ROYAL PERTH HOSPITAL HOMELESS TEAM

THIRD EVALUATION REPORT
NOVEMBER 2023

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This report has been produced by members of the Home2Health research team at the Institute for Health Research (IHR) at the University of Notre Dame Australia (UNDA), on behalf of the Royal Perth Hospital (RPH) Homeless Team.

ACKNOWLEDGEMENT OF COUNTRY

Home2Health acknowledges the traditional owners and custodians of the land on which it is located and has undertaken this research: *the Wadjuk people of Noongar Nation.* The authors pay their respects to Elders both past and present, for they hold the knowledge, language, traditions, and culture of their people and of their land. Sovereignty has never been ceded. ***It always was and always will be, Aboriginal land.***

The authors sombrely recognise the complex web of factors and trauma underpinning the vast overrepresentation of Australia's traditional custodians among people experiencing homelessness.

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We also acknowledge the many people experiencing homelessness in Perth. This research is imperative in reducing the health disparities that coalesce with homelessness.

DISCLAIMER

The opinions expressed in this report reflect the views of the authors and not necessarily those of the RPH Homeless Team or the Royal Perth Bentley Group (RPBG) more broadly.

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THE FACT THAT RPH HOMELESS TEAM STAFF WORK BOTH IN THE HOSPITAL AND IN THE COMMUNITY HAS CONTRIBUTED GREATLY TO CONTINUITY OF CARE [FOR PATIENTS EXPERIENCING HOMELESSNESS].

I BELIEVE HAVING THE HOMELESS TEAM PRESENT WITHIN THE HOSPITAL HAS IMPROVED LINKAGES FOR HOMELESS PATIENTS IN THE COMMUNITY AND IMPROVED SUPPORT FOR THOSE PATIENTS ABOUT WHERE TO GET REQUIRED ASSISTANCE.

NOT ONLY DOES HAVING THE RPH HOMELESS TEAM IMPROVE OUTCOMES FOR THE HOSPITAL, MORE IMPORTANTLY IT IMPROVES OUTCOME FOR PATIENTS BY SUPPORTING THEM TO ACCESS COMMUNITY SUPPORT, ACCOMMODATION...

- **RPH STAFF MEMBER**

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ACRONYMS & ABBREVIATIONS

AOD	Alcohol and Other Drug
BNL	By Name List
CBD	Central Business District
cPTSD	Complex Post Traumatic Stress Disorder
DAMA	Discharge Against Medical Advice
ED	Emergency Department
EMHS	East Metropolitan Health Service
EMW	Emergency Medical Ward
EUPD	Emotionally Unstable Personality Disorder
FDV	Family and Domestic Violence
FSH	Fiona Stanley Hospital
FY	Financial Year
GP	General Practice/General Practitioner
HDFFP	Homeless Discharge Facilitation Fund Project
Hep C	Hepatitis C
HHC	Homeless Healthcare
HIV	Human Immunodeficiency Virus
IVDU	Intra-venous drug use
KEMH	King Edward Memorial Hospital
KHP	King’s Health Partners
LT	Long-term
MCOT	Mobile Clinical Outreach Team
MH	Mental Health
MHHP	Mental Health Homeless Pathway Project
MRC	Medical Respite Centre
NDIS	National Disability Insurance Scheme
NFA	No Fixed Address
OT	Occupational Therapist
PTSD	Post-Traumatic Stress Disorder
RGH	Rockingham General Hospital
RPH	Royal Perth Hospital
RPBG	Royal Perth Bentley Hospital Group
RPH Homeless Team	Royal Perth Hospital Homeless Team
SCGH	Sir Charles Gairdner Hospital
SD	Standard Deviation
SNS	Safe Night Space
ST	Short-term
SW	Social Worker
TBI	Traumatic Brain Injury
TBMHC	Trauma-Based Mental Health Conditions
THC	Tetrahydrocannabinol
UK	United Kingdom
US	United States
UNDA	University of Notre Dame Australia
WA	Western Australia
WACHS	WA Country Health Service

EXECUTIVE SUMMARY

HOMELESSNESS IN WA

The 2021 Australian Census[1] shows that, in Western Australia (WA):

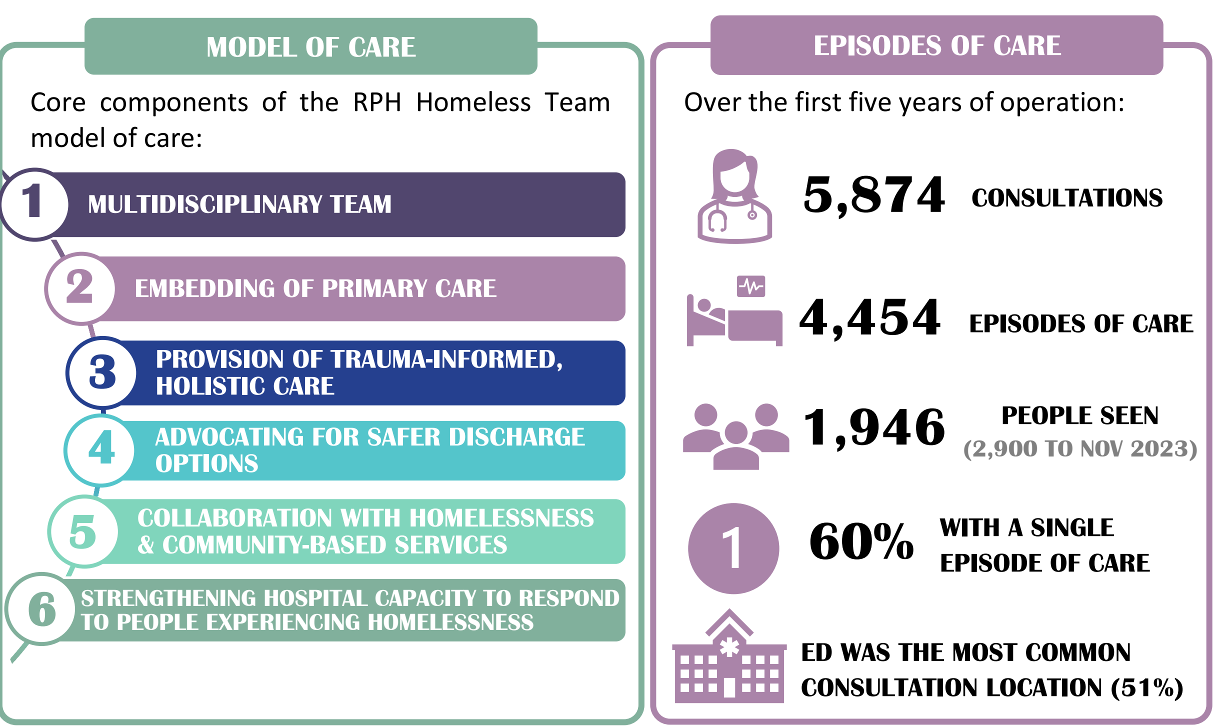
9,700 PEOPLE ARE EXPERIENCING HOMELESSNESS *(39% increase from 2016)*

THE PROPORTION OF ROUGH SLEEPERS (24%) IS HIGHEST IN THE COUNTRY

43% OF ROUGH SLEEPERS ARE ABORIGINAL AND/OR TORRES STRAIT ISLANDER

THE RPH HOMELESS TEAM

The Royal Perth Hospital (RPH) Homeless Team was established in June 2016 with the overarching aim of identifying and providing support to patients experiencing homelessness within RPH. The Homeless Team model was initially based upon the UK Pathway approach[2] but has been adapted over time to suit the WA context. Prior evaluations of the Homeless Team in 2018[3] and 2019[4] described the role and function of the Team, patient demographics, and changes in healthcare utilisation of patients after receiving support. The present evaluation describes the Team's aims, mission, and model of care (including the patient referral process), the housing and health needs of ***patients seen over the first five years of operation***, including any changes in hospital use, and the wider contributions of the Homeless Team to addressing homelessness in WA over the ***seven years since inception***.



DEMOGRAPHICS & HEALTH NEEDS OF HOMELESS TEAM PATIENTS

OF THE 1,946 HOMELESS TEAM PATIENTS:

65% MALE

42 YEARS OLD ON AVERAGE

33% ABORIGINAL OR TORRES STRAIT ISLANDER

15% BORN OVERSEAS

72% ROUGH SLEEPING AT FIRST CONTACT

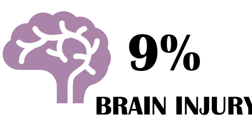
HEALTH NEEDS

On first assessment with the Homeless Team:

25% HAD AN INJURY *(wounds & fractures)*

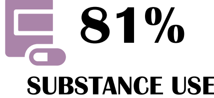
24% HEPATITIS B OR C

16% RESPIRATORY CONDITION



9% BRAIN INJURY

Additionally, Homeless Team patients had histories of:



81% SUBSTANCE USE

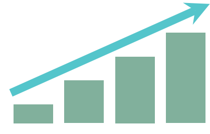
27% DEPRESSION

14% DELIBERATE SELF-HARM *(injury & overdose)*

13% SCHIZOPHRENIA

HEALTH SERVICE UTILISATION

IN THE THREE YEARS PRIOR TO FIRST HOMELESS TEAM CONTACT



Consistent with the hospital use profile of people experiencing homeless globally, hospital use of patients seen by the Homeless Team **increased steadily over the three-year period leading up to first contact**.

IN THE THREE YEARS PRIOR TO FIRST HOMELESS TEAM CONTACT:

>21,000 ED PRESENTATIONS

ONE-THIRD OF PATIENTS HAD >10 PRESENTATIONS

~9,100 AMBULANCE ARRIVALS TO ED

>9,000 INPATIENT ADMISSIONS

>55,000 DAYS ADMITTED

$156mil IN EQUIVALENT WA HEALTH COSTS^

$80k PER PERSON *(over 3 years)*

^ based on average costs of $894 per ED presentation,[5] $1,034 per ambulance arrival to ED,[6] $2,879 per non-psychiatric inpatient day admitted,[5] and $1,596 per psychiatric day admitted for WA public hospitals[7]

CHANGES IN HEALTH SERVICE UTILISATION

Comparing **six months** pre-to-post first Homeless Team contact, among the entire cohort (n=1,946):

MOST PATIENTS HAD REDUCED HOSPITAL USE POST-HOMELESS TEAM SUPPORT

ONE IN TWO (56%) HAD FEWER ED PRESENTATIONS *(14% unchanged)*

TWO IN FIVE (41%) HAD FEWER AMBULANCE ARRIVALS *(34% unchanged)*

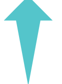
ONE IN TWO (56%) HAD FEWER INPATIENT ADMISSIONS *(21% unchanged)*

TWO-THIRDS (63%) HAD FEWER NON-PSYCHIATRIC DAYS ADMITTED *(11% unchanged)*

DISCHARGE DESTINATION PLAYS A SIGNIFICANT ROLE IN CONTINUED HOSPITAL USE

Large variations in pre/post hospital use were observed depending on discharge destination, with **patients discharged to rough sleeping experiencing increases in use** and those discharged to accommodation experiencing decreases.

