

# Healthcare and Homelessness

Learning from health services in California and Oregon, USA

Report of findings on a study trip supported  
by the Winston Churchill Memorial Trust

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## Acknowledgments

Firstly, I want to acknowledge tangata whenua. Homelessness in Aotearoa New Zealand is entangled with history, raupatu and intergenerational trauma. Acknowledgements also to those people experiencing homelessness today, tonight and tomorrow in cities and towns across NZ, whose struggles and health needs motivate this work.

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Lastly, much gratitude goes to George and Bell, for allowing me the time to undertake this journey and helping me along the way.

*There are some enterprises in which a careful disorderliness is the true method.*

Herman Melville

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# Contents

Executive summary.....	4
Objectives .....	4
Introduction.....	5
Key Learning .....	7
Homeless Health: an overview .....	8
Site visit summaries .....	12
○ Los Angeles .....	12
○ San Francisco .....	19
○ Portland.....	23
Method .....	24
Comparisons .....	25
Recommendations.....	28
Conclusion .....	29
Reporting.....	29
References.....	30
Appendices.....	33

## **Executive Summary**

This report reflects the findings of a study trip to California and Oregon (USA) undertaken in 2016 to observe and learn from homeless healthcare services. My objectives included the development of quality health service responses in Aotearoa New Zealand (NZ) for people experiencing homelessness. I was able to visit and spend time with some excellent clinicians and inspiring health services, immersing myself in their clinical settings. In this report I will present a brief background to homelessness and health, then summarise my US site visits and describe some specific homeless health initiatives. These site visit summaries are bookended by my key learnings and my recommendations from this study trip.

My recommendations include an emphasis on trauma informed practices, integrated and mobile services, and the inclusion of physical health and primary care clinicians in homeless health outreach. Peer or consumer governance structures are suggested, as are the development of best practice guidelines for homeless health providers (which the author will propose in appropriate forums). Service linkages and pop-up ‘health hubs’ are also suggested, as another way to meet the needs of this otherwise underserved population.

## **Objectives**

The objectives of this Winston Churchill Memorial Trust Fellowship were:

- Improving current health service provision for people who are homeless in NZ.
- Improving the health of this underserved population, who often present with complex health and social need.
- Comparison with service models and therapeutic approaches utilised in California and Oregon will enable me to provide specific recommendations for local NZ services.
- Contribute to the professional development of health workers in the NZ homeless sector and build the capacity of current services to provide specialised health interventions for this population.
- It was also expected that this Fellowship would inspire and develop my own nursing practice, which it has certainly done.

## Introduction

Ko Stack te maunga

Ko Moana tuauriuri te moana

Ko Partizanka te waka

Ko Brian Martin rāua ko Elaine Bennett ōku mātua

Ko Garrick Martin tōku ingoa

Te Whanga-nui-a-Tara te wā kāinga

Kei Tāmaki Makaurau toku kāinga inaianei

I am a NZ Registered Nurse working in mental health and homeless health services for the past decade. During that time homelessness has risen in profile in NZ's cities, raising considerable public concern and challenges to health service providers. Various local initiatives have risen to meet this challenge; however the health needs of homeless people remain underserved. Considerable effort is going into social housing needs, but specialist health initiatives by appropriately skilled clinicians are needed to compliment this homeless sector work. My Winston Churchill Memorial Trust Fellowship focused on the provision of health services to people who are homeless, looking to US services for their expertise and clinical experience.

In Los Angeles I spent time with Venice Family Clinic Homeless Outreach team and Homeless Health Care Los Angeles. In San Francisco I joined the Street Outreach Service's mobile clinic and visited health services in the downtown Tenderloin district. In Portland I visited the innovative Central City Concern and attended the National Health Care for the Homeless Council Annual Conference.

I had specific questions for my site visits and consultations, regarding the practicalities of service provision, the therapeutic models they use, and their staff training and skill mix. I was also interested in the inter-agency agreements and management of such health programs, as well as the ways they measure outcomes or record health information for a largely transient, poorly engaged population. There is limited health service in NZ tailored specifically for people experiencing homelessness, with an associated professional isolation for NZ clinicians. The US has a different health service funding system, based around health insurance. However, the scale of homelessness in the US has produced innovative programs

which I have been aware of for some time, both from published research and specific service models that have been implemented in NZ, such as Assertive Community Treatment<sup>1</sup>.

The extent of homelessness in the USA is described as a crisis by the National Health Care for the Homeless Council. Homelessness is highly visible, with people living in tents or makeshift shelters, and less conspicuous encampments along waterways or in parks. A system of emergency housing and social support has grown around this problem, along with targeted health services that are clinic based or mobile. Mental health problems are a major health issue linked to homelessness, as both determinant and symptom of rough sleeping. Relative to NZ there is less community mental health provision and higher incarceration rates in the US, an aspect of their homeless landscape in that would require its own study focus<sup>2</sup>.

The Affordable Care Act (2010), known as Obama-care, improved the health care availability to many homeless people. The National health Care for the Homeless Council states: “Since 2014, 22 million people gained insurance through either Medicaid or the private insurance marketplace, and many millions more gained additional protections in the plans they already had”<sup>3</sup>. For example, Los Angeles County Department of Health provides a “safety net” for those without health insurance, where individual’s treatment can be “billed” to an insurer subsequent to the health intervention. Some clinics also provide free treatment for undocumented migrants who don’t receive payment under Medicaid.

However, the US health insurance landscape, with its federal, state and county funding, is not especially relevant to the NZ context. My focus was on the treatment models and approaches for this vulnerable population, seeking clinical learning and best practice examples. I will present these key learnings, followed by a background on homelessness and health from a NZ perspective. I will then describe my site visits, followed by comparisons with the NZ health services context, and then by my recommendations for NZ health and homeless services.

