

DEEP END LIVING LAB COMMUNITY FORUM

INTRODUCTION

The Deep End Living Lab team is working to improve health outcomes of people experiencing homelessness and unstable housing. Our model is based on a similar grassroots advocacy movement in Scotland: [‘General Practitioners \(GPs\) at the Deep End’](#) which is built on principles of engagement, common purpose, collegiality, advocacy, and joint projects.

Our work has two key priorities:

- (i) improving screening for homelessness in healthcare, and
- (ii) supporting health and social service navigation and integration.

The Deep End Living Lab held a community forum **to identify the shared priorities for housing and health** on Thursday, 22 February 2024. The hybrid forum was held at the Monash Conference Centre in Melbourne, Australia and via Zoom.

The aim of the forum was to use a co-design approach, involving stakeholders and consumers to:

- Develop a prioritised list of knowledge gaps relating to homelessness and ageing healthily in Victoria. This will form the basis for research development and funding applications for ongoing work.
- Further build collaborative relationships with representatives from health and housing sector service providers, program managers and policy advisors.

The forum brought together people with lived experience and key stakeholders in housing and health including Austin Health, Bolton Clarke, City of Melbourne Council, City of Melton Council, Council to Homeless Persons, Jesuit Social Services, Launch Housing, McAuley, Melbourne City Mission, Monash University, Mornington Peninsula Shire, OnCall Group, Peninsula Health, Salvation Army, St Vincent’s Health Australia, Star Health, Victorian Health Promotion Foundation (VicHealth), VincentCare and Wyndham City Council.

Insights from the Scottish and international Deep End Movements as well as our ongoing Australian research were presented for context, followed by a Q&A to clarify points of interest for the attendees. Please see the attachment with the slides from Dr David Blane and Nilakshi Gunatillaka.

SHARED PRIORITY SETTING

Attendees contributed to a robust discussion on shared priorities for the health and housing sectors.

What are the shared priorities for housing and health that would help improve outcomes for consumers?

Reflect on what is being done, where the gaps are and which organisations/groups should be involved.

Over 30 ideas were identified to address current gaps in service delivery for people experiencing homelessness and unstable housing (Appendix 1).

The group consolidated these into 11 shared priority areas for the housing and health sectors. These are listed below. Some ideas were discussed further prior to consolidation and these discussions are summarised in Appendix 2.

Shortlist of 11 shared priorities

1. Training for people with lived experience to engage with delivering training, consultation, and employment pathways
2. Leveraging the experience of people with lived experience to minimise stigma in healthcare and community
3. Urgent care hubs with trained staff to support emergency department
4. Mental health paramedicine
5. Agency collaboration including systems for sharing information, creating wrap around social care, and using data for advocacy and funding
6. Taking a holistic view of the person and their family when accessing the health system
7. Reviewing exemplars to roll out best practice models
8. Coordinating and expanding services and systems for embedding housing and health, including metro and rural considerations
9. New long-term funding models in the community that don't rely on Medicare
10. Upskilling clinicians on what to do and how to ask about housing, involve people with lived experience in that training
11. More and more appropriate social housing designed with consumers

Following the consolidation process, attendees were asked to reflect on the priorities and categorise them using a new, useful, and feasible (NUF) matrix. Each person in attendance (in-person and in Zoom) voted for their top three preferences in each category. The outcomes of the voting activity are reflected in Appendix 3.

Figure 1 Results from the NUF matrix



New

Attendees considered having new long-term funding models to support health service delivery in the community that reduce services' reliance on Medicare to be the most novel idea.

Useful

Attendees highlighted the need for more (and more appropriate) social housing that is co-designed with consumers as the most useful idea.

Feasible

The idea that was voted most feasible within the current context was building strong, ongoing agency collaboration for service delivery and integration to better support consumers, while leveraging shared data and information systems to advocate for the sector.

Building capacity among people with lived experience of homelessness to be involved in all aspects of service co-design and workforce development, including upskilling healthcare workers to proactively discuss housing was also considered feasible. These strategies were also proposed as mechanisms for reducing stigma and improving consumer experiences of the health and social care system.

NEXT STEPS

The Deep End Living Lab team will continue to work with our academic and community partners to reflect these shared priorities in our ongoing work.

We will support the health and housing sectors' ongoing advocacy efforts by using our research to highlight consumer perspectives on navigating health services while experiencing housing instability. For example, we are building a freely available, online art gallery to showcase the community's experiences. We have permission from the creators of the artworks shown at the Community Forum to include their works in the art gallery and will include more works as they become available.

We are collaborating with a major hospital network and a consumer advocacy organisation to co-design a training module health care workers. We expect the training module to expand health care workers' knowledge of homelessness and housing instability as well as improve their confidence and skill in sensitively discussing housing with patients. We hope to evaluate the effectiveness of the training module and support it's scale up to other jurisdictions in the longer term.