DISCHARGED TO ROUGH SLEEPING



↑ **3%** ED PRESENTATIONS

↑ **36%** DAYS ADMITTED AS AN INPATIENT

DISCHARGED TO ACCOMMODATION

↓ **6%** ED PRESENTATIONS

↓ **22%** DAYS ADMITTED AS AN INPATIENT

IMPLICATIONS FOR THE HEALTH SYSTEM

Comparing the six months pre- to six months post-first Homeless Team contact, the changes in hospital use of the cohort were associated with an estimated reduction of:

↓ **$7.2mil** IN ASSOCIATED HOSPITAL COSTS^

OR

$3,700 PER PERSON

>3 x CHEAPER THAN HOMELESS TEAM OPERATIONAL COSTS PER PERSON

"I became homeless at the age of 49, just after I found out my kidney's had failed and started dialysis at RPH within a week of that…. I also have sleep apnoea, heart failure, cellulitis in my legs and diabetes and I spent most of the time being homeless living in my car. I got very sick and it was predicted that if I had to spend another summer in the car I wouldn't survive. No one should be homeless, let alone sick people" – **Patient supported by the Homeless Team**

"I thought I was going to die before meeting you guys, I couldn't have known people out there that would give me the time of day without wanting something in return. So really thank you all, you have saved my life." – **Patient supported by the Homeless Team**

KEY BENEFITS OF THE HOMELESS TEAM

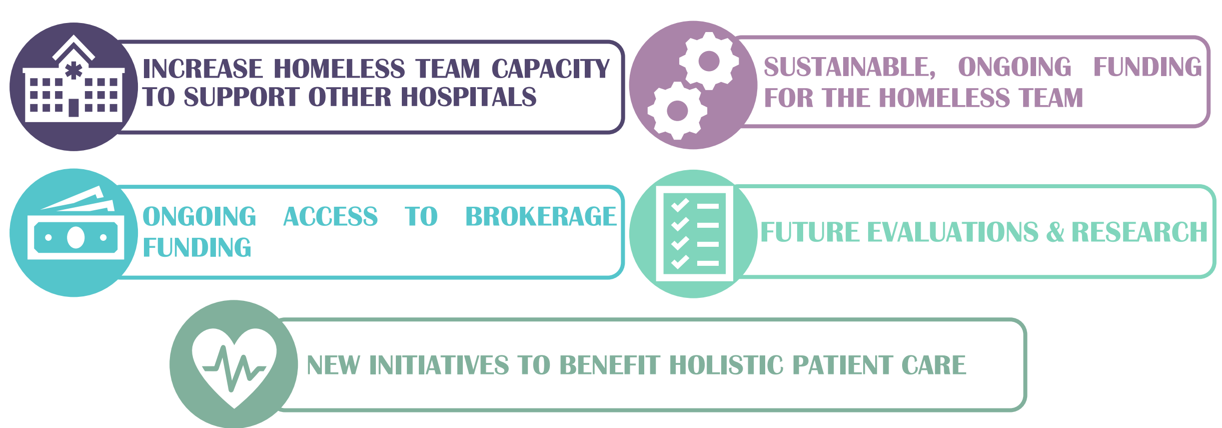
The Homeless Team has generated many beneficial outcomes for patients, the hospital, and the wider WA health system. Its impact also extends beyond RPH and the patients directly supported, with the Team making a wider contribution to addressing homelessness in WA.

IMPROVED HEALTH OUTCOMES FOR HOMELESS PATIENTS	Improved outcomes for patients are evident through the detection and addressing of underlying health issues, greater access to primary care and reduced hospital use.
IMPROVED CARE COORDINATION	Via advocacy, facilitating links to other health and homeless services, and improved discharge planning (including discharging to accommodation).
ENHANCING RPH CAPACITY TO SUPPORT HOMELESS PATIENTS	Increased RPH staff confidence to identify and respond to the needs of patients experiencing homelessness. Brings homelessness expertise into the hospital.
IMPROVED CAPACITY FOR OTHER HOSPITALS & HEALTH SERVICES	Increased understanding and capacity across services regarding impact of homelessness and health, and via the support and advocacy provided to other services' clients.
REDUCE WA HEALTH SYSTEM BURDEN	Reductions in hospital use including representations, reduced length of stay when discharged to accommodation. Freeing up bed blockages for others.
THE WA HOMELESS SECTOR	Via involvement in multiple homelessness sector initiatives, resulting in more holistic support and improved outcomes for people who may otherwise have slipped through service gaps. Increased presence of health "at the table".
NATIONAL & INTERNATIONAL BEST PRACTICE	The Homeless Team model and evidence of impact is considered an exemplar of best practice and has been used by other organisations and policy makers to inform health-led initiatives to address homelessness.
WIDER CONTRIBUTIONS TO ADDRESSING HOMELESSNESS	Impact on wider contribution to addressing homelessness in WA, including through participation in high-level advisory groups and committees, advocating on policy and service gaps, and involvement in collaborative, cross-sector initiatives.

RECOMMENDATIONS AND LEARNINGS

The Homeless Team is a valuable asset to the WA health system and the community as a whole. It continues to model how effective collaboration between health and community services can make a real difference in the lives of people experiencing homelessness and connect vulnerable rough sleepers to housing, support services, and long-term primary care.

To sustain this impact, this report makes recommendations across five areas:



1 BACKGROUND & REPORT CONTEXT

This is the third evaluation report of outcomes for the Royal Perth Hospital (RPH) Homeless Team, covering the Team's first **seven years of operation**. The first and second reports examined outcomes from the Team's first 18 months[3] and 2.5 years[4] of operation, respectively.

This chapter sets the scene of homelessness in Western Australia (WA) and outlines the link between homelessness and poor health and the overall aims and methodology used for the evaluation.

1.1 HOMELESSNESS IN WESTERN AUSTRALIA

Homelessness is a substantial societal and health issue both in WA and Australia. This report uses the Chamberlain and McKenzie[8] definition of homelessness, which distinguishes between 'primary', 'secondary', and 'tertiary' homelessness (Figure 1). People experiencing **primary** homelessness (rough sleeping or street-present homelessness) are the most disengaged from support, have the worst health outcomes, and represent the largest economic burden to the health system.

PRIMARY HOMELESSNESS

Experienced by people without conventional accommodation, *e.g., rough sleeping in parks, lanes, shop alcoves, sleeping in cars or squats.*

SECONDARY HOMELESSNESS

Experienced by people who frequently move between forms of temporary shelter or accommodation, *e.g., couch surfing, youth refuges, emergency accommodation.*

TERTIARY HOMELESSNESS

Experienced by people staying in accommodation that falls below minimum community standards *e.g., boarding housing and caravan parks.*

Figure 1: Definitions of Homelessness

Data on homelessness from the 2021 Australian Census show that the number of people sleeping rough in WA has more than doubled since 2016, with 2,315 individuals experiencing primary homelessness on Census night and the number of people experiencing homelessness on any given night increasing by 8% to almost 10,000.[1] Disturbingly, Aboriginal and/or Torres Strait Islander (hereafter 'Aboriginal') people currently account for 43% of the known rough-sleeping population in WA, a dramatic rise from pre-COVID-19 figures of around 30%.[1]

In Perth, as in many major cities, chronic homelessness and rough sleeping is concentrated in the inner-city area, which falls within the East Metropolitan Health Service (EMHS) catchment. The most recent Department of Communities Housing Authority Annual Report (2022-2023)[9] showed that, since the onset of COVID-19:

- the **number of people on the public housing waiting list** has increased by nearly 40% to approximately 19,500 people (from around 14,000 pre-COVID),
- *the **average waiting time for accommodation** increased by 41% to 133 weeks (from 94 weeks pre-COVID),*
- *the **number of people provided with housing assistance** decreased by nearly 60% to only 6,384 provisions of actual assistance (from nearly 16,000 pre-COVID).*

Further, the priority public housing waitlist, which is for people who have a priority need for public housing due to currently experiencing homelessness, family and domestic violence or medical conditions aggravated by their current living situation, increased in length by 31% between 2021 and 2022.[10] However, as shown in the evaluation of the recently ended 50 Lives 50 Homes Housing First program,[11] even on the priority waitlist the average wait for a one bedroom unit is 16 months. Across WA, crisis and transitional accommodation for people experiencing homelessness are at full occupancy, and demand for domestic violence and youth accommodation services is at an all-time high. This high demand cannot be met, due to a severe bottleneck arising from a lack of longer-term public or affordable housing options.

Additionally, many more people are at heightened **risk of homelessness** or cycling in and out of homelessness or precarious housing, with 278,300 people assisted by Specialist Homelessness Services in 2020-21 around Australia, including 24,470 in WA.[12] Earlier identification and intervention for people at risk of homelessness or oscillating in and out of homelessness is critically relevant to the WA Health system, as healthcare usage and associated costs escalate the longer people are homeless.[13]

1.2 HOMELESSNESS & POOR HEALTH INTERTWINED

Homelessness internationally and within Australia and WA is strongly linked to both poorer health outcomes and barriers to health care access and engagement, with these factors having a cumulative exacerbating effect the longer people remain homeless.

1.2.1 HEALTH INEQUALITY MEASURES ASSOCIATED WITH HOMELESSNESS

Experiences of homelessness are associated with enormous health inequalities, multiple complex health issues and relatively poor health outcomes overall, including:

- ***Life expectancy gaps*** of 20-40 years, as reported internationally, including in North America,[14,15] Europe,[16-20] Africa,[21] and Australia.[22-24] Data from the evaluation team has shown an average age at death of **50 years** for people who have experienced homelessness in Perth and who have been in contact with a service evaluated by the team in the past six years.
- ***Premature mortality rates*** of 8-12 times higher than the general population, as reported in a Lancet meta-analysis.[14]
- ***Preventable deaths.*** Treatable and preventable conditions accounted for one in three deaths of people experiencing homelessness in a recent UK study.[16] A recent Australian study found that external causes, including accidents, alcohol and other drugs, cardiovascular disease and cancer, were the leading causes of death for people experiencing homelessness, amongst whom the average age at death was 57 years.[23]
- ***Accelerated aging.*** Long-term homelessness is associated with accelerated ageing, with a US study finding that the prevalence of 'geriatric' conditions among people experiencing homelessness was comparable to that of housed populations 20 years older.[25] Earlier onset of chronic diseases, cognitive decline, and frailty are commonly seen by the Homeless Team.
- ***Chronic Health Conditions.*** Experiencing homelessness increases the risk of many health problems, including psychiatric illness,[26,27] substance use,[26,27] chronic disease, musculoskeletal disorders,[28] skin and foot problems,[29] poor oral health[30] and infectious disease.[26]
- ***Multi-morbidity*** is 'the norm'; people experiencing homelessness typically have multiple physical health conditions, along with mental health and alcohol and drug (AOD) use issues.[31] Co-occurring health issues, particularly when untreated, cause other health complications.