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<sup>1</sup> The author of this report manages a mental health service using the ACT model

<sup>2</sup> A interesting lay perspective on this is provided by Aviv (2011) in the New Yorker, <http://www.newyorker.com/magazine/2011/05/30/god-knows-where-i-am>

<sup>3</sup> <https://www.nhchc.org/wp-content/uploads/2016/11/post-election-faq.pdf>

## Key Learning

- Mobile health services are an effective way to deliver services to an otherwise excluded or vulnerable population. These can be completely detached services or linked to a ‘home clinic’, but the aim is to see people where they are.
- Health service models need to be responsive to the specific health needs of people who are homeless, who experience higher rates of mental health problems, addictions and acquired brain injury. Comorbidity may be as important as housing status.
- Integrated services were observed to be successful at meeting this population need.
- Partnerships between Non- Government Organisation’s (NGOs) and Government (both state and local) appeared to benefit patients by removing barriers and streamlining clinical pathways. Pooled funding was also more sustainable.
- Trauma informed care and harm reduction philosophies are considered best practice in many US homeless services. These approaches are known in NZ but not as effectively applied or as embedded as observed in US services.
- Philosophies and values can be meeting points for different services or organisations. Often in NZ the meeting point is ‘case by case’, whereas some effective partnerships I observed in the US were based on a shared vision, e.g. trauma informed practices.
- Screening for homelessness in Emergency Departments can greatly improve appropriate service response and care, with current screening and self-reporting likely to be ineffective (based on US research).
- Housing *is* health care - Rapid housing solutions and other Housing First approaches can improve the health of people by first housing them.
- Consumer/client governance structures improve service delivery and accountability.
- Therapeutic groups (both open and closed) can offer effective mental health and addiction treatment to this population (which may be contrary to NZ service perceptions of client capability due to transience).
- Language matters. The US health services I visited were clear that they served people who were experiencing homelessness, rather than ‘homeless people’.
- Primary care providers such as the Tenderloin Health Service in San Francisco were doing much that low-cost primary care services offer in NZ. The point of difference appeared to be their *co-location* with homeless social services and their *external partnerships*, although much of this relates to the scale of the homeless sector in California.

## Homeless Health: an overview

A significant body of research has accumulated in the past decade or more regarding the social condition of ‘homelessness’, both internationally and in NZ<sup>4</sup>. This has included research on pathways into homelessness and its lived experience. The health impacts and health service responses to homelessness are noted in most of the related literature, although local health service responses remain variable and somewhat ad hoc. The provision of health services to people experiencing homelessness requires an understanding of best practice treatments and available approaches, where otherwise this population may be underserved and chronically burdened with ill health.

The term ‘homeless’ refers to a range of un-housed or inadequate living conditions, from ‘rough sleeping’ to ‘rooflessness’; secondary homelessness as the use of night shelters or emergency accommodation; and tertiary homelessness as insecure tenancies and ‘sub-standard’ accommodation such as some in hostels or boarding houses<sup>5</sup>. Statistics New Zealand (2009), in consultation with the homeless sector, developed a four-tier definition of homelessness to clarify national census data collection:

- Without shelter (e.g. rough sleeping)
- Temporary accommodation (e.g. night shelters)
- Sharing accommodation (e.g. couch surfing)
- Living in uninhabitable housing.

The results from the winter 2016 census found 177 people sleeping rough in Auckland’s central city, which is more than double the figure found three years previously. It is important to note that this figure is an under-estimate and does not include people living in boarding houses which are also classed as secondary homelessness. 53% of those counted identified as Maori, 33% as Pakeha/NZ European, and 9% were of Pacific Island ethnicity<sup>6</sup>, which reflects the established correlation between social and material deprivation, ethnicity, and poor health outcomes in New Zealand<sup>7</sup>. The street count found 25% of rough sleepers in Auckland

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<sup>4</sup> For example: Hodgetts, Stolte, Nikora & Groot (2012); Hodgetts et al. (2010); Bukowski (2009); Scanlan (2009); Groot et al. (2008); Daiski (2007); Al-Nasrallah et al. (2005); Marvasti (2003).

<sup>5</sup> Richards (2009); Leggat-Cook (2007).

<sup>6</sup> New Zealand Herald (2016).

<sup>7</sup> Durie (1998).

central were female, which mirrors data from the UK<sup>8</sup> where a majority of homeless rough sleepers are males aged between 25 and 50 years old. There is however a recognised ‘hidden homeless’ population of women<sup>9</sup>.

Pathways into homelessness are varied, but predisposing factors include mental health, substance abuse, domestic violence, and lack of accessible housing<sup>10</sup>. Co-existing mental health and substance abuse problems are common. A 2003 report on iterative homelessness in Australia<sup>11</sup> found that this population to be “... deeply traumatised and grief-stricken and struggl[ing] with desperation in a context of self-loathing, shame and fear”. Mental Health and addiction services are therefore crucial for improving the wellbeing of people experiencing homelessness, along with social services and housing. Accessing these services and determining what type of treatment may be of help are questions that this Fellowship aimed to consider.

Recovery is a key concept within mental health services internationally and certainly in NZ, as reiterated in The Mental Health Commission’s (2012) *Blueprint II: Improving mental health and wellbeing for all New Zealanders*. Recovery is happening when there is hope and when a person can live well with or without the symptoms of mental health problems. As such, recovery is additionally difficult for marginalised and homeless service users.

