PRIMARY
HEALTH
NETWORK

Health Where Children Are

Integrating health care for children experiencing DFSV and homelessness

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Primary Health Networks — and what we are here to do

There are 31 PHNs across Australia, each covering a defined geographic region. Our role is not to deliver frontline services — it is to make the system work.

C Coordinate

We coordinate and integrate local health care services in collaboration with Local Hospital Networks (LHN) — to improve quality of care, people's experience, and the efficient use of resources.

C Commission

We commission primary care and mental health services to address population health needs and gaps in service delivery — and to improve access and equity where it matters most.

C Capacity-build

We build capacity and provide practice support to primary care and mental health providers — so they can deliver quality care to the communities that need it most.

HNECC PHN covers Hunter, New England and the Central Coast — one of the largest PHN regions in Australia by geography.

INTERNAL

Case study

A child in crisis accommodation.
A GP at the door.
Integration in practice.

INTERNAL

Children are often the invisible people in our systems

1 in 3

SHS clients are experiencing family violence

27%

of people accessing SHS support are under 18

18,900+

children homeless on any given night

76,000

children sought help from homelessness services (2023-24)

Source: AIHW Specialist Homelessness Services 2023-24

Children experiencing homelessness face disproportionate poor health outcomes and mortality risk

What homelessness exposes children to

- Chronic illness and untreated injuries
- Mental health conditions and trauma
- Malnutrition and dental disease
- Disrupted schooling — multiple school changes
- Developmental delays, undetected hearing loss
- Exposure to ongoing violence



The gap is not just health — it is survival

Children with SHS history make up 1 in 13 of all child deaths nationally — almost 10% — despite being a tiny fraction of the SHS client population. This is not a health inequality. It is a mortality risk.

SHS alone cannot address it. Integration with primary care is not optional — it is essential.

Source: AIHW 2023-24; AIHW 2025

Our response: bringing health care to where children already are

THE MODEL

PHN-commissioned outreach GP and nurse clinics, delivered inside DFSV services and homelessness settings — where families already are.

- Bulk-billed — zero cost barrier
- Trauma and DFSV informed health care
- Children seen alongside parents
- Immunisations, development checks, mental health
- Warm referral into specialist services
- PHN + HNELHD + DFSV / HOMELESSNESS services co-designed

69% of clients at our outreach clinics are children (0-17)

>50% of children in Outreach Healthcare identify as First Nations

300 interagency case conferences connecting health, DFSV and housing

70+ specialist referrals — paediatricians, speech pathology, audiology, OT

Source: HNECC PHN Supporting Outreach Pilots Dashboard 2025-26

Commissioning integration to reduce fragmentation and system gaps can be challenging

The tension we have to design around

A child with developmental delay is in refuge. She needs her GP, a speech pathologist, a nurse. This is exactly the right moment to intervene.

At the same time, the refuge — under enormous pressure from the housing crisis — has found a housing option. She needs to move.

HEALTH worries about

- Losing contact after move
- Incomplete assessment
- No GP in new area
- Referral chain broken

HOUSING is under pressure to

- Meet housing allocation KPIs
- Reduce refuge waitlist
- Move families on safely
- Comply with tenure timelines

The commissioning response

Integration Coordinators

Fund people whose job is to be the connective tissue — not a service, a systems broker. Holding the whole picture when each sector can only see their part.

Prioritise protected time weekly

Health, housing and DFSV sitting together every week — sharing context on this child, this family, right now. Not referrals. Shared decision-making. This built relationship was also an osmosis of learning between two sectors.

Make the wins visible across the whole system

When each sector can only see its own slice, no one has the full picture. We built shared reporting so health, housing and DFSV teams could see outcomes together and the difference they were making together – not just their own slice of it.

Co-design, co-production and integration workshops are worth the investment

GP, paediatrician, speech pathologist and OT, co-located in the refuge. Families don't repeat their DV story. The team already knows.

Source: HNECC PHN Supporting Outreach Pilots Dashboard 2025-26

What we have learnt integrating homelessness and health services requires

01 Fund the integration as an activity, not just the clinical services

Integration requires a dedicated role — someone who understands both systems, bridges the gaps, and has protected time to build relationships. Most commissioning funds the service. We also need to fund the connective tissue.

02 Invest in the work before the work

Co-design is not just consultation. It is where the social contract gets built.

03 Don’t let goodwill do the work of governance

Shared vision, data sharing agreements, consent pathways, and clear escalation structures are what make integration safe, sustainable, and transferable — not the goodwill of the people currently in the room.

04 Expect conflict. Agree how you’ll behave before it does.

Different organisations carry different risk thresholds, KPIs and obligations. We built time into our co-design process to name that honestly — and to agree on how we wanted to show up when things got difficult. That agreement has been more useful than any protocol.