1.2.2 BARRIERS TO HEALTH CARE ACCESS & ENGAGEMENT

The multiplicity of poor health outcomes for people experiencing homelessness are the culmination of many inter-related factors at the individual, health service and society levels, as depicted in Figure

2. This diagram draws on both published literature and observations of the Homeless Team and Homeless Healthcare staff. Homeless Healthcare (HHC), operating in Perth, is the largest provider of primary care services to people experiencing homelessness in Australia.

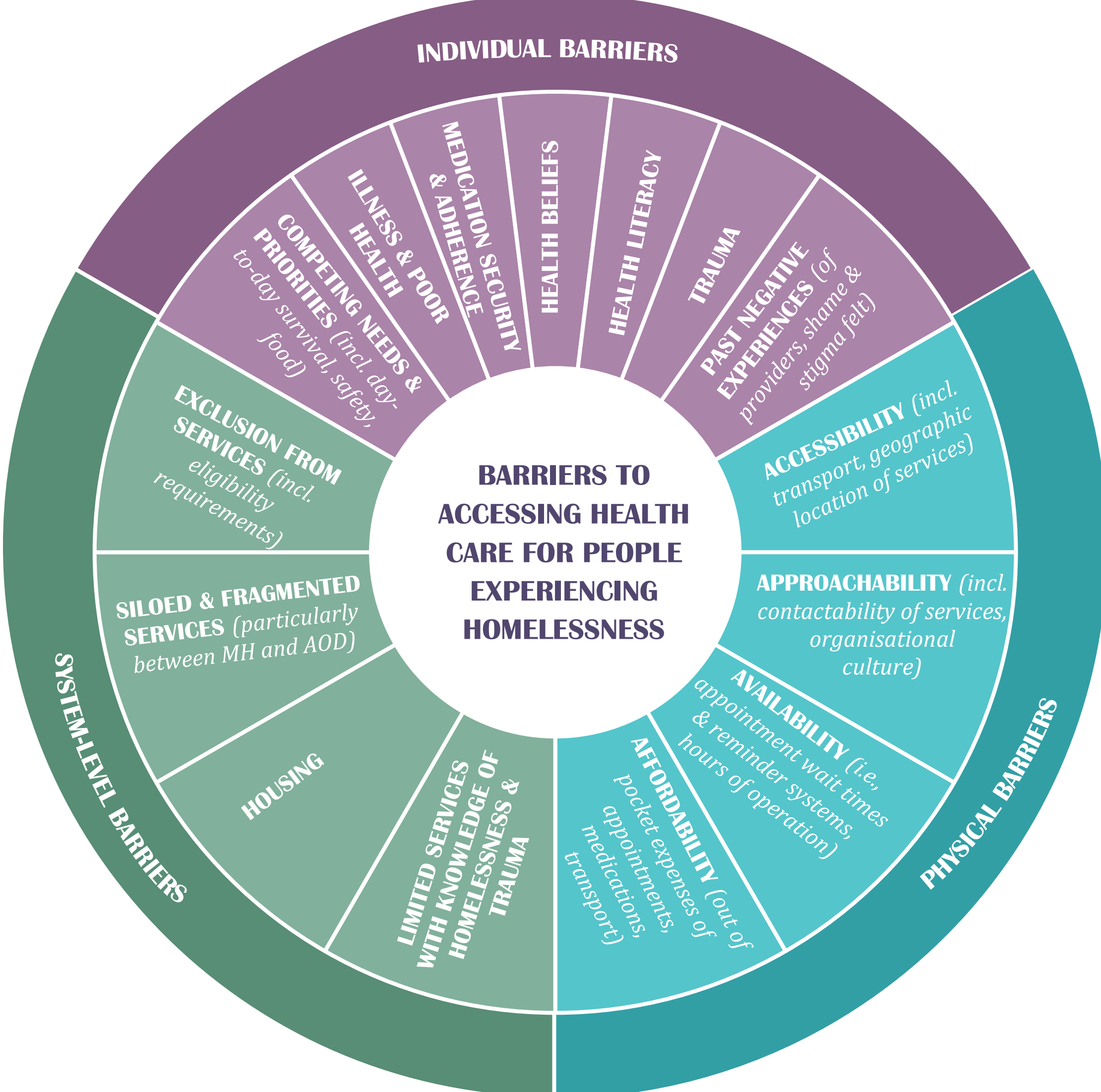


Figure 2: Barriers to Accessing Health Care for People Experiencing Homelessness

Notes: Hybrid model developed based on clinical observation, models by Schwarz et al (2022)[32] and Bennett-Daly et al. (2022),[33] Maslow's Hierarchy of Needs[34] and the social determinants of health.[35]

The way in which individual circumstances and health system factors compound barriers to timely healthcare engagement has been aptly described by the Medical Director of HHC.

> *"Homeless people often struggle to trust health practitioners, and many have had bad experiences of the health system. The transient nature of homelessness and the focus on day-to-day survival also makes comprehensive medical care difficult. Underlying all of these are the social determinants of health and trauma; things that have usually been outside of the control of the individual, but have a lasting impact on health. The result is the progressive deterioration in health and greatly shortened life expectancy."*
>
> **– Dr Andrew Davies, Medical Director, HHC**

Similar observations have been made by homeless health practitioners elsewhere. For example, O'Carroll et al (2019) wrote in a paper from Ireland:

> *"Homeless people tended to present late in their illness; default early from treatment; have low usage of primary-care, preventative and outpatient services; have high usage of Emergency and Inpatient services; and poor compliance with medication. They tended to avoid psychiatric services."*[36, p.1]

That populations with greatest need have less access to the timely health care they need is sadly not a new phenomenon and is often referred to as the 'inverse care law', i.e., the principle that:

> *"the availability of good medical care or social care tends to vary inversely with the needs of the population served".*[37, p405]

In addition to barriers to healthcare access, people experiencing homelessness face substantial barriers to complying with many medical treatment regimes, and without housing find it nearly impossible to get the rest and nutrition required to support recovery after hospital discharge. Homelessness precludes the basic amenities needed for hygienic wound care, washing of self and clothing, and storage of medications securely or by refrigeration. As a result of these impediments, there is often poor control of manageable health conditions,[2,38] which in turn contributes to high prevalence and frequencies of emergency department (ED) use and unplanned hospital admissions by people experiencing homelessness; hence the ***revolving door of homelessness and poor health.***

This imbalance of social determinants fuels deteriorating health outcomes and persistent use of acute healthcare, leading to a revolving cycle of hospital use and ill health (Figure 3).[39]

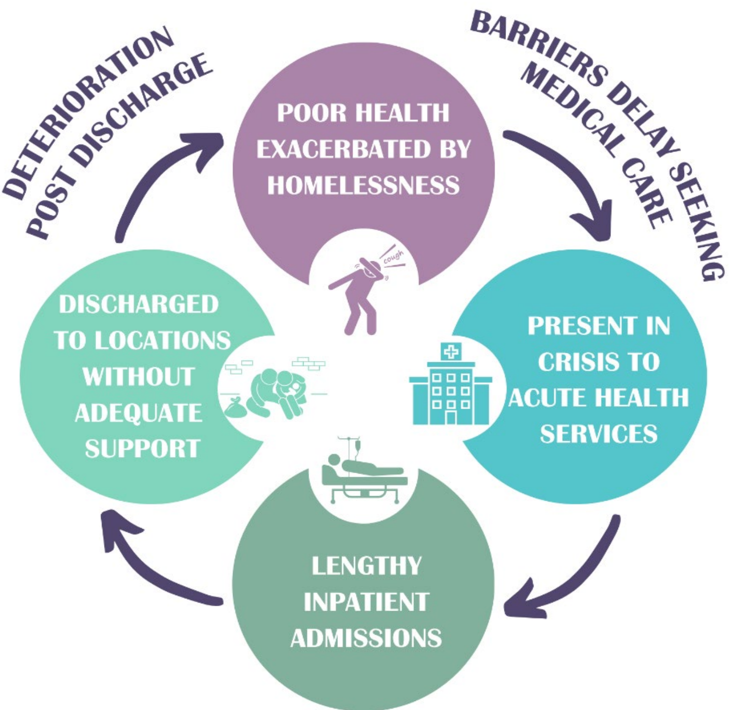


Figure 3: Revolving Door: Homelessness & Poor Health

The final report of the WA Sustainable Health Review[40] also acknowledged the disproportionately poor health of people experiencing homelessness, and the barriers and challenges of ensuring timely and appropriate healthcare for this population group. A high prevalence of chronic health conditions and barriers to diagnosis and treatment related to homelessness were noted to contribute to:

> *"a reliance on acute health services, supporting the need for increased focus on partnership with other government agencies and community organisations."*[40 p.82]

Underlying the immediate and health system barriers to healthcare access and engagement, the influence of the social determinants of health and underlying trauma cannot be overstated.[26,41] Recognition of the social determinants of health disparities experienced by people who are homeless (Figure 4) underscores the Homeless Team's ethos, role, and work within the hospital and community, and is therefore central to this evaluation.

