CLINICAL AND EXPERIMENTAL
OPTOMETRY

EDITORIAL

Eye care for homeless people: Ten years on

Clin Exp Optom 2013; 96: 441–442 DOI:10.1111/cxo.12082

Piers Carozzi BSc(Optom) FACO
Outreach Services, Australian College of Optometry, Melbourne, Victoria, Australia
E-mail: pcarozzi@aco.org.au

It was in 2001 that a wide-eyed optometrist turned left into Grey St, St Kilda heading toward the Sacred Heart Mission, the site of the first 'homeless' eye-care clinic. St Kilda is an inner bayside suburb of Melbourne, renowned for its variety of lifestyles and its nightlife. As he slowed down and wound down the window for a clearer view of the unfamiliar area, one of St Kilda's working girls sensed her next client had just arrived and approached the car. After the initial confusion, the optometrist apologised profusely to the lady and explained that he was merely lost and the transaction ended prematurely. Neither of us seemed too disappointed by this course of events and with this, the homeless persons eye-care program of the Australian College of Optometry began.

Ten years ago there was little happening in Melbourne in homeless eye care. As an optometrist working at the Australian College of Optometry, I did not know much about homelessness. There were the occasional 'odd bods', who attended one of our mainstream public optometric clinics, usually with a caseworker in tow but homelessness was not on our radar as a subgroup of disadvantaged people. The Royal District Nursing Service's Homeless Persons Program (RDNS HPP), a nursing program for homeless people started the ball rolling, showing us the problem existed and how our current service delivery model was not suited for a 'homeless' population.

The target group of patients at the Australian College of Optometry comprises those who receive a pension and hold a health care card. There are about one million such cardholders in the State of Victoria and some four million in Australia. There is a great variety of relative wealth within this group and a strong argument can be made for a public health service, such as at the Australian College of Optometry to be targeting the most needy in this group.

The first step in getting started was a mindset, a willingness to get involved, to identify a gap in service provision and to try to do something about it. As someone employed in the public health sector since graduation with an interest in social justice, this was an easy step for me to make. It will be a harder leap for private sector optometrists but one that should be considered, and one that can be done in their local community. It may cost only a half-day per month. Optometrists will learn a lot about life, meet interesting people and do some good.

We then began to learn about homelessness, to understand more about the people we would be seeing. We know that homelessness is more than not having safe and secure housing. It is associated with poverty, with a lack of security and with social isolation. Mental illness, drugs and substance abuse are often involved in the road to homelessness or develop as a response, a coping mechanism to homelessness. The literature talks of the homeless subculture, built from a shared experience, a shared predicament, which at first supports homeless persons and allows them to survive, but then may make it hard to break out of the homeless cycle as it becomes that which is familiar. It can occur in episodes, often beginning at a young age, with people drifting in and out of homelessness.

On the 2011 census night, 105,000 people were homeless in Australia, with about six per cent sleeping rough. Most (39 per cent) were living in severely crowded buildings or in supported accommodation for the homeless (20 per cent). Seventeen per cent were 'surfing' temporary accommodation, while the same percentage were in boarding houses. The majority of homeless people were single (55 per cent), 44 per cent were female and 60 per cent were younger than 35 years.[1]

Homelessness can be categorised as primary, secondary and tertiary homelessness, where primary homelessness is sleeping rough or in tents or improvised shelter. Secondary homelessness includes those in temporary or crisis accommodation or regularly moving between one form of accommodation to another. Tertiary homelessness includes people who live in boarding houses, caravan parks and similar places. They are considered homeless because their accommodation is below the minimum standard of a small self-contained flat and they often have shared facilities.

It quickly became evident that our institutional model of eye care at the Australian College of Optometry, of a central facility with set rules and structures, was not appropriate for the people we were trying to see. This model presented barriers to eye care for homeless people. It also became evident that it was difficult to do this work on your own, that collaboration and partnerships were essential in the provision of eye care for this population. We work with organisations that already provide services for homeless people, organisations that have knowledge, networks and experience in this field. Sites were chosen carefully, where other services for homeless people existed, whether it be meal services, accommodation, other health care, counselling services or drug and alcohol services. Partnerships were made with organisations such as the RDNS HPP and with the workers in those organisations. These workers became our allies, identifying homeless people who would benefit from eye care, assisting them in attending their appointments and being a link if further care and referral are required.

A model was developed based on assertive outreach principles used by the RDNS HPP, using portable optometric equipment, providing domiciliary eye-care services at community settings run by organisations that provide services for homeless people. We have a van that can accommodate equipment for comprehensive eye examinations

to reduce the need for referral for further investigation.

We currently visit about 10 sites across Melbourne on a regular (at least monthly) basis to provide multiple access points to eye care in familiar settings, where homeless people congregate.

Flexibility was a key theme in building a system with the patients' needs in mind. We learned quickly to address issues of cost and the range of glasses available to the people we saw, accessing cheap frames or drawing on the kindness of frame companies to make glasses affordable for the people we see.

We built a team of optometrists, people who showed an interest in this type of work and received training from the RDNS HPP in 'the homeless experience', to prepare them for the program. Administration and dispensing staff provide support to the clinical team. Optometrists are usually involved one day per week or per fortnight to spread the load among the team, the philosophy being that this would make the program more sustainable and not just rely on the goodwill of a few.

As the program grew, we included the pension-level Supported Residential Services (SRSs) into the program. SRSs are privately operated businesses that provide personal support and shared accommodation for people who are generally frail, have mental illness or disability. There are 180 SRSs providing accommodation and care for over 6,000 people. There are two levels, 'Pension level' and 'Above pension level'. 'Pension level' means that at least 80 per cent of residents pay the pension rate for their accommodation.[2] This means that the residents pay the vast majority of their pension to the SRS, for rent, meals and medications, meaning they have very little disposable income and do not have the means to pay for glasses. They are typically older people (mean age 70 years) but some are as young as 20. Ninety-six per cent of residents in a 'Pension level' SRS have a disability.

Supported Residential Services represent a tertiary level of homelessness and participants are provided eye care by the Australian College of Optometry as part of its homeless service.

The service visits around 40 'Pension level' SRSs across Melbourne. We typically see 900 to 1,000 people per year in our homeless persons eye-care program and visiting SRS facilities.

The homeless persons eye-care program raises interesting questions about our role as optometrists and our responsibility to our community. This editorial might provide some ideas for optometrists who are interested in working with marginalised groups.

Optometry is a primary care profession that should be available to as many people in our community as possible. The Australian College of Optometry's homeless persons eye-care program is an example of a response to a marginalised group in our community. The lessons we have learnt may have application to other similar groups. Our approach has been characterised by proactivity, by learning and by educating ourselves about the people we are trying to help. We have found it necessary to work in partnership with other organisations and people already involved in helping, to work with empathy and to be flexible in the way we provide care. Programs like this represent an opportunity to give something back to our community, to those less fortunate.

REFERENCES

1. Australian Bureau of Statistics. 2049.0 Census of population and housing: estimating homelessness, 2011. Canberra: Australian Bureau of Statistics 2012. Available at http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/EB59F237159F7102CA257AB100170B61/$File/20490_2011.pdf
2. Department of Human Services Victoria. 2008 Supported residential services census. Summary report: residents. Melbourne: Department of Human Services Victoria 2009. Available at: http://docs.health.vic.gov.au/docs/doc/90DED4814BA8B030CA257A46007D4F2D/$FILE/census08_residents.pdf