Engagement focused services, such as outreach mental health services, are a partial response to this. Therapeutic relationships are central to mental health care, yet for hard-to-reach and transient people this therapeutic engagement requires both skill and time.

The lived experience of marginalisation and homelessness impacts upon the health on this under-served population<sup>12</sup>. Being homeless is likely to be harmful to physical and mental health, with poor nutrition, access to daily hygiene needs, anxiety and depression. Commonly cited medical conditions associated with homelessness include diabetes, seizure disorders, chronic respiratory disease and breathing problems, hepatitis, arthritis and musculoskeletal problems, cardiovascular disease, skin conditions, malnutrition, and poor dental care<sup>13</sup>.

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<sup>8</sup> Wigmore & Veitch (2003)

<sup>9</sup> Bukowski (2009).

<sup>10</sup> Richards (2009, p24)

<sup>11</sup> Robinson’s (2003, p4)

<sup>12</sup> Hodgetts, Radley, Chamberlain & Hodgetts (2007); Atkinson (2000)

<sup>13</sup> Nikora, et al. (2012); Daiski (2007)

Homelessness often exacerbates these health problems, with limited access to health care and late presentation both contributing to increased severity of physical illness<sup>14</sup>.

Looking at the international literature on homeless health services it is clear that integrated social and health services are considered favourable. Multidisciplinary health team structures and health outreach services are important for engaging a 'hard to reach' homeless population. Assertive or Intensive Community Treatment is one model commonly used to deliver health services for people who are street homeless, both in NZ and in similar social contexts such as USA, Australia and the UK. This model emphasises gradual engagement and working relationships, and as such is not a brief intervention. The USA was the origin of Assertive Community Treatment as a model, although in NZ it is largely used as a community mental health service model.

Integration of social and health services is considered 'best practice' within international literature<sup>15</sup> and is encouraged by Government policy and programmes in NZ. For example improving links between Primary Care health providers and Secondary Mental Health Services<sup>16</sup>, and improving the physical health of mental health service users as with Te Pou o te Whakaaro Nui's *Equally Well* programme.<sup>17</sup>

Collaborations between non-government organisations, local Councils, District Health Board services such as mental health and community alcohol and drug services, Housing New Zealand, NZ Police, Community Probation Service, and other agencies have emerged in recent years within the homeless sector. For example, in Auckland there is a Memorandum of Understanding between key homeless sector agencies - non-governmental, local government and public sector - as well as the Auckland Rough Sleepers Initiative. In Wellington there is a strengths-based case coordination process called Te Roopu Āramuka Whāroaroa<sup>18</sup>, and the Ending Homeless Strategy Te Mahana<sup>19</sup>.

Leggat-Cook's (2007) report *Homelessness in Aotearoa* identified lack of housing as a key barrier to social inclusion, and this appears even more so the case ten years on, especially in

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<sup>14</sup> Daiski (2007)

<sup>15</sup> National Health Care for the Homeless Council (2013); Gillig & McQuisition (2006)

<sup>16</sup> <http://www.tepou.co.nz/news/the-collaborative-with-a-capital-c/803>

<sup>17</sup> <http://www.tepou.co.nz/initiatives/equally-well-physical-health/37>

<sup>18</sup> <https://www.anzappl.org/new-zealand/wp-content/uploads/sites/5/2014/12/Aramuka.pdf>

<sup>19</sup> <http://wellington.govt.nz/~media/have-your-say/public-input/files/consultations/2013/02-te-mahana-homelessness-strategy/2014-temahana-strategy-final-draft.pdf>

Auckland. Housing First is a model gaining traction in NZ, following relative successes in similar social contexts such as the USA, Canada and Australia. Housing is proposed as the central intervention around which other services fit, often utilising an Assertive Community Treatment approach alongside its tolerant housing provision. As summarised by Australian service Micah Projects (2013):“Housing First involves the rapid identification and provision of suitable, long-term housing, coupled with the necessary services that individuals and families require to maintain this housing.”.

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### **Trauma Informed Practice**

Trauma informed practice is a philosophy or approach to health and addiction service provision. Distinct from trauma *counselling*, it is an approach that understands how past and recurrent trauma can affect people. Select guidelines are provided in the reference section, which include ideas for orienting services toward a trauma informed approach. The Canadian resource *Trauma Informed Practice Guide* (Arthur et al, 2013), provides these core principles:

**Trauma awareness**

**Safety**

**Trustworthiness**

**Choice and collaboration**

**Building strengths and skills**

## Site visit summaries

I visited homeless health services in Los Angeles and San Francisco, California, and Portland, Oregon. As I drove between LA and Portland I passed through other cities and regions where homelessness was an obvious issue, such as the encampments visible along the Russian River<sup>20</sup> near Guerneville. I stopped in at homeless services in places such as Santa Cruz, but my report will focus on the services I spent significant time with and who provided most learning.

A note on photos: I have provided photographs of some of the services I visited. However, it's generally not considered respectful to take photos of people who are street homeless, and at times would be ill advised. Many images are already in the public record and easily found on the internet, such as through LA Times and SF Chronicle<sup>21</sup>, or through any of the organisations I visited.

## Los Angeles

- **Venice Beach and Santa Monica**
- **Downtown LA and Skid Row**

Los Angeles County covers an area of 12,305 km<sup>2</sup> with a population of 10 million.