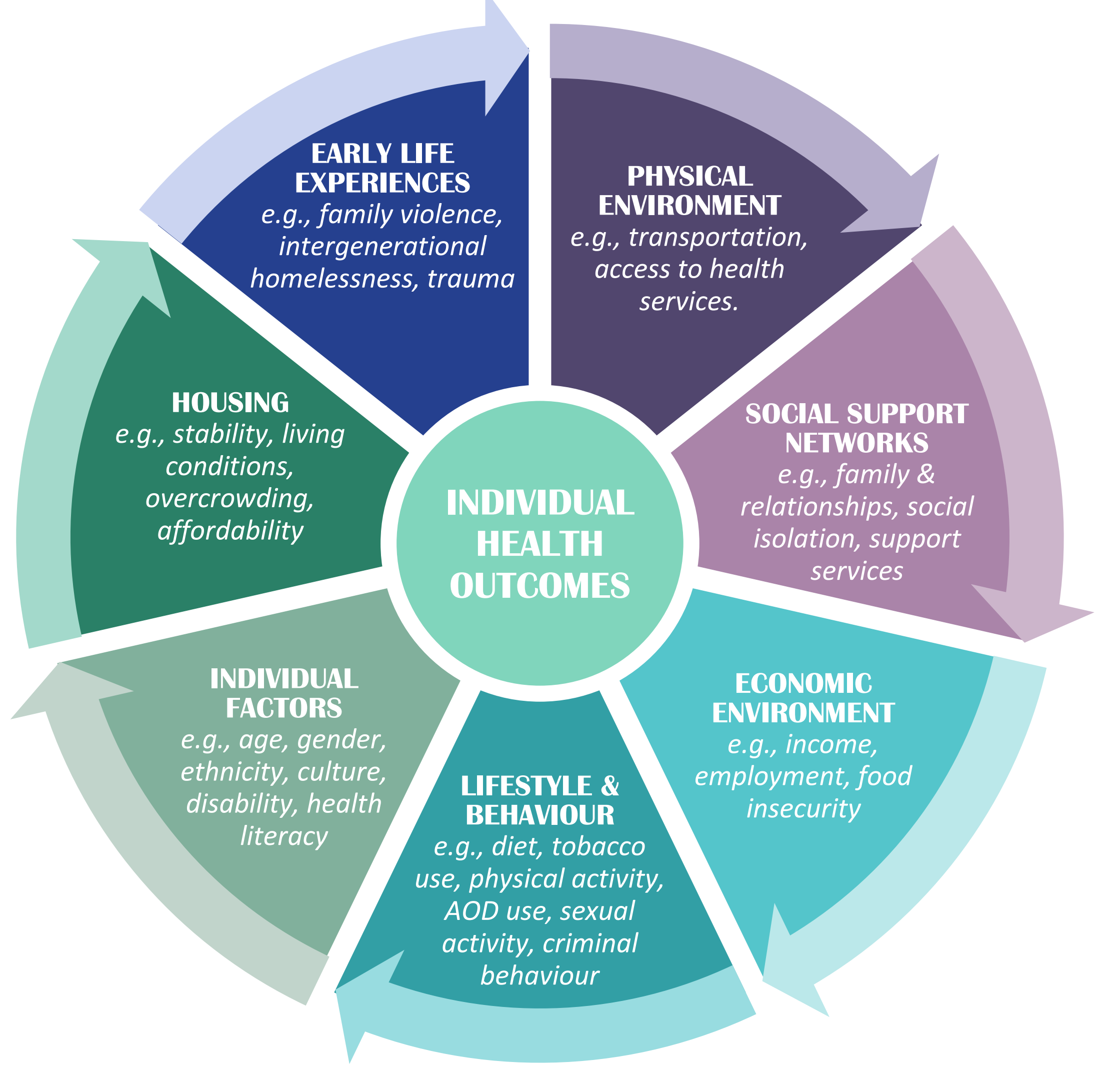


Figure 4: Social Determinant of Health Impacts on People Experiencing Homelessness

1.3 RATIONALE FOR HOSPITAL INVOLVEMENT IN HOMELESSNESS

Hospital admissions are an opportunity for a comprehensive and holistic assessment of a person's needs, to enable appropriate personalised care planning that integrates health, social care, and housing. A hospital stay can be an opportunity to start addressing the often complex and underlying issues that have led people to their present situation.

1.4 STRUCTURE OF THIS REPORT

Following this chapter:

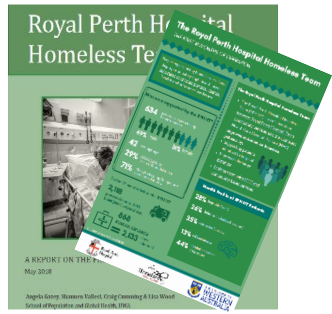
- **Chapter 2** describes the history of the Homeless Team evaluation by Home2Health, including its aims and methodology,
- **Chapter 3** describes the background of the Homeless Team, including its aims, mission, and model of care, and the processes of patient referral and interaction with the Homeless Team,
- **Chapter 4** describes the demographic, housing and health needs profiles of patients seen by the Homeless Team over its first five years of operation (the 'cohort'),
- **Chapter 5** describes the health-service use of the cohort prior to and following first contact with the Homeless Team,
- **Chapter 6** examines the benefits of the Homeless Team, as observed by RPH staff,
- **Chapter 7** describes wider contributions of the Homeless Team in addressing homelessness,
- **Chapter 8** describes the cumulative complexity of homelessness, including in relation to illness and access to support, and
- **Chapter 9** summarises key conclusions and learnings associated with the evaluation.

Image 1: Homeless Team Reviewing Patient

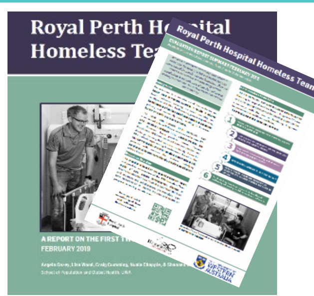
2 THE RPH HOMELESS TEAM EVALUATION

2.1 PREVIOUS EVALUATION REPORTS

Home2Health has been actively involved in the evaluation of the RPH Homeless Team since 2017. During this time, the team has produced two comprehensive evaluation reports,[3,4] each accompanied by a corresponding infographic snapshot, and seven academic publications (5 peer-reviewed).[39,41-46] These publications have sought to explore different facets of the Homeless Team and provide insight into the Team's interactions with and impact on the wider WA health system. The two evaluation reports are described briefly below, and the academic publications are described in Table 32 in the appendices.



Evaluation Report 1 (May 2018) provides an overview of the structure, processes, patient flow, and patterns of contact of the Homeless Team in its **first 18 months of operation**. It provides an overview of the health profile and health-service utilisation patterns for **634 patients** supported by the Homeless Team operation during this period. The report highlights the important role of the Homeless Team in linking these patients with support services, providing advocacy for those particularly vulnerable, and liaising with external organisations to facilitate continued support following discharge.



Evaluation Report 2 (Feb 2019) outlines the expansion and evolution of the Homeless Team since its commencement, with team structure changes, targeted initiatives and collaborations improving the support provided to a cohort of highly vulnerable individuals. Changes in the health profile and level of service utilisation for **1,014 patients** supported in the first **2.5 years of Homeless Team operation** are investigated. Overall, reductions in ED presentations and inpatient admissions pre/post Homeless Team contact were observed.

2.2 EVALUATION AIMS

This evaluation has a longitudinal, mixed-methods design. Its aims were to:

- describe the purpose and model of care of the Homeless Team, and any changes and adaptations made over time,
- describe the different types of support provided to people experiencing homelessness at RPH by the Homeless Team,
- document the demographic profile and housing and health needs of patients supported by the Homeless Team, including any changing patterns of contact over time,
- examine the health-service utilisation of patients prior to contact with the Homeless Team, identify changes in hospital use/demand post-reception of support, and
- investigate the impact the Homeless Team has had on RPH and its staff more broadly.

2.3 METHODOLOGY

2.3.1 RESEARCH DESIGN

This report forms part of a broader University of Notre Dame Australia (UNDA) program of research pertaining to the Homeless Team and HHC, and the health, economic, social and wellbeing benefits of the services they provide. It draws on data from the larger mixed-methods study and utilises a variety of qualitative and quantitative data sources, including administrative hospital data, the Homeless Team database, case studies, and observational data from RPH and HHC staff. RPH staff perspectives have also been captured through interviews and a mixed-methods online survey.

2.3.2 POPULATION COHORT

As noted, this report covers the first **seven years of operation** of the Homeless Team (June 2016 to present). However, to allow examination of follow up, the cohort examined comprises 1,946 patients who were seen by the Homeless team over its first **five years of operation**: June 2016 to June 2021.

2.3.3 DATA SOURCES

Figure 5 summarises the multiple qualitative and quantitative data sources used for this evaluation.

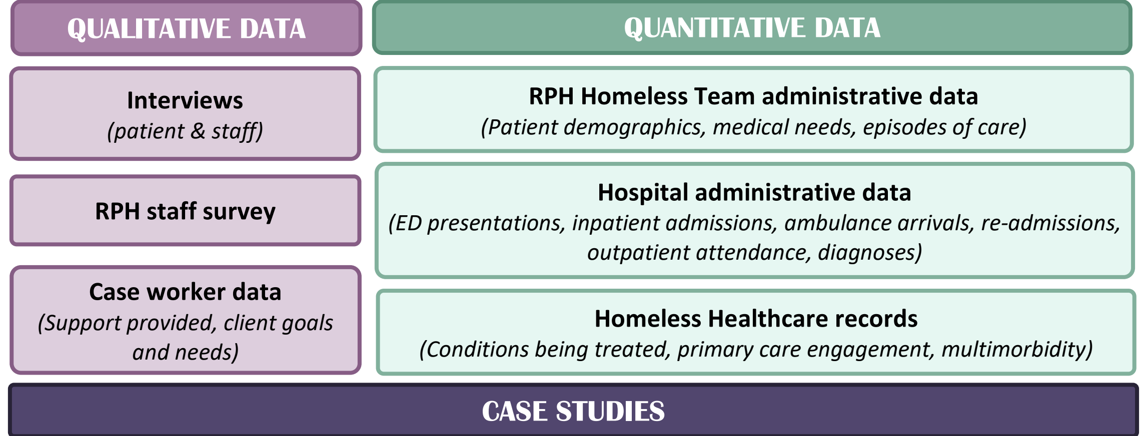


Figure 5: Data Sources

2.3.3.1 RPH Homeless Team Administrative Data

The daily activity of the Homeless Team (i.e., of the nurses and case workers) on the hospital's wards and in the RPH ED is collected daily or weekly by the Administrative Assistant to record the work accomplished and source any additional background information needed. These data are then entered into a custom-made Homeless Team database held on an RPH data site under password protection. This database was established at the inception of the Homeless Team following advice from individuals involved with the UK Pathway model of homeless health care regarding the importance of collecting robust data from the outset.[2] Entry of data into the database entails: (1) the Administrative Assistant entering demographic, dates of episodes of care and other non-clinical data, and (2) the Clinical Lead entering clinical data such as patients' past medical history and diagnoses for each episode.

Figure 6 summarises the information captured in the database. This information pertains to:

- patient-level demographics, identifiers/linkage and homelessness history,
- episode- and sub-episode-level case worker and Homeless Team consultations, and
- patient physical and mental health and substance use at first contact.