The Deep End Living Lab team also hopes to collaborate with health and housing sector organisations to identify and address existing knowledge gaps through research.

For more information, please contact:

Nilakshi Gunatillaka

Program Manager & Research Officer, Monash University

✉ Nilakshi.Gunatillaka@monash.edu

Project partners:



APPENDIX 1: ALL IDENTIFIED PRIORITIES FOR HEALTH AND HOUSING SECTORS

- Access potential housing if people go to ED or GP → how to work with people experiencing homelessness before they get to healthcare
- Additional measures for people from overseas at risk of homelessness e.g., non-permanent visa holders, people ineligible for Centrelink
- Ageing workforce
- Appropriate housing and learning how to live in a house
- Case coordination and generalism in service providers
- Co-location and embedding housing, legal, financial, immigration services in hospital and health services
- Co-location of services (both in metro and regional areas)
- Collecting data from pilot models and people with lived experience
- Community care outside of ED and GP
- Consider housing as a health intervention so it becomes a priority like medicines
- Consumer voice → what really happens
- Continuity for consumers/patients
- Educating health staff about social issues and services
- Embedding services both ways
- Get better support if [people with lived experience] have an addiction
- Holistic look at the person/family accessing the health system, i.e., model to look at the social determinants of health (housing, food etc) more than the medical
- How can we get help without acute sickness?
- Identifying best practice models for coordination of services
- Lead tenant model (peer model)
- Medicare is not helping complex care, so we need new long-term funding models that don't rely on Medicare → true health and housing models
- Mental health paramedicine e.g., CATT teams to receive more resources
- More housing (appropriate and affordable) is the priority → More/new and existing housing
- Multidisciplinary team
- One-stop shop in the community
- Organisations that should be involved in the conversation → GPs, community health providers, local councils, housing providers
- People feel pushed into the ED, judiciary, addiction areas vs being supports to maintain social connections and mental health wellbeing via GP and community services
- People with lived experience informing research and policy
- Reliance on third sector
- Research that is led by people on the ground e.g., GPs → directed towards policy makers (will it inform policy?)
- Rurality is an issue around access to services → gap in mobilisation of services and regional services (locality based)
- Shared advocacy from funding bodies to support housing
- Short pilots → nothing long term, losing trust

Full Report from the Deep End Living Lab Community Forum | Feb 2024

- Single point of contact that any services could contact to get information about their client, e.g., MyGov or Centrelink
- Systems for agencies to collaborate → share knowledge about clients and better coordinate their care
- There is no “Victoria Health” so there’s no coordinated data and no coordinated response or services
- Training for hospital staff who frequently care for people experiencing housing issues on how to manage patient’s sense of fear/judgement, previous limited support, and mechanisms to manage lack of address or working phone in hospital systems to ensure continuity of care
- Upskilling clinicians on how to ask, knowing the system and setting realistic expectations
- Urgent care hubs → similar to GPs clinics, but with co-located with social work, food, laundry to reduce reliance on major hospital Eds
- Wraparound social care that embeds homework clubs, social groups for people at risk of homelessness in places where they gather e.g., community kitchens
- Wraparound support that considers housing, social connection, addiction, justice (police involvement) → maintain out of systems

APPENDIX 2: ADDITIONAL DETAILS ON SHARED PRIORITIES

1. Training for people with lived experience to engage with delivering training, consultation and employment pathways

People with lived experience should be supported gain additional skills that would allow them to engage with and lead training and advocacy that would benefit their community more effectively.

A training or employment pathway for people with lived experience should be developed for them to be equipped with the confidence and resources to then lead and deliver training to healthcare workers. People with lived experience are particularly well suited to this as they can use their personal experiences to guide healthcare workers on better ways to ask about housing, and help people understand what to expect from the health and housing systems.

2. Leveraging the experience of people with lived experience to minimise stigma in healthcare and community

Any training should involve people with lived experience and include awareness raising and methods to deal with the stigma associated with homelessness and housing instability both within the healthcare system and the broader community.

3. Urgent care hubs with trained staff to support emergency department

Two urgent care hubs for the Melbourne area were proposed, with the expectation that they would act as an intermediary between emergency departments and community based primary care. Staff would receive more training and support (than is available to hospital-based staff) to be able to respond to people experiencing homelessness or housing instability. For example, those who are frightened of health care settings and may present as frustrated, loud or occasionally aggressive.

The group discussed the utility of setting up a new service against addressing service delivery gaps within existing services. The group also discussed the need for boundary spanner and outreach roles for health care workers, with a focus on nursing. An example that was presented was the funded Alcohol and Other Drug outreach workers and nursing specialists that collaborate local hospitals and police.