I spent a week in Los Angeles, initially in the Venice Beach/Santa Monica area and then Downtown<sup>22</sup>. According to the 2016 homeless census reported by the LA Times<sup>23</sup>, there are 43000 people sleeping rough or in emergency shelters in Los Angeles, with 4700 in the Downtown area and 870 in Venice Beach. As in NZ, these street count figures are considered an under estimate. Venice and Santa Monica Beach are relatively affluent areas of Los Angeles and are common tourist destinations. The temperate beach climate is also favoured by rough sleepers, who congregate along the board walk but also live in tents and temporary shelters in the beach suburbs parks and streets. There are also shelters and housing assistance programs, and boarding houses akin to those found in New Zealand's main cities.

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<sup>20</sup> <https://www.theguardian.com/us-news/2016/apr/13/california-redwoods-homeless-camp-guerneville>

<sup>21</sup> <http://projects.sfchronicle.com/sf-homeless/>

<sup>22</sup> This was the most 'different' to the NZ context and so I will describe this more fully.

<sup>23</sup> <http://www.latimes.com/projects/la-me-homeless-los-angeles-2016/>

Skid Row is an area of Downtown LA (DTLA) directly adjacent to the regenerating central district and surrounded by gentrifying inner city areas. The resulting housing crisis appears to have fuelled street homelessness in DTLA. There are thousands of people sleeping on the streets of Skid Row, in tents or makeshift shelters on the sidewalk. The rates of illicit drugs, mental health problems, and associated distress and violence are obvious. This was perhaps the least familiar and comparable social context to New Zealand that I visited, although I was able to learn from a number of impressive NGOs working in these confronting conditions.

The two organisations I spent most time with in LA were the Venice Family Clinic's homeless health outreach program in Venice and Santa Monica, and Homeless Health Care Los Angeles at their Downtown Harm Reduction Centre, their Beverly Boulevard HQ and biweekly pop-up health care day in the nearby suburb of Westlake. I visited a number of other organisations, which will also be noted.

### **Venice Family Clinic's homeless health outreach program**

The Venice homeless health outreach program is based out of two primary care clinics, with a MD (i.e. a family physician), Physician's assistant, Clinical Social Workers, Nurses and others. I attended the morning multi-disciplinary team meeting, where they discussed care planning, patient updates and outreach activities. Then I accompanied Rose (Clinical Social Worker), Colely (MD, family physician) and Carrie (Physician's Assistant<sup>24</sup>) on outreach in Venice and Santa Monica.

Rose, Colely and Carrie had clients to look for in outreach, in local parks and streets, as well as patients to visit in supported accommodation. For example, we looked for an older man reported seen and discharged from a nearby hospital. When found he was assessed (physically, mentally, socially) and supported as best as possible. This man was an "undocumented migrant" from Central America who'd been rough sleeping in the area for many years. His physical health was frail, but he would have to remain sleeping in the park and the team would aim to him again soon. Carrie's hand written notes (including physical health observations) would be entered into the electronic health record once back at the clinic.

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<sup>24</sup> A Physicians Assistant is a medical role working under supervision of a Physician. This is not an established health worker role in NZ. <https://www.aapa.org/What-is-a-PA/>  
My observation is that the PA role fulfilled (in outreach, at least) some of the tasks of a District nurse in NZ.

We then visited the Ocean Park Community Centre social service and night shelter in Cloverfield Blvd., Santa Monica. The team engaged with several people there, talking turns to lead interactions depending on the persons need (e.g. medical or more social working) and their existing rapport.

Another contact was with a woman living on the streets of Santa Monica, with a mental health diagnosis and comorbid physical health problems. She had an ulcerated leg, which the team re-dressed with a pressure bandage and topical medication. The outreach team are not mental health specialists but this intervention was holistic, caring for the physical, the social and mental health needs. This was simple but effective therapeutic outreach engagement in action; all the while members of the public passed us by, some noticing, some not.



Venice outreach team, Los Angeles

## Homeless Health Care Los Angeles

- **Centre for Harm Reduction (Downtown)**<sup>25</sup>
- **HHCLA main office**
- **Homeless Care Day in MacArthur Park**

At HHCLA's Centre for Harm Reduction, Downtown LA, I met with Jen (L&T Director) and Chloe (Program Director). The Centre for Harm Reduction is a multipurpose clinical site in the heart of Skid row's street homeless population. HHCLA provide counselling and drug treatment, including needle exchange and a peer support programme to prevent opiate overdose. They also offer Health Care Screening, individual and group therapy, and a transitional housing broker. They have a doctor's clinic, counselling rooms, a kitchen for clients, meeting space and resource room, quiet spaces for sensory modulation etc. They also do regular outreach with Housing for Health, St Johns Wellness Centre and the LAPD, but their Skid row Centre appeared to be a lively, community-owned hub of health advice and social support.

I also visited HHCLA's Main Office on Beverly Blvd., which has a health clinic and pharmacy downstairs and offices, training and group rooms upstairs. There I met Monica, the coordinator of the Homeless Care Days that happen every second and fourth Friday at MacArthur Park in the Westlake district, which I attended later that week. The Homeless Care Day is a "pop up" hub of health and social services that are authorised to use a corner of the Park. I was informed that this initiative had grown slowly over a year, from having only a few services to the lively event it is now. There were half a dozen mobile services<sup>26</sup>, including a primary care clinic bus, a full dental clinic, an HIV and Hepatitis C rapid testing center, TB screening, mental health services (termed *behavioural* health), and transgender health services. Also present were the Department of Public Social Services<sup>27</sup> and governmental licensing/identification services. This bi-weekly mobile hub appeared well utilised by the local homelessness population, and the organisational networking and collegiality was also obviously welcomed. This initiative was certainly an inspiration.

