

[^] Including NFA patients treated at hospitals within the South East Health boundary only.

^{*} Including patients from SAAP accommodations located within the South East Health boundary only.

Data source: NSW Inpatient Statistics Collection.

TABLE 22: NUMBER OF INPATIENT EPISODES BY HOMELESS STATUS AND DRG, 1997/98

DRGV3.1	No Fixed Abode [^]		SAAP Clients [*]		SEH residents			
	No. of episodes	% of total	No. of episodes	% of total	No. of episodes	% of total		
Schizophrenia	841		61	23.8	56	12.4	1754	0.8
Other mental disorder DRGs	842-848		16	6.3	10	2.2	6174	2.8
Alcohol/Drug intoxication	860-863, 371-372		72	28.1	79	17.5	1811	0.8
/withdrawal/dependence related DRGs								
Toxic effects of drugs	888-889		18	7.0	26	5.8	1065	0.5
Other			89	34.8	280	62.1	206828	95.0
Total			256	100.0	451	100.0	217632	100.0

[^] Including NFA patients treated at hospitals within the South East Health boundary only.

^{*} Including patients from SAAP accommodations located within the South East Health boundary only.

Data source: NSW Inpatient Statistics Collection.

Appendix D

Tables describing non government organisations in South Eastern Sydney which provide for homeless people

TABLE 23: NGOs PROVIDING NON- CORE SERVICES TO HOMELESS PERSONS AND RECEIVING SEH FUNDS

Non-government organisations	Service	Area Funds
Independent Community Living Association (ICLA) inc	Supported accommodation and rehabilitation service	1998/99 funds \$230,000
Phoebe House Inc	A residential project for women on methadone pregnant or parenting	1998/99 funds \$374,600
Psychiatric Rehabilitation Association	A community rehabilitation program for people with mental illness	Funds 1998/99 - \$161,800
Aftercare Association of NSW – Clovelly	A residential project for people with mental illness	1998/99 funds \$148,500
Bobby Goldsmith Foundation Inc	Financial, housing and other assistance for people with HIV/AIDS	1998/99 funds \$435,500
Women's Alcohol and Drug Action Committee	A service providing detoxification and short term rehab program for women with children and AOD problems	1998/99 funds \$671,900
Red Cross	Glen Mervyn, a residential rehabilitation for pregnant young women with substance use disorder, some homeless	1998-99 funds \$163,800
Sydney PWA Day Centre	Provides nutritionally accessible food and meals with advice, support and referral for people with HIV/ AIDs and their immediate partners	Since 1/7/97 formerly part of CHS&P1998/99 - \$225,000
Ted Noffs Foundation, Inc (PALM-Program for Adolescent Life Management)	An alcohol and drug adolescent treatment service, including residential treatment at Randwick	1998/99 funds \$163,400
Foley House	HIV/AIDS accommodation, info and assessment to young people at risk of acquiring/ transmitting hepatitis and HIV	Since 1989/90 1998-9 funds \$718,800
Salvation Army	Bridge House-nursing hostel- 24 hour detox, residential rehab alcohol and other drugs	1998/99 - \$539,400
Salvation Army	William Booth institute -residential rehabilitation for those affected by alcohol and other drugs	1998/99 - \$222,800

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TABLE 24: SAAP FUNDED SERVICES

Organisation	Service/resources	LGA
Wesley Mission	Edward Farrer Lodge	South Sutherland
The Haymarket Foundation	Albion Street Lodge (proclaimed place)	South Sutherland
St Vincent de Paul Society	Matthew Talbot Hostel	South Sutherland
AIDS Council of NSW	ACON Housing Project	South Sutherland
Salvation Army	Samaritan House	South Sutherland
Mission Australia	"The Opposition" Youth Crisis Centre	South Sutherland
Mission Australia	Cannell House (Proclaimed Place)	South Sutherland
The Station Ltd	The Station	Sutherland
Salvation Army	Knudsen Place	South Sutherland
City Women's Hostel Inc	City Women's Hostel	South Sutherland
Mission Australia	A Woman's Place	South Sutherland
Mission Australia	Women in Supported Housing	South Sutherland
St Francis Welfare Ltd	Come In Centre (housing support work)	South Sutherland
Factory Community Inc	The Factory Youth Centre	South Sutherland
Salvation Army Oasis Youth Support	John Irwin Lodge	South Sutherland
Women & Girls Emergency Centre Inc	Women and Girls' Emergency Centre	South Sutherland
Women's Housing Company	Women's Housing Company	South Sutherland
Society of St Vincent de Paul	Vincentian Villane	Sutherland
Salvation Army	Foster House	Sutherland
Society of St Vincent de Paul	Ozanam Youth Lodge	Sutherland
Mission Australia	The Rocks	Sutherland
Dolores Single Women's Refuge	Dolores Single Women's Refuge	Waverley
Eastern Suburbs Community Youth Association	Randi Youth Accommodation	Waverley
Caretakers Inc	Caretaker's Cottage	Waverley
R Miles Women's Housing Scheme Inc	R Miles Women's Housing Scheme	Randwick
St Laurence House Inc	St Laurence House (Youth Refuge)	Randwick
Ontions Youth Housing Association Inc	Ontions Youth Housing	Randwick
The Ted Knoffs Foundation Inc	PAI M (Program for Adolescent Life Management)	Randwick
Killara Women's Refuge	Killara Women's Refuge	Randwick
St Vincent de Paul Society	Marian Villa Arncliffe	Rockdale
St George Accommodation for Youth Ltd	St George Accommodation for Youth	Rockdale
St George Women's Housing Inc	St George Women's Housing Scheme	Rockdale
FASV - Eastern Area Service For Youth	Eastern Area Service For Youth (FASV)	Sutherland
Southern Sutherland Refuge Association	Southern Sutherland Youth Refuge	Kogarah
Presbyterian Social Service Department	Iannali Youth Crisis Accommodation Project	Sutherland
Church of Christ Carindah	Iacaranda Cottage	Sutherland
Sutherland Family Counselling	The Bridge Youth Refuge -Sutherland	Sutherland
St Vincent de Paul Society	Amelia Women's Refuge	Sutherland

There are two SAAP funded telephone information lines:

- Homeless Persons Information Centre
- Youth Emergency Accommodation Hotline

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TABLE 25: OTHER VOLUNTARY AGENCIES SERVING HOMELESS AND DISADVANTAGED PEOPLE

Organisation	Service Type	Location
Our Lady of Snows	(free meals)	Sydney
Baptist Church	City Parish	Sydney
Society of St Vincent de Paul	St Vinnies For Youth Food Van	Newtown . South Sydney
St Canice's Church	(free meals)	South Sydney
Mission Australia	Lois' Place (women's drop in centre)	South Sydney
Mercy Family Life	ACHA- Assistance With Care And Housing For The Aged	South Sydney-serves City of Sydney and Glebe also
Mission Australia	Missionholme (frail aged disadvantaged persons' hostel)	South Sydney (Central Sydney AHS, Redfern)
Salvation Army	Winderradeen House	Sydney
Mission Australia	Frederick Chambers Court (hostel for frail aged disadvantaged persons)	South Sydney

TABLE 26: SERVICES SUPPORTING PEOPLE AS THEY LEAVE PRISON (NOT IN SEH AREA)

Organisation	Location
CRC Justice Support Accommodation	Broadway
Guthrie House	Enmore
Life after Prison	North Parramatta
Glebe House	Glebe
Rainbow Lodge	Glebe