4. Mental health paramedicine

Not discussed further.

5. Agency collaboration including systems for sharing information, creating wrap around social care, and using data for advocacy and funding

Although there are many organisations that are working to address housing and health issues affecting people with lived experience of homelessness, there isn't a shared language across these sectors which limits collaboration. It is important to recognise that this is intersectoral work and that we need to work together.

Additionally, there are challenges with access to and availability of longitudinal data is needed to demonstrate when initiatives work (i.e. to create a strong evidence base). This is further exacerbated by issues around collaboration described above.

Greater emphasis on multi-sectoral collaboration, through organisations such as Melbourne Zero would be valuable for service coordination as well as funding and sustainability.

6. Taking a holistic view of the person and their family when accessing the health system

There needs to be a greater focus on social determinants of health (i.e. housing, food, etc.) within the health system, rather than a more clinical or medical view. Additionally, we need to consider wraparound support when dealing with housing issues. For example, considering social connections, mental health wellbeing, and other aspects of one's life.

An approach that was proposed as a way of prompting health care workers to consider their client's social circumstances was to have a USB stick with the clients' story so that clients can share them easily with health professionals, rather than explain their situation every single time

7. Reviewing exemplars to roll out best practice models

We should look to exemplar services from across Australia, and internationally, and consider how we can adapt them to our local context.

For example, a model such as the 'Recognise, Respond, Refer (RRR) framework', which provides a three-pronged process could be locally adapted to support health professionals when working with people who are experiencing homelessness or housing insecurity.

Another example was an international model of care that pairs paramedics, social workers, and police to provide care for people experiencing housing instability where they are. While it can be episodic, there is continuity of care and follow-up as trust was built. (Refer to: https://www.thespec.com/news/hamilton-region/stories-from-the-front-line-of-hamilton-s-social-navigator-program/article_224c84dc-2624-5f71-af71-2be622a93b31.html)

8. Coordinating and expanding services and systems for embedding housing and health, including metro and rural considerations

Not discussed further.

9. New long-term funding models in the community that don't rely on Medicare

The need for stable, sustainable funding was highlighted as a major area of concern. The lack of stable funding has led to many short-term projects. While they may deliver useful, effective services in the short term, the withdrawal of those services after funding ceases creates disengagement and mistrust within the community.

The group discussed how GPs' services are constrained by Medicare item numbers which do not sufficiently recognise the additional time needed to provide holistic care for complex patients.

10. Upskilling clinicians on what to do and how to ask about housing, involve people with lived experience in that training

There is a skills gap in the health workforce relating to asking their clients about housing, their knowledge of the system for housing support and their expectations of services. Clinicians and staff within the healthcare workforce would benefit from training on how to ask about housing and what to do to help people experiencing homelessness or housing insecurity.

One recommendation was to incorporate this training into medical education or clinical placements. The group advocated for people with lived experience to be involved in this training, as they are experts in navigating the system and can explain what clients would expect from health professionals in these circumstances.

There was also a proposal to train health care workers in both the health and social welfare needs of their clients to be the first point of contact when people present to health services, who can identify and address social needs while working alongside other health workers.

11. More (and more) appropriate social housing designed with consumers

The group agreed that housing supply was entirely inadequate. They spoke about the need for housing to be available for all people experiencing homelessness and housing instability. They also spoke about housing that was fit-for-purpose (i.e., 1- and 2-bedroom units, youth specific housing, disability specific housing, large inter-generational family units for some of the culturally linguistically diverse communities, as well as housing that can be safe and appropriate for the many other forms of 'households').

APPENDIX 3: VOTING OUTCOMES FOR EACH OF THE SHARED PRIORITIES

#	Shared priority	New	Useful	Feasible	Total
1	Training for people with lived experience to engage with delivering training, consultation, and employment pathways	7	3	15	25
2	Leveraging the experience of people with lived experience to minimise stigma in healthcare and community	3	5	10	18
3	Urgent care hubs with trained staff to support emergency department	9	5	-	14
4	Mental health paramedicine	6	1	3	10
5	Agency collaboration including systems for sharing information, creating wrap around social care, and using data for advocacy and funding	4	5	13	22
6	Taking a holistic view of the person and their family when accessing the health system	1	2	3	6
7	Reviewing exemplars to roll out best practice models	3	5	8	16
8	Coordinating and expanding services and systems for embedding housing and health, including metro and rural considerations	5	3	3	11
9	New long-term funding models in the community that don't rely on Medicare	19	10	3	32
10	Upskilling clinicians on what to do and how to ask about housing, involve people with lived experience in that training	1	5	11	17
11	More and more appropriate social housing designed with consumers	4	26	5	35