<sup>25</sup> <http://www.hhcla.org/how-we-help.html>

<sup>26</sup> I have included the flyer for Homeless care Days in eth appendices

<sup>27</sup> Similar role to MSD in NZ

In Downtown LA I also visited the LA County Department Mental Health Services, Star Clinic and Housing for Health, and other services. I spent a morning walking around Skid Row, where many services are located. The LA County Department of Mental Health Services is on the same street as Housing for Health and the Skid Row Housing Trust. Around the corner on East 6<sup>th</sup> Street is the Star Clinic, and further down the Midnight Mission on the corner with S San Pedro St, which is across the intersection from the Weingart Center's Hope Row Resource Centre. Along S San Pedro St is the LAMP community center. Another two blocks over on East 4<sup>th</sup> St is the HHCLA Center for Harm Reduction where I spent my first day in Downtown LA. Looming in the middle of all this is the Police station that takes up a full city block. Even so, for someone used to homeless outreach and mental health work, Skid Row was still an unnerving place for a walking tour.



Homeless Care Day, MacArthur Park, Los Angeles

The LA County Department Mental Health Services was unlike our local community mental health centers on first impressions. It had a buzzer entrance, armed security guards (who were somewhat perplexed by having a NZ visitor), airport-style security for bag checks, plus full plexiglass screens at counters with a small grill for talking. Whilst community mental health care in the US was not the focus of my Fellowship inquiry, I was glad to be able to speak with a staff member about their services. The staff had a skill mix and clinical qualifications

similar to NZ (RNs, CSWs, Clinical Psychologists, Psychiatrists and a similar Multidisciplinary team approach). They received formal referrals from others service (as occurs in NZ) with a triage process determining if they have a “severe and debilitating chronic illness” (i.e. an “Axis I mental illness”). They provided a Crisis Resolution Service (case-loads indicated at 40 -50 clients), as well as a Wellness program and therapeutic groups.

An important note was the need for a “warm hand off” (meaning referrals should be accompanied by a phone call at least, e.g. referral from HHCLA to Department Mental Health would be accompanied by direct contact with the referring service). I was told that this expectation of a “warm” hand-over is reciprocated with referrals back to the local NGOs.

As well as many people living on the street, downtown LA has emergency housing providers and Single Room Occupancies (SRO’s) – which are similar to what are called boarding houses in NZ. Transitional housing and Housing Trusts were also present, providing pathways out of rough sleeping. Across the road from the Department of Mental Health was one such place, the Skid Row Housing Trust building<sup>28</sup>. This eco-designed building provides Housing first accommodation, as well as the Star Clinic primary care centre and the offices of Housing for Health. I was not able to view the inside of the accommodation at the Housing Trust building, but met with an MD (physician) at the Star Clinic. As a primary care clinic offering services to the local population the clinical staff obviously had some experience with challenging health conditions, as well as difficult social and behavioural problems.

One of my aims in downtown LA had been to visit the famous LAMP community, however I was unable to meet anyone from LAMP who would or could make time with me and their Wellness centre appeared closed. The LAMP and near-by Midnight Mission premises were both very busy with day activities and drop in, resembling the crowds at Auckland City Mission at Christmas time (except it was just a ‘normal day’ here). However, my focus was on health services rather than housing and so the HHCLA proved most beneficial for transferable learning to a NZ context.

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<sup>28</sup> <http://skidrow.org/>

The HHCLA staff spoke about the current homeless ‘state of emergency’ and various organisational and government responses. Of relevance was Los Angeles County’s new Single Point of Entry for housing referrals, using a Vulnerability Index screening tool<sup>29</sup>. I heard that this was less ad hoc and chaotic than the previous system, but also more removed and bureaucratic. There was some concern that this manualized, form-filling approach could negatively impact the types of interactions staff might have with new service users. In a service where rapport and engagement is crucial, but so is accurate data and shared health records, this dilemma appeared unresolved.

**Overheard conversation in a Skid Row waiting room**

Good morning ma’am, I need to see a doctor

- Sorry, they’re not available today

But I was told to come down here to see the doctor

- Sorry we aren’t taking new patients currently, but you could come back next week and try to be seen as a walk-in

But I need to see a doctor to get a housing referral

- LAMP do housing referrals but they open at 8am and they’ll only do the first 10 people in line, so get there early

Well, OK... I need help for today and hope for tomorrow

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<sup>29</sup> The vulnerability Index has been suggested for use in Auckland at time in past years, and is used in the Australian homeless sector

## San Francisco

- **Street Outreach Services and the San Francisco Community Clinic Consortium**

Public Health figures suggest around 10,000 adults are homeless in San Francisco<sup>30</sup>, with the growth of tent encampments and emergency shelter needs becoming a major concern for the City. I visited health services in the down town and Tenderloin area of San Francisco, and joined with a mobile medical outreach in the nearby Mission district.

A highlight of my trip was the day spent the Street Outreach Services (SOS) mobile clinic. SOS is a program of San Francisco Community Clinic Consortium<sup>31</sup>. I first met with Director of Community Services, Beth Rittenhouse-Dhesi, who outlined the twenty seven year history of SOS and the San Francisco Community Clinic Consortium's (SFCCC) program's for San Francisco's vulnerable populations. SFCCC is a non-profit whose activities include:

1. Outreach, using a Health Care for the Homeless Federal Grant, to run the SOS program and nine clinics around the city.
2. Federal contracts for vulnerable populations, such as people experiencing homelessness or living with HIV.
3. Advocacy at the City, State and Federal level on health policy and law.

SOS provides urgent health care and link the person enrolled into a clinic. SOS are not authorised to provide ongoing primary care health services. They can refer the people they see in outreach to appropriate clinics or social service.