PATIENT CONTACTS WITH THE HT

CASE WORKER CONTACTS

- Date
- Patient status *(e.g., individual, partnered, family)*
- Location *(e.g., ED, inpatient ward)*
- Length of consult
- Support/service provided (e.g., basic needs, referrals to accommodation)

RPH HOMELESS TEAM CONTACTS

Episode level information

- Number *(patient-level)*
- Comorbidity *(up to 3, e.g., medical, injury)*
- Presenting diagnoses *(up to 3)*
- Home situation
- Admission & discharge dates, LOS
- Discharge destination *(e.g., rough sleeping, family/ friends, ST housing)*

Linked by: **UMRN, episode number**

Sub-Episode level information

- Date
- Location *(e.g., ED main, ED observation ward, surgical inpatient ward)*

Linked by: **UMRN**

PATIENT-LEVEL INFORMATION

Demographics

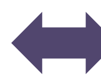
- Name
- DOB
- Gender
- Age
- Sex
- Cultural background *(incl. Indigenous status)*
- Country of birth
- DOD *(if applicable)*

Identifiers/linkage information

- UMRN
- HHC patient identifier
- BNL identifier
- VI-SPDAT status *(completed, date)*
- External program participation status *(e.g., Housing First)*

Homelessness history information

- Known to HHC *(y/n & degree)*
- Time spent homeless *(e.g., recurrent, short-term, long-term)*
- Housing requirement *(e.g., Housing First, transitional)*



Linked by: **UMRN**

PATIENT HEALTH AND SUBSTANCE USE AT FIRST CONTACT

Substance use

- AOD use (general)
  - Problematic *(y/n)*
  - Daily alcohol consumption *(y/n)*
  - Inject drugs *(y/n)*
- Street DOA use *(type, e.g., alcohol, meth)*
- Pharma DOA use *(type, e.g., morphine, fentanyl)*

Health

- Physical morbidity *(e.g., COPD)*
- Psychiatric morbidity *(e.g., schizophrenia)*
- Disability *(y/n, type)*

Figure 6: RPH Homeless Team Database

Notes: **ED** = Emergency Department, **LOS** = length of stay, **ST** = short-term, **UMRN** = unique medical record number, **DOB** = date of birth, **DOD** = date of death, **HHC** = Homeless Healthcare, **BNL** = By Name List, **VI-SPDAT** = Vulnerability Index – Service Prioritisation Decision Assistance Tool, **AOD** = alcohol or other drug, **DOA** = drug of abuse, **COPD** = chronic obstructive pulmonary disease

As illustrated in Figure 6, the Homeless Team database is a unique, comprehensive dataset containing a broad range of information on a population of largely chronic rough sleepers in the Perth metropolitan area. One of its strengths is the correct identification of homelessness status and type of homelessness for individuals, features/characteristics that are notoriously poorly recorded elsewhere, e.g., in hospital data. Other strengths include the maintaining of information on individuals' public hospital medical record numbers, HHC primary care database identifiers and Perth 'By Name List' (BNL) identifiers, all of which can be used to ascertain individuals' use of hospital and other health services to complement their support. The routine recording of linkage keys to other homelessness databases is particularly important as it facilitates cross-service support which improves the patient experience.

2.3.3.2 RPH Homeless Team Case Worker Notes

Homeless Team data also include notes made by its case workers, which are stored separately to the main Homeless Team database. These data include valuable information not often captured in other hospital data, including:

- When a patient was first seen by the Homeless Team,
- The ward in which each patient first presented and was seen,
- Any known history of interactions with the Homeless Team and other community organisations,
- Psychosocial and medical history,
- Most recently known housing situation (e.g., public housing, street present),
- Referrals to community organisations (e.g., AOD services, housing support, primary care support), and
- Brokerage support offered to the patient (e.g., connection to short-term accommodation, transport, everyday basics).

2.3.3.3 Administrative Hospital Records

Administrative hospital data, including ED presentations, hospital inpatient admissions and outpatient appointments for all Homeless Team patients for the 10-year period between 1 January 2013 and 31 December 2022 were obtained for eleven public metropolitan hospitals via the Data and Digital Innovation team at the EMHS:

- Bentley Health Service
- Armadale Health Service
- Kalamunda District Community Hospital
- Graylands Hospital
- Fiona Stanley Hospital (FSH)
- Fremantle Hospital Health Service
- Sir Charles Gairdner Hospital (SCGH)
- Osborne Park Hospital
- Royal Perth Hospital (RPH)
- King Edward Memorial Hospital (KEMH)
- Rockingham General Hospital (RGH)

These hospitals constitute all public hospitals for adults in metropolitan Perth. However, they exclude WA country hospitals and the three public-private partnership hospitals in Perth (Joondalup Health Campus, Peel Health Campus, and St John of God Midland Public Hospital). Therefore, the available data largely but incompletely represents the hospital use of patients experiencing homelessness seen by the Homeless Team in Perth.

Data matching for the purpose of obtaining hospital data was facilitated through use of a unique study ID for individuals, to enable the hospital data to be provided to the team without names or other identifying information. The data fields received, which include both patient demographic and event information, are listed in Figure 7.

EMERGENCY DEPARTMENT

- Triage date & time
- Departure date & time
- Arrival means (e.g., Ambulance, Police, taxi)
- Length of episode
- Disposition (e.g., discharged, admitted)
- Diagnosis code (ICD) & description
- Intent (e.g., unintentional, alleged assault)
- External cause (e.g., cut, pierced, stabbed, blunt force)

OUTPATIENT APPOINTMENT

- Clinic category (e.g., plastic surgery, dermatology)
- Appointment date & time
- Outcome (e.g., reappointment, did not attend)
- Tier 2 code (ABF classification for non-admitted care)

MORTALITY DATA

- Date of death

INPATIENT ADMISSION

- Admission date & time
- Departure date & time
- Arrivals means
- Admission type (e.g., elective, waitlist, non-elective direct)
- Discharge specialty (e.g., emergency medicine, burns)
- Length of stay
- Number of psychiatric bed days
- Number of ICU bed days
- Discharge destination type (e.g., home, against medical advice)
- DRG code & description
- Clinical coding record type (diagnosis, procedure)
- Coding priority
- Coding type (e.g., principal diagnosis, additional diagnosis, procedure)
- Diagnosis code (ICD) & description

Figure 7: Hospital Data Fields

Notes: **ABF** = Activity Based Funding, **DRG** = Diagnosis-Related Group, **ICD** = International Classification of Diseases (code), **ICU** = Intensive Care Unit

2.3.3.4 RPH Staff Survey

As part of this evaluation, a short online Qualtrics survey (Appendix A) was developed and distributed to relevant RPH staff members either directly or via senior RPH management. The purpose of this survey was to inform an understanding of the degree to which the program was impacting upon those directly or indirectly involved in the project, and to provide an opportunity for anonymous feedback.

The feedback survey received a strong response, from 133 participants across RPH. Due to the survey being sent via numerous group distribution email databases, it was not possible to calculate an overall response rate.

Most respondents were participants located in ED main (41%) and ED Observation Ward (27%). The remaining responses came from inpatient wards, including the medical, psychiatry and surgery wards. Respondents consisted of a range of professions/roles including nurses (36%), social workers (33%), and senior doctors (22%), with the remainder being a combination of Aboriginal Liaison Officers and allied health workers, among others.

2.3.3.5 Interviews with People Supported by the Homeless Team and With Staff

Over the course of the evaluation, semi-structured interviews have been undertaken with:

- Patients who were supported by the Homeless Team, and
- Homeless Team and HHC staff (including case workers, HHC nurses who are part of the Homeless Team, the Clinical Lead of Homeless Team, the HHC Medical Director and the Medical Respite Centre (MRC) staff).

Data from the interviews have informed the descriptions of the role and scope of Homeless Team activity, case studies, and interpretation of findings.

2.3.3.6 Case Studies

The case studies used throughout this report have been compiled by triangulating multiple data sources, including clinical staff observations, hospital service utilisation data extracted from the Perth

metropolitan patient database (Web-PAS), Homeless Team case worker notes, HHC patient records and interviews with patients and staff. **Pseudonyms have been used for all case studies.**

2.3.4 DATA ANALYSIS

2.3.4.1 Patient Demographics

The demographic profile of the cohort was examined based on information recorded in the Homeless Team database, complemented by information contained in the hospital data. Specifically, demographic characteristics examined were sex, age, and Indigenous status (Aboriginal or non-Aboriginal).

2.3.4.2 Who was Supported and What were their Needs?

The profile of the cohort is described with respect to:

- The locations and number of patient consultations provided by the Homeless Team,
- The number of unique patients seen by the Team,
- The homelessness and housing needs of patients seen by the Team, including their home situation when seen, their discharge destination and changes between the two, and
- Their health needs, including their co-morbidities, physical and psychiatric health burden, substance use, dual diagnosis, and tri-morbidity.

The number of consultations provided by the Team are examined over time for a period extending for six months beyond the first five years of operation (Jun 2016 – Jun 2021), i.e., to end-Dec 2021.

2.3.4.3 Health Service Utilisation

The hospital use of the cohort is examined pre- and post-first contact with the Homeless Team. Hospital use was examined pre/post first contact only because: (1) this allowed for examination of the longest follow up possible, and (2) the first contact represents the start of a process of engagement with HHC, whether through further hospital contacts (with the Homeless Team) or in HHC clinics in the community.

2.3.4.3.1 Temporal Adjustment to the Pre/Post Hospital Use Periods

The pre/post figures are calculated relative to individuals' **dates of discharge from hospital for the admission or presentation during which they were first seen by the Homeless Team.** This is important because the impact of Homeless Team contact with those patients can only be measured after they have left hospital. However, for convenience and interpretability the terminology used still refers to periods of hospital use pre/post 'first contact with the Homeless Team'. Figure 8 illustrates the adjustment, which affected 43% of the cohort (828 of 1,946 individuals). The mean and median number of days between first contact with the Team and hospital discharge were 7.9 days and 2 days, respectively (range 1 – 327 days).

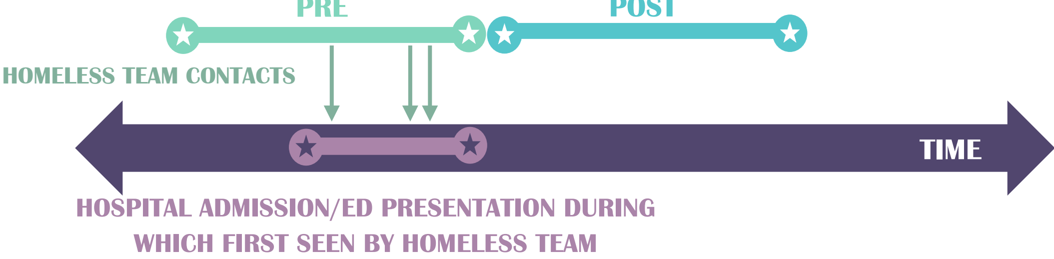


Figure 8: Follow Up Periods Pre/Post First Contact

2.3.4.3.2 Follow Up Periods

Based on the limits of available hospital data (Table 1), three follow up time periods are examined:

- Six months and one-year pre/post (data available for 100% of the cohort; n=1,946), to examine the hospital use of the cohort over a short period post-contact with the Team, and
- Three years pre/post (data available for 72% of the cohort, n=1,394), to examine the long-term hospital use of the cohort post-contact with the Team while still capturing a relatively large proportion of the cohort.

Table 1: Cohort Follow Up Pre/Post First Contact

Follow up Period	n (% of cohort) Pre ^	Post
6 months	**1,946 (100%)**	**1,946 (100%)**
12 months (1 year)	**1,946 (100%)**	**1,946 (100%)**
18 months	1,946 (100%)	1,943 (99.8%)
24 months (2 years)	1,946 (100%)	1,764 (91%)
30 months	1,946 (100%)	1,568 (81%)
36 months (3 years)	**1,946 (100%)**	**1,394 (72%)**

Notes: ^ all individuals had at least three years of hospital data pre-first contact with the Homeless Team

2.3.4.3.3 Accounting for Death

Unfortunately, premature death is common amongst people experiencing homelessness. Therefore, to avoid reporting potentially misleading results, supplementary pre/post hospital use analyses were conducted to account for death during follow up. This involved calculating post-contact hospital use figures (e.g., ED presentations) based on rates of use observed for individuals in the periods post-contact leading up to their deaths. The supplementary results are provided in the Appendices and referred to in the main text.