SOS have their own paid staff, plus volunteers through the Americore program. They also had resident and junior doctors on rotation on the clinics, and the Department of Public Health shares clinical resource and staffing from their own clinics. SFCCC also has a Consumer Advisory Panel which advises the Executive Board, with stipends paid for this work.

They had recently started using an electronic health record for outreach. Medical contacts will be logged in the SOS electronic system and the notes faxed across to the persons Department of Public health clinic. The Department of Public Health are then responsible for

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<sup>30</sup> <http://projects.sfchronicle.com/sf-homeless/numbers/>

<sup>31</sup> <https://www.sfccc.org/street-outreach-services/>

the ; ‘billing’ of the patient to the right funding stream – SOS do not arrange that, although they may help to arrange the required identification in order to access that funding.

I spent the afternoon with the SOS mobile clinic with Manny, who maintains and manages the bus, along with coordinator Ilana, Americore volunteer Sophie and a volunteer junior doctor. They would pull the mobile clinic up to street dwellings and tent encampments, open the bus doors and welcome people to the clinic. Aside from free health check-ups and urgent assessments, they would also provide basic hydration and snacks, socks and advice. I observed them providing wound care, referrals for dental and hearing services, referral for drug counselling, and advice with accessing legal help and transitional housing (to move off the streets).

The mobile clinic is set up with a curtained assessment room at the back, easily cleaned vinyl seats and bulk medical supplies and health promotion pamphlets. The mobile clinic has a rough schedule and route but doesn’t take patient bookings. As an urgent medical service they don’t aim to enrol patients. The population of street homeless is not fixed, with the City’s clearing of tent encampments in one area resulting in another encampment somewhere else. The SOS mobile clinic is also used for “pop-up” hubs, much like the one coordinated by HHCLA in MacArthur Park, Los Angeles.



Street Outreach Service Mobile Clinic, San Francisco



Aboard the SOS Mobile Clinic, San Francisco

Also visited in San Francisco was the Homeless Outreach Team (HOT), based in City Hall<sup>32</sup> premises as a County funded initiative. They worked in conjunction with the Tom Waddell Urban Health Clinic (which was a State funded primary care and Mental Health service in downtown San Francisco). I was informed that mental health and alcohol and drug services had recently amalgamated into a behavioural health service. I visited their premises but was not able to ride along with them, although I later met two impressive staff from the SF HOT team at the NHCHC conference I attended in Oregon.

I also visited Glide, a large non-profit social service in the heart of the Tenderloin district. The Tenderloin Health Service, upstairs in Glides multi-storey building, is another member of the San Francisco Community Clinic Consortium. The clinic waiting room was full when I visited, offering primary care, health screening, sexual health, counselling services, and referrals for specialist services.

<sup>32</sup> Equivalent to local government in NZ

A surprise find in the Tenderloins district was Lava mae<sup>33</sup>, a non-profit organisation that has established mobile shower and hygiene services for use by people experiencing homelessness. This public health initiative aims to provide “dignity, one shower at a time”, and is a model that could well be applied in a NZ context, where access to washing facilities has been an identified problem for rough sleepers. I had not heard of this initiative and saw it as directly transferable to the NZ street health context.



Lava Mae – a San Francisco Public Health initiative

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<sup>33</sup> <http://lavamae.org/>

## Portland

- **National Health Care for the Homeless Council annual conference**
- **Conference off-site visits**

The National Health Care for the Homeless Council's annual conference<sup>34</sup> was a two day event, book ended by two days of training and workshops. Aside from the intensive learning opportunity I enjoyed being around so many health professionals who work in the homeless sector. In NZ there are relatively few clinicians in the homeless sector, and even less are Nurses, whereas attendance at the NHCHC conference was over a thousand, including many inspiring homeless peer workers who are an important part of the US sector workforce.

Particularly rewarding learning opportunities for me included teaching sessions on:

- Acquired brain injury within homeless health settings.
- Homeless Screening in the emergency department – under-reporting and poor screening.
- Integrating trauma informed care and harm reduction philosophies into existing services.
- A primer on running mobile health clinics.
- Consent, dementia and decision making.

Central City Concern in Portland NGO with a Housing Rapid Response<sup>35</sup> and Supported Housing service, within the Housing First model. They also provide health services and have a mobile medical clinic. This outreach clinic was similar in many regards to the SOS mobile clinic in San Francisco, although Central City Concern provide more of what seemed primary care follow-up, as well as urgent treatment and assessments at city homeless encampments. Their mobile clinics also had scheduled times at some of the local Housing First projects, aiming to further remove barriers and encourage access to health care for their housed clients.

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<sup>34</sup> <https://www.nhchc.org/training-technical-assistance/2016-national-conference-policy-symposium/session-descriptions/>

<sup>35</sup> <http://www.centralcityconcern.org/services/health-recovery/housing-rapid-response/>

A second off-site visit from the NHCHC conference was to Portland's Outside In<sup>36</sup>, a health and counselling service that offers housing support and advocacy. This site visit was crowded, but this was still an impressive organisation to hear from. It was clear that consumer voices are central to their service provision, which was a strong feature of much that I saw in Portland.

## Method

My method for selecting health services to visit in the USA reflected my prior knowledge of the homeless health sector; my study objectives and key areas of interest; and the success of my negotiation to arrange access with specific services.

My postgraduate studies in Nursing focused on service and treatment approaches for mental health and homelessness. From that study I was aware of interesting research and literature on health care approaches in the US, such as mobile health clinics. The US National Health Care for the Homeless Council (NHCHC) is a network of clinician and health centres, consumers and advocates. I have been aware of their initiatives and practice guidelines for some time, as well as their network of clinical and collegial supports.

I used the NHCHC to identify professional organisations providing health services to people experiencing homelessness. I contacted clinicians at a number of health services in Los Angeles, Phoenix, San Francisco and Portland, seeking site visits and the opportunity ride-along with outreach and mobile clinics. Some clinical services proved to be more able to accommodate an international nurse visitor. I did not want to impose on busy health services, and I wanted more than a cursory overview. My itinerary (refer appendix) allowed flexibility for causal visits, but I prioritised those services where I could join them for the day. My itinerary had originally included the city of Phoenix in Arizona, but without confirmation from two key organisations that I could ride-along with them, I decided not to drive the 370 miles from LA to Phoenix, instead spending an extra two days in Los Angeles which allowed me to visit the Homeless Care Day (HHCLA), which provided key learning.

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<sup>36</sup> <http://outsidein.org/>

## Comparisons

The purpose of this WCMT Fellowship was to learn from US homeless health services, and some of these comparisons (those not noted elsewhere) are highlighted below.

- The Venice Family Clinic had a morning MDT<sup>37</sup> meeting and case management system that was immediately familiar to me, with shared team plans and client prioritisation. They used a basic database projected on to the meeting room wall, which they updated manually each day, plus a digital health record updated from hand written notes in outreach. They experienced problems from not having a sector-wide shared health record, which is similar to the case in NZ.
- Venice outreach was similar in its engagement focus to that seen in Auckland and Wellington homeless outreach. Clinicians were visible but not intrusive, speaking not only to their patients but picking up the ‘street news’. They linked in with other services such as the main emergency shelters. The main contrast was the key role that medical staff had – MD’s and PA’s – in providing and coordinating this outreach.
- There is no direct equivalent to NZ’s legislation for compulsory mental health treatment orders under the Mental Health (Compulsory Assessment and Treatment) Act 1992. There seems to mostly be inpatient compulsory treatment, where perceived risk to self and others is implied (as in NZ), and “501 Holds” for crisis interventions and assessments. This is related to the American constitutional emphasis on individual freedom, although the USA’s high incarceration and homeless rates somewhat complicate this health politics.
- I observed less use of expensive antipsychotic or other medications, partly because health insurance can’t always cover long term prescription of IMI<sup>38</sup> antipsychotics (whereas Pharmac<sup>39</sup> subsidises a number of antipsychotic medications in NZ). IMI’s are still used, e.g. Risperdol Consta, but only if the patient prefers that form of administration. I did not spend much time with the Department of Mental Health Services in California, so this may only relate to homeless health services.
- The health services often had high security, especially downtown LA, with buzzer entrance and sometimes armed security guards.

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<sup>37</sup> Multidisciplinary team

<sup>38</sup> Intra Muscular Injection

<sup>39</sup> The NZ Government agency responsible for managing publically funded pharmaceuticals

- A Harm Reduction approach was seen to be imbedded in some of the most impressive health services I visited (e.g. HHCLA), whereas in the NZ alcohol and drug treatment, secondary mental health and primary care services are less closely aligned (although NZ's Blue Print II policy aims to knit these closer together). A Co-existing Problems (CEP) approach is considered best practice in NZ mental health services, where mental health workers are trained in basic substance abuse treatment, including motivational interviewing. However in some of the services I visited in the US this CEP approach was more integrated. For example, HHCLA provides a case management program for co-existing problems, called an Integrated Treatment Program. The closest thing to this in NZ is CADS Dual Diagnosis consultation and brief intervention service. I was told that only recently have treatment for co-existing mental health and addiction issues been “billable” by HHCLA. This now allows them to pay clinicians to provide evidence based harm reduction interventions.
- The use of Naloxone<sup>40</sup> for opiate overdose was more wide spread in the US, although so is illicit opioid use. This had an interesting effect on enhancing peer support, since this medication is likely administered by friends in the instance of overdose. The HHCLA Centre for Harm Reduction in Skid Row had an *overdose super hero map* on their wall, marking the places where people had saved their friends from overdose with naloxone.
- Problems encountered by service users having a lack of formal identification appears to be a similar theme in both the US and NZ. Identification services and social security services working together with homeless agencies was observed to be a response to that. I was informed by HHCLA staff that this alone could save up to six hours queuing in two separate governmental offices, which could also equate to many hours of a case managers time. This resonates with local experience, and MSD<sup>41</sup> being signatories to the Auckland Homeless MOU has helped address some such issues.
- The use of a centralised referral system and screening tool, such as Coordinated Care Management System in Los Angeles County, appeared to have benefits as well as challenges. Similarly, the use of the Vulnerability Index screening tool provided better information regarding people's needs, but also increased form-filling as a staff activity (which was not always positive for client rapport).