2.3.4.3.4 Stratification by Discharge Destination

A key aim of the hospital data analysis of this report was to examine the relative impact on hospital outcomes of differences in discharge destination of patients post-first contact with the Homeless Team. Specifically, the pre/post hospital use analyses were repeated stratifying patients' discharge destination as either 'Rough Sleeping / Streets" or "Accommodation", where the latter comprised temporary, transitional or short- or long-term accommodation.

2.3.5 ESTIMATING ASSOCIATED COSTS

The burden of the hospital use of the cohort pre/post-first Homeless Team contact is estimated based on the most recently released average ED presentation, inpatient bed day, psychiatric bed day and ambulance arrival costs for WA public hospitals (Table 2). The evaluation team regularly checks for updates to these figures.

Table 2: Health System Data Cost Sources

Type	Amount	Source
ED presentation	$894	Average ED presentation cost for WA taken from page 6 of the 2023 IHACPA infographic report for ***NHCDC Public Hospitals Report 2020-21.***[5]
ambulance arrival	$1,034	Calculated per total WA expenditure/total WA incidents from Tables 11A.11 and 11A.4 of Part E of the ***2023 Report on Government Services***.[6]
psychiatric inpatient bed day	$1,596	Average cost of a psychiatric inpatient bed day for WA taken from Table EXP.7, per *Expenditure on mental health-related services* sub-section of the **AIHW *Mental health report 2023***.[7]
non-psychiatric inpatient bed day	$2,879	Calculated per average admitted acute care weighted separation/average LOS per page 4 of the 2023 IHACPA infographic report for ***NHCDC Public Hospitals Report 2020-21***[5]

Notes: **ED** = Emergency Department, **IHACPA** = Independent Health and Aged Care Pricing Authority, **LOS** = length of stay, **WA** = Western Australia, **AIHW** = Australian Institute for Health and Welfare, **NHCDC** = National Hospital Cost Data Collection

2.3.6 ETHICS APPROVAL

Human Research Ethics Committee (HREC) approval for the evaluation was granted by the University of Western Australia (UWA) HREC in January 2022 (2021/ET000610), and cross-institutional ethics approval was granted by the University of Notre Dame Australia (UNDA) HREC in April 2022 (2022-041F). Ethics approval for the hospital data for the evaluation was initially obtained from the RPH HREC (project number RGS0000000075), with the RPH HREC also providing site ethics approval for each site and governance approvals obtained directly from each site. All data collected and collated during the evaluation has been stored according to the HREC approval and UNDA and Western Australian University Sector Disposal Authority guidelines.

Image 2: RPH Homeless Team Staff

3 THE RPH HOMELESS TEAM

3.1 BACKGROUND & PURPOSE

The RPH Homeless Team was established in June 2016 as a response to large numbers of people experiencing homelessness recurrently presenting to RPH. Due to being the primary public hospital in Perth and its inner-city location, RPH sees a far greater proportion of homeless patients than other WA public hospitals.[4] Since the onset of COVID-19, the number of ED presentations to RPH by people experiencing homelessness not previously seen by the Homeless Team, many of whom were not known or connected to services, has increased.[43] As noted, the Homeless Team was established based on the evidence-based UK Pathway model of care,[2] and was the first of its kind to be established outside of the UK.

3.1.1 AIMS

The overarching aim of the Homeless Team is to identify and provide support to patients experiencing homelessness within RPH. However, this aim comprises several sub-aims:

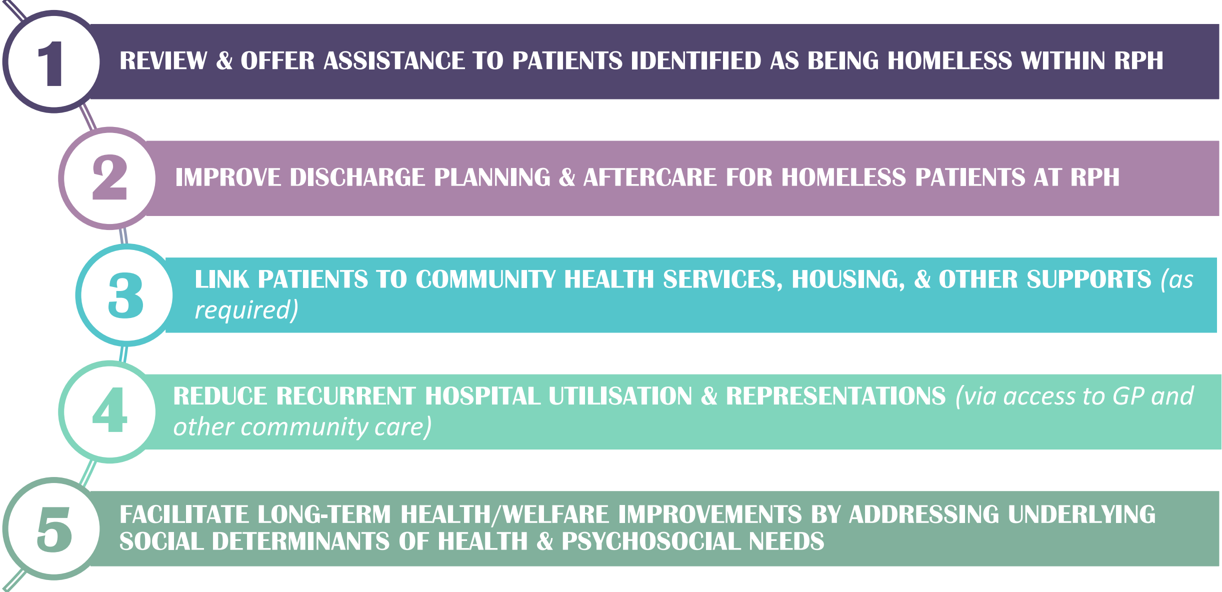


Figure 9: RPH Homeless Team Aims

3.1.2 MISSION STATEMENT

Broadly, the mission of the Homeless Team is to:

> *Identify people experiencing homelessness within RPH and, through improved discharge planning and linkages with community-based support services, improve their health and wellbeing.*

However, over time the Homeless Team has expanded its scope of work beyond RPH, often advocating or advising on healthcare for homeless patients seen elsewhere in the EMHS catchment and responding to requests for advice about homeless patients from other public hospitals. This has included supporting the establishment of the Mental Health Homeless Pathways project based at Bentley hospital.

3.2 MODEL OF CARE

The Homeless Team model of care (Figure 10) was inspired by and based on the evidence-based UK Pathway approach to supporting people experiencing homelessness in hospital settings by providing in-reach primary care alongside psychosocial support.[2] It has since expanded and further adapted for the WA context, and to help meet the enormous health needs of the increasing number of people experiencing homelessness in Perth.

Figure 10: Elements of the Homeless Team Model of Care

3.2.1 PROXIMITY TO HEALTH, HOUSING, & HOMELESSNESS SERVICES

In most large cities, rough sleepers cluster in inner-city areas, close to homelessness services, crisis accommodation and inner-city public hospitals. The same is true for Perth, where RPH, the only inner-city hospital, accounted for 53% of all metropolitan ED presentations by 'no fixed address' (NFA) patients in 2019, almost five times the proportion for SCGH and FSH, the second and third-largest Perth hospitals, in that year.[47] Figure 11 shows the locations of homelessness and accommodation services. At many of these locations, HHC runs mobile community clinics. Other health services utilised by the Perth homeless population are also shown.

Figure 11: Proximity of RPH to Homelessness & Other Services

Note: Red circle indicates an approximate 2 kilometre radius around RPH

3.2.2 MULTI-DISCIPLINARY TEAM

Integrated, multidisciplinary, and collaborative care is central to the Homeless Team model to provide effective care, as many people experiencing homelessness present with multiple healthcare and other support needs.

The Homeless Team is a collaborative partnership between RPH and HHC, whereby primary care provides in-reach into the hospital setting. The RPH staffing component of the Homeless Team consists of a half-time ED consultant, Dr Amanda Stafford, as the Clinical Lead and a full time Administrative Assistant/Peer worker. These inaugural staff have not changed over time. Daily primary care in-reach from HHC is provided via general practitioners (GPs) and registered nurses, facilitating continuity of care beyond the hospital. The Team also included experienced homelessness case workers. A unique element of the Homeless Team model is a long-standing research partnership with Home2Health, which provides ongoing independent evaluation and leads relevant research. Figure 12 provides an overview of the collaborative services and their respective roles in the Homeless Team.

ROYAL PERTH HOSPITAL

CLINICAL LEAD

Key Roles:
- Organisation & leadership of Homeless Team
- Facilitate work of the HHC GPs, nurses and caseworkers within RPH
- Collaborate and liaise with RPH staff regarding Homeless Team patients
- Maintain Homeless Team database
- Supervise the Homeless Team Administrative Assistant
- Provide advocacy to extend scope of patient care

ADMINISTRATIVE ASSISTANT

Key Roles:
- Find and collate lists of homeless patients for Homeless Team rounds
- Coordinate Homeless Team round information between different days and care providers
- Collect data on for the Homeless Team database
- Receive phone referrals and enquiries

HOME2HEALTH RESEARCH TEAM

Key Roles:
- Evaluation of Homeless Team and HHC health and economic impact
- Ensuring ethics approval for all research
- Manage linked hospital database
- Development of reports, infographics and papers
- Facilitate contributions to international evidence-based best-practice
- Data-driven identification of service gaps

HOMELESS HEALTHCARE

GPS

Key Roles:
- Review of Homeless Team patients requiring GP input
- Collaborate with treating team regarding in-hospital management of patients and discharge planning
- Coordinate care between hospital and community
- Rotate with HHC mobile clinics to facilitate continuity and ongoing/long-term healthcare

NURSES

Key Roles:
- Initial engagement with Homeless Team patients
- Ascertain if patient has GP, if not inform patients about HHC GP clinics
- Support treating team regarding nursing care planning during inpatient stay and assist with discharge planning
- Advocate for patients within the medical setting
- Rotate across Street Health and other HHC clinics to provide continuity of ongoing healthcare, building rapport, trust and engagement

CASEWORKERS

Key Roles:
- Practical patient support
- Hospital in-reach with patients
- Psychosocial support
- Connect patients to other services
- Investigate housing and accommodation options

Figure 12: RPH Homeless Team Collaborative Service Roles

3.2.2.1 How Casework Supplements the Clinical Roles

The Homeless Team case workers have a core role in advocating for patients during their time in hospital, supporting patients with practical needs, coordinating and connecting patients with external services, and helping to link patients with accommodation options. With entrenched homeless sector experience, the case workers bring integral care to the delivery of a holistic homeless care model. The embedding of case workers within the Homeless Team enables patients' non-medical needs to be addressed by workers with the knowledge and expertise to achieve the outcomes for each patient's unique situation and strengthens the capacity for the core medical team to treat patients' medical issues. This collaborative approach enhances overall capacity to meet patient needs and has a positive impact on patients' experience. Figure 13 displays the diverse delivery of service provided by the case workers, exemplifying their rich homeless sector experience, invaluable homeless service collaborations, and linkage capabilities.

PRACTICAL SUPPORT

- Booking accommodation in local facilities
- Facilitating family reunification and return to Country by organising transport, accommodation, sufficient medication & support once home
- Assisting with applications for ID, Centrelink support, housing applications
- Informing community case worker of patient's admission and encouraging improvement in patient planning

SUPPORTING RPH PATIENT CARE

- Building rapport with homeless patients and identifying psychosocial housing and other support needs
- Building strong connections with hospital staff in different areas (e.g., ED, social work, Aboriginal Liaison Officers, mental health clinicians) to facilitate pathways of care, and act as intermediary between staff and patient
- Improving discharge planning, including sourcing accommodation/housing

PSYCHOSOCIAL SUPPORT

- Identifying and supporting people to have their complex and interlinked social and medical needs met
- Taking a non-judgmental approach that helps people feel heard, safe and comfortable when engaging with healthcare providers
- Encouraging people to remain in hospital to complete their hospital treatment e.g., Paid TV subscriptions, visits

CONNECTING TO OTHER SERVICES

- Connecting clients to services that can assist with housing, legal and financial support, mental health or AOD services, e.g., Street Law, MCOT, Red Cross, Women's refuges, homelessness services
- Referrals to Medical Respite Centre
- Supporting clients to re-engage with services/programs they were previously connected to
- Acting as intermediary link between government agencies and clients
- Advocating for patient-case conferences to 'brainstorm' with services alongside patient

HOUSING & ACCOMMODATION

- Investigating short-term and crisis housing options to avert discharge to the street
- Creating timeline plan to allow smooth transition from hospital to long-term housing goals
- Supporting people through accommodation assessments, accessing priority housing waitlist, or community housing

CAPACITY BUILDING BEYOND RPH

Supporting social workers at both RPH and other hospitals by providing advice and information and sharing their expertise regarding available health, homelessness and housing/accommodation services that provide support for people experiencing homelessness.

Figure 13: Key Homeless Team Case Worker Roles

Notes: **ID** = identification, **MCOT** = Mobile Clinical Outreach Team, **TV** = television, **ED** = Emergency Department

3.2.3 TRAUMA-INFORMED HEALTHCARE

Trauma-informed care is essential in working with people experiencing homelessness, where early childhood and adult experiences of trauma are pervasive. Understanding the factors that resulted in the individual's current homeless and health status allows for a more comprehensive provision of service. Trauma-informed practices equate to improved recovery time and outcomes, greater post-discharge support and limited occurrences of re-traumatisation and future hospitalisation.[48]

The Homeless Team's ability to look beyond the presenting need of an individual, identifying underlying contributing factors to address trauma at its core, is a cornerstone of their specialised delivery of care within the hospital setting. The importance of this feature is captured by the following quote from a respondent to the RPH staff feedback survey:

> *"A patient experiencing domestic violence came in with injuries from an assault. The patient was very withdrawn, and it was hard to gain a history. The HHC team provided a history to medical/nursing staff, also discussing the patient's triggers/relievers around hospital admissions. They had an extensive conversation with the patient which sometimes time does not allow when nursing. The patient was more open to care after and was linked up with social work and supported into safe crisis accommodation."* **– RPH Staff Member**

Image 3: RPH Homeless Team Nurse and Patient Consultation

3.2.4 HOLISTIC APPROACH TO HEALTH

For people experiencing homelessness, the reason for hospital presentation usually captures just one of many underlying health and social issues, with multi-morbidity being common along with other complex, intersecting needs.[46] This can be particularly challenging in the ED context, where the presenting health issue may be accompanied by a combination of other acute and chronic health issues, along with significant social concerns, foremost amongst which is the absence of a safe place to stay.[46]

The Homeless Team contributes diverse and adept medical insight. However, its ability to relate to and build trust and rapport with homeless patients has also been a key strength of the program since its inception. Building rapport and showing understanding of the factors resulting in individuals' problematic medical and housing situations improves service delivery. This is especially true in the case of homeless individuals, who in other contexts can encounter medical providers who are often uninformed of individuals' situations and may not be trauma-informed in their care or understanding

of the complex psychosocial needs of individuals experiencing homelessness. This situation is captured by the examples related by RPH staff members below:

> *"… there was a young homeless patient who had underlying undiagnosed schizophrenia but was always managed as drug-induced psychosis. With the input of the HHC team this young gentleman accessed appropriate community mental health care and housing. When I saw him on an otherwise purely medical presentation to ED a few months later I was astonished by the level of quality of life he had achieved."* **– RPH Staff Member**

> *"The beginning of a throughcare model, where you are assessing the holistic needs of a person rather the focusing on one factor."* **– RPH Staff Member**

Image 4: RPH Homeless Team Nurse during Patient Meeting

3.2.5 EMBEDDED PRIMARY CARE

Embedded access to primary care is a core pillar of the Homeless Team model that helps to overcome the extensive barriers that limit access to primary care for people experiencing homelessness. People experiencing homelessness are faced with multiple barriers that limit their access to primary care.[44] This is partially overcome by bringing primary care 'to the bedside'. The integration of HHC staff into the Homeless Team allows for continuity of care for patients when they are discharged, and it is this integration with primary care that has been particularly commended by public health and hospital colleagues in other states.

The importance of the embedded primary care component of the Homeless Team has been recognised in an Australian Productivity Commission report[49] that noted:

> *"The team's composition is another key to its success. It is in the unique position of having GP in-reach from a specialist homeless healthcare primary care service, coupled with case workers with strong ties to housing and community services."*[49]

Box 1 demonstrates the impact of embedding primary care through hospital in-reach and illustrates how continuity of staff across different settings can facilitate increased engagement and decreased hospital use.

Box 1: Benefits of Primary Care Integration with the Homeless Team

Background: *"Greg"* was a man in his early forties who had experienced homelessness on and off for years. A history of extensive childhood trauma, family breakdown and early engagement in substance use (from age 9), who was first seen by the Homeless Team in mid-2017.

Hospital Use: Between mid-2016 and 2018, he had 16 ED presentations and 12 hospital admissions, (totalling 60 inpatient days), largely associated with alcohol dependence. At only 37 years old, Greg was transferred to the palliative ward for a severe lung infection.

Support Provided: In the first year of support from the Homeless Team, Greg was still frequently presenting to hospital. The Homeless Team worked collaboratively with HHC GPs, to support his with his harmful alcohol use in attempt to source appropriate accommodation. Greg's lack of stable accommodation was a significant factor in his alcohol use that perpetuated his cycle of hospital presentation, stress, and deteriorating health.

Greg was supported to access stable accommodation at a transitional housing service, where he continued to see HHC GPs at their mobile clinics run onsite. HHC provided medical care and psychosocial support, enabling him access to with Centrelink and encouraging him to return to his TAFE studies.

Current Situation: Given that Greg was assessed as palliative in 2018, he had come a long way since his initial contact with the Homeless Team. Through their support, Greg was successfully linked with ongoing community care, and accessed accommodation, higher education, and social connection. He had regular primary care management via HHC, contributing to a steady decline in ED utilisation over a three-year period. Whilst some of the damage to his health was irreversible, he was able to be managed via primary care and outpatient clinics.

Sadly, Greg passed away in mid-2022 from advanced liver disease but was no longer homeless for his final years of life.

Having the same HHC staff working both within the Homeless Team and other HHC community settings, including the MRC, fosters **continuity of care**. Providing a service with familiar/consistent faces across the health system fosters trust and, overall, enables engagement with primary care for a group of people who typically have fallen through the cracks of the health system. Providing a pathway away from tertiary healthcare reliance into engagement with primary care, and the associated benefits of this, have been noted by numerous RPH staff members, e.g.:

> "*There are daily examples, but the connection of homeless patients to community services and appropriate follow-up is extremely useful with regards to discharging a homeless patient with ongoing care needs.*" **– RPH Staff Member**

> *"Essentially a two-way linkage between homeless health and the hospital, RPH staff members know that these people can be followed up. Plus, Homeless Healthcare can get in early with new clients or at least touch base with those that slip through the safety nets. From my perspective it makes homelessness care a collaborative affair and that the hospital care is not in isolation.*" **– RPH Staff Member**

3.2.6 PATIENT ADVOCACY

A key role of the RPH Homeless Team is to advocate for patients experiencing homelessness, both within the hospital and to external organisations. This advocacy underpins other core Homeless Team objectives and is often central to linking patients with community-based services and ensuring patients have access to appropriate supports when discharged. The importance of the Homeless Team's patient advocacy was noted in the WA Sustainable Health Review:

> *"[The Homeless Team] illustrates the role that homelessness- and trauma-informed health professionals can play in advocating for appropriate housing and community support as a cost-effective alternative to recurrent hospital use."*[40]

Types of patient advocacy undertaken by the Homeless Team are highlighted in Table 3.

Table 3: Types of Patient Advocacy

<table>
<tr><th colspan="2">Types of Patient Advocacy</th></tr>
<tr><th>Support Letters & Applications</th><th>Health-Related Patient Advocacy</th></tr>
<tr><td>Includes support letters to:
• Department of Housing (to get patients on priority list, or to escalate urgency of them getting housed due to deteriorating health)
• Centrelink (including New Start) – to ensure payments are not ceased, or to get the re-instated, or paid to a different bank account person can access
• Advocate for NDIS assessment (particularly around psychosocial disability).
Applications on behalf of patients for:
• Referral to residential AOD rehabilitation programs, assistance with accessing other AOD services or support
• Transitional or supported accommodation</td><td>• Liaison with medical/ward staff to delay discharge until underlying health issues contributing to frequent presentation have been identified and addressed
• Advocating for medical tests or mental health assessments, particularly in situations where patient is known to Homeless Team, and there are underlying health issues that have not been diagnosed or treated
• Advocacy on behalf of homeless patients who need a planned admission e.g., for elective surgery
• Facilitating pre-planning with other hospital staff for complex treatments or discharge
• Advocating for community mental health teams or MCOT to follow up with patient after discharge</td></tr>
<tr><th>Connecting People to Homelessness Services</th><th>Return to Country/Home</th></tr>
<tr><td>• Advocating on behalf of client to see if they can be taken on by a homeless service with case-management support team (e.g., Street to Home, HEART).
• Attending DoC Office of Homelessness Weekly Rough Sleeper Coordination Group advocate for people who urgently need accommodation and housing.</td><td>• Supporting Aboriginal patients to "return home" through liaison with return to country programs with DoH and DoC.
• Arranging brokerage-funded transport for patient to regional area or interstate where they have accommodation and support network options
• Supporting patients to reconnect with family members where contact has been lost or there is estrangement</td></tr>
<tr><th colspan="2">Accommodation Advocacy</th></tr>
<tr><td colspan="2">• Providing patients with temporary ID documentation to meet accommodation requirements. The Homeless Team has developed an ID letter that includes a photo and verifies the person's name, DOB and identity (Appendix B).
• Liaising with accommodation providers to accept people experiencing homelessness. The team has developed a service engagement agreement for patients being discharged to philanthropic accommodation arranged by the team, and has procedures in place if any damages occur.
• Collaborating with accommodation providers around discounted weekly rates, meal package options, etc.</td></tr>
</table>

Notes: **HEART** = Homeless Engagement & Intensive Assertive Outreach Service, **DoC** = Department of Communities (WA Government), **DoH** = Department of Health (WA Government), **AOD** = alcohol and other drug, **MCOT** = Mobile Clinical Outreach Team, **DOB** = date of birth, **ID** = identification

As part of the stakeholder survey that was distributed to RPH staff regarding the impact of the Homeless Team, 80% of respondents agreed that the Team provided advocacy for patients (e.g., in relation to access to community services or housing), with a further 14% being in partial agreement.

> *"HHC develop rapport with patients in the hospital and in the community. They are also able to negotiate with non-government services effectively. With their relationships in the community and being able to extend that to patients is of valuable assistance to RPH."* **– RPH Staff Member**

> *"One of many examples would be organising and advocating for Indigenous patients getting them back to their communities."* **– RPH Staff Member**

3.2.7 SAFER DISCHARGE FACILITATION

Successful hospital discharge allows individuals to smoothly transition from a period of poor health back into the community. However, this period immediately post-discharge often still requires further recovery. Discharge onto the streets or inadequate recovery time in unsuitable accommodation can result in poor health outcomes and numerous re-presentations within a short-time frame for this population. Hospital discharges normally send individuals back to their stable housing, but most people experiencing homelessness do not fit into this pathway, and require specialised care and an integrated cross-sectorial model of homeless-service care (from trauma-informed practices to post-discharge care and housing linkage).[50]

Patients who are homeless often have immediate basic needs relating to the very circumstances of being homeless. This can range from needing clothes or toiletries while in hospital, through to transportation or short-term accommodation when they are discharged. Assisting people with such issues not only helps them practically, but also builds trust and rapport. Being able to offer practical support to patients is also about respecting their dignity.

Since 2018, the Homeless Team has been fortunate to receive an annual allocation of brokerage funding to facilitate safe discharge planning. Figure 14 shows how the funds have been spent.

POST-HOSPITAL ACCOMMODATION

Use of brokerage funds to secure short-term accommodation to prevent discharge to streets, including:

- Hostels
- Motels
- Short-term lodges
- Low-cost hotels

Referring patients to crisis or refuge accommodation e.g.,

- Rental bond
- Upfront rental fees

TRANSPORTATION

Assisting patients to access:

- Medical or social care appointments or services
- Accommodation
- Places to stay where patients have social support networks
- Return to country

Includes taxi vouchers, SmartRider cards, regional bus/train tickets, airfares where warranted.

PREVENTING HOSPITAL RE-ADMISSION

Miscellaneous support to prevent hospital re-admission and loss of accommodation:

- Tenancy advocacy, forensic cleaning, pet supplies
- AOD rehabilitation intake fee
- Mobile phones so contactable for follow up appts.

HYGIENE & BASIC NEEDS

Supporting patients with essential personal and hygiene items e.g.:

- Provision of clean underwear, socks, clothing essentials
- Hygiene packs, toiletries
- ID

SUPPORT DURING INPATIENT ADMISSIONS

Facilitating patient stays & preventing DAMAs:

- In-room TV rental
- Cafeteria vouchers

INCOME-RELATED SUPPORT

Reducing financial barriers:

- Assistance with Centrelink or bank account access
- Basic clothes/shoes to attend job interviews.

Figure 14: Types of Brokerage Funding Expenditure

Notes: **DAMA** = discharge against medical advice, **AOD** = alcohol and other drug, **TV** = television, **ID** = identification

In the RPH staff feedback survey, there were several unprompted comments about the role of brokerage funding, e.g.:

> *"Providing accommodation, clothes, taxi vouchers, providing help for Centrelink etc. A team that is able to take over the whole situation so that nurses are not weighed down on their social issues. For many of them it can be someone they have confidence in to help them out. To reduce many representations to the ED."* **– RPH Staff Member**

> *"I have had many patients assisted by the Homeless Healthcare team. One in particular, the team organised food vouchers and accommodation for two nights for a patient that was newly*

destitute and provided options for ongoing requirements. That patient felt that someone cared, understood them and their outlook was one more of hope." **– RPH Staff Member**

"I have worked in hospitals in the Eastern states and this program is the best I have seen in terms of actually providing practical support and funding. It has made a big difference to discharge timelines and having appropriate plans for homeless people that aren't discharge back to the street." – **RPH Staff Member**

However, some staff also noted barriers to the use of brokerage funds, particularly when trying to secure short-term accommodation for patients experiencing homelessness. E.g.:

"There are accommodation places that are very wary of taking bookings for homeless people." – **RPH Staff Member**

The pervasiveness of trauma and AOD dependence among the WA homeless population, along with strong stigma and stereotypes, are factors observed to contribute to some accommodation providers being reluctant to take bookings for patients experiencing homelessness. It was also noted that some accommodation providers were rarely willing to accept women who are pregnant or mothers with children who are escaping family and domestic violence (FDV) due to the associated increased responsibility of care. To help overcome these barriers, the Homeless Team developed a number of supporting documents to reduce providers' hesitancy in accepting patients, including ID verification checks, a behavioural code of conduct that patients agree to abide by, and a guarantee that RPH will cover any damages or additional costs created during patients' stays (Appendix B).

3.2.8 STRENGTHENING HOSPITAL CAPACITY

Having a dedicated team with embedded homelessness experience and strong links with the Perth homelessness sector has been shown to strengthen the confidence and capacity of other RPH staff to identify and support patients experiencing homelessness. This is done both formally and informally.

Formally, the Homeless Team is regularly invited to speak at professional development sessions for RPH staff, including:

- An annual invited RPH Grand Round presentation for hospital staff,
- RPH ED Registrar Teaching Sessions 1-2x/year,
- Nursing education study days 1-2x/year, and
- Outpatient clinic education on special issues with homeless patients.

Informally, there is considerable opportunistic contact with other RPH staff around how best to support the needs of homeless patients. For example, during the Homeless Team's daily ward rounds, the Team interacts with hospital staff at all levels, including medical, nursing and allied health, to provide background information, request information about patients' medical plans and help the hospital team to adapt their care to realistic goals.

The Clinical Lead of the Homeless Team also works with hospital staff, often at senior clinician level, to provide advice and organise multi-disciplinary meetings on the most complex homeless patients. These bring parties together from within and outside the hospital, e.g., community mental health services, the Office of the Public Advocate, community homelessness services and the Office of Homelessness (WA Government Department of Communities). This also includes streamlining complex patient care within the hospital, obtaining rapid access to important hospital care, and keeping community homelessness services informed about their clients who are in hospital. The Clinical Lead is also responsible for producing Patient Management Plans for the RPH ED, including for patients experiencing homeless, designed to guide and educate ED Clinicians in best-practice care of this marginalised population within the ED.

RPH social work staff working in the ED and inpatient wards particularly have noted that the presence of the Homeless Team alleviates pressure, through them having access to a dedicated homelessness service with in-depth knowledge of community resources and potential discharge locations. This

upskills the social work staff, including the Aboriginal Liaison workforce and Welfare Officers, with knowledge about homeless community support and accommodation services.

3.2.9 ENGAGEMENT WITH HOMELESSNESS & COMMUNITY SERVICES

The Homeless Team frequently receives requests from external organisations to provide advice on the healthcare and associated needs of people experiencing homelessness, particularly those with complex issues and multifaceted diagnoses. Examples include various homelessness services, WA police, Street Law and the WA Aboriginal Legal Service. These requests often relate to people already known to the Homeless Team, or whose homelessness has led to hospital presentations at RPH or other public hospitals in WA. Figure 15 provides examples of requests for advice that have been received from different types of organisations and sectors in recent years.

REQUESTS FOR ADVICE & COLLABORATION FROM OTHER ORGANISATIONS & SERVICES

OFFICE OF THE PUBLIC ADVOCATE
- Requesting guardianship orders be respected e.g., regarding consent for medical procedures & discharge plans
- Providing medical reports and evidence at SAT as part of guardianship applications
- Requesting hospital representation at multi-disciplinary meetings about complex homelessness

DEPARTMENT OF COMMUNITIES
- Providing information about individuals and their specific housing needs to improve housing retention
- Participating in multi-disciplinary meetings with DoC Office of Homelessness
- Participating in service planning meetings around homelessness regarding health services needed
- Assisting with locating hard-to-find individuals who have been allocated public housing properties

CRISIS & TRANSITIONAL ACCOMMODATION PROVIDERS
- Gaining access to medical information (with patient consent) e.g., diagnoses & medication lists
- Organising procedures & outpatient appointments in hospital
- Facilitating access to MH & other services where there is resistance to taking on homeless patients

PUBLIC HEALTH DIVISION *(Dept. of Health)*
- Requesting advice on how to set up ED screening for syphilis for ED presenting homeless patients during outbreak commencement of screening and treatment in the ED.
- Requesting patient alerts and management plans for high-risk infectious patient who cannot be found in the community e.g., HIV and syphilis to alert and treat opportunistically when presenting to ED

DEPARTMENT OF HEALTH
- Liaising with Homeless Team to get homeless patients in the hospital vaccinated for Covid opportunistically during the initial outbreak 2020 and opening of WA borders in 2022

MENTAL HEALTH SERVICES
- Following up on mental health plans to ensure enacted in the community
- Advocating for itinerant homeless patients to be kept by a single MH team rather than location-based transfers
- Giving opportunistic anti-psychotic depot medication in ED to non-compliant homeless individuals not linked to MH services

Figure 15: Recent Examples of Requests for Homeless Team Advice

Notes: **DoC** = Department of Communities (WA Government), **SAT** = State Administrative Tribunal, **MH** = mental health, **ED** = Emergency Department

The responses to these requests can range from simple telephone advice through to meetings, involvement in multi-disciplinary case conferences, and/or ongoing collaborations to address the needs of individuals or cohorts. As noted by the Clinical Lead of the Homeless Team:

> *"These consultations provide a navigation service for complex individuals across multiple types of services and are based on the Homeless Team's in-depth knowledge and experience in homelessness and the health issues in marginalised individuals, with the aim of achieving effective interventions."* **– Dr Amanda Stafford, Clinical Lead, RPH Homeless Team**

The Homeless Team's primary expertise encompasses hospital healthcare (Clinical Lead), specialist homelessness medicine primary care (HHC registered nurses) and experience working in community homelessness services. This allows the Team to confidently interact with the multiple outside agencies in the health and social sector spaces, requesting advice and setting up collaborations which assist with improving patient outcomes