<sup>40</sup> <http://www.medsafe.govt.nz/Profs/datasheet/n/Naloxoneinj.pdf>

<sup>41</sup> Ministry of Social Development

- Central City Concern’s Housing Rapid Response model in Portland was interesting, as it aimed to house people from the streets quickly and then wrap health and social services around with an intensive outreach services (ACT) and then later transitioning them to a less intense case management service. Currently in Auckland and Wellington it seem it is more an either/or situation, because the transition to a less intense service involves transfer to a different organisation, whereas Central City Concern in Portland aim to provide continuity in this transition.
- Medical Respite<sup>42</sup> is relatively unknown in NZ homeless health services, whereas respite is a key component of community-based mental health services. The high level of physical ill health experienced by rough sleepers is acknowledged, but the only option is often to admit someone to hospital. Medical respite services may merit further investigation in NZ.
- Staff skill mix was noted to be different, with Medical Doctors and Physicians Assistants doing outreach along with clinical Social Workers and counsellors which is different to the NZ context. For example, it is more common for Registered Nurses and unregulated support workers to carry out homeless outreach in Auckland.
- A final comparison concerns the stark differences between health and social welfare systems in NZ and the USA. In 2006 the journalist Malcolm Gladwell published an article called *Million-Dollar Murray* in the *New Yorker* magazine. Citing the huge costs attributed to *not* proving a home to one homeless military veteran, Murray Barr, Gladwell asserted that keeping people in homelessness costs far more than housing them with supports. The case of Million Dollar Murray is cited across the homeless literature internationally, including in New Zealand, as part of an argument for funding early intervention and Housing First solutions. However, the Million Dollar Murray argument is a reflection of the US’s different political economics and market model of health, as well as the significant issues arising from a high incarceration rate and large military, with veteran’s homelessness and Post-Traumatic Stress Disorder being notable issues in the US homeless sector. This is further reason why my focus has been on learning from the therapeutic models, such as Trauma Informed Care.

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<sup>42</sup> <https://www.nhchc.org/resources/clinical/medical-respite/tool-kit/>

## Recommendations

1. **Mobile health services** are an effective way to deliver health care to an otherwise underserved population.
2. **Integrated services** were observed to be successful at meeting population need.
3. **Street Health Partnerships.** Integrated services and mobile health services could provide safe and collegial service provision for underserved rough sleeper population. This could include District Nursing, Mental Health Outreach, Community Alcohol and Drug Services, Primary Care providers, urgent medical services such as ambulance services, plus the homeless sector and social housing providers. Guidance of tangata whenua and involvement of kaupapa Māori health services would be crucial, and could draw on existing initiatives such as Te Mahana Homeless Strategy group in Wellington.
4. **Healthcare pop-up hubs** could be replicated, bringing together existing resources.
5. **Trauma Informed Practices (TIP) and Harm Reduction** philosophies could be promoted and operationalised within the homeless sector.
6. **Best Practice Guidelines.** The author will propose and circulate best practice guidelines for health services in the NZ homeless sector, based on these findings and existing research. This would include encouragement for TIP and an emphasis on **continuity of care** and **warm hand-over**.
7. **Screening for homelessness in Emergency Departments** – improve data and health service focus. Flow-on benefits for community health/primary care follow-up<sup>43</sup>.
8. **Housing = health care** – a continuum of housing solutions is lacking in NZ by comparison with the US homeless health sector; shelters - transitional housing - permanent supported housing - independent living.
9. **Peer Governance structures.** Peer Support is an existing model used in NZ, in both mental health and homeless sectors. However, client/consumer governance structures could be further explored for strategic vision and accountability.
10. **Improve structures to staff homeless health workers.** By comparison, this study trip suggests that peer support and supervision for homeless health care clinicians may be currently lacking, which may reduce the sustainability of the workforce.
11. **Specific tools** that allow services to collaborate include shared technology and health informatics systems. This could be improved in wider homeless sector in NZ.

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<sup>43</sup> Refer Ledyard and Ulas (2015).

## **Conclusions**

This Winston Churchill Memorial Trust Fellowship was an excellent and invigorating opportunity. I had an existing knowledge of homeless health service from my own nursing work and an awareness of international research and initiatives. However, the experiential learning offered by this Fellowship opportunity has been invaluable, with insights and observations that I could never have gleaned without being on the street with these US homeless health workers. With an observed rise in street homelessness in NZ and an ongoing housing crisis, it behoves health and homeless services to plan and adapt to meet population need. I hope my contribution – reporting my findings and proposing best practice guidelines – will be useful for this developing health service response.

## **Reporting**

Presentation of findings have so far included my own service; a public presentation for the homeless sector in Auckland; the management team of High & Complex Needs at ADHB; and Te Ao Māramatanga (New Zealand College of Mental Health Nursing) in Auckland. Presentations are planned in Wellington, as well as education sessions on Trauma Informed Practice. Articles for health and homeless sector audiences are also planned in 2017.

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## Appendix: travel schedule

Tuesday 10<sup>th</sup> May – Friday 13<sup>th</sup> 2016

### Los Angeles

- Venice Family Clinic – Homeless Outreach
- Los Angeles Homeless Health Care LA, 2330 Beverly Blvd.
- Center for Harm reduction, 512 East 4th St., DTLA
- Housing for Health and the Star Clinic, Corner Maple Ave and e 6<sup>th</sup> St, DTLA
- Los Angeles Department of Mental Health Services , Maple Ave, DTLA
- Midnight Mission Shelter, 601 South San Pedro St., DTLA
- LAMP community, 526 San Pedro Street, DTLA
- Homeless Care Day, MacArthur Park, Westlake

Monday 16<sup>th</sup> May – Tuesday 17<sup>th</sup> travel to San Francisco.

En route: Casual visit – Santa Cruz Homeless Services and Clinic, Coral St, Santa Cruz.

### Wednesday 18<sup>th</sup> – Monday 23<sup>rd</sup> May

#### San Francisco Bay Area

- Street Outreach Service and San Francisco Community Clinic Consortium.  
<http://www.sfccc.org/street-outreach-services>
- Glide, 330 Ellis Street, Tenderloin District
- Homeless Outreach Team – City Hall
- Tom Waddell Urban Health Clinic

### Monday 30<sup>th</sup> May – Friday 3<sup>rd</sup> June

#### Portland

- National Health Care for the Homeless Council
- Conference, Portland.
- Central City Concern, 727 W. Burnside
- Outside In, 1132 SW 13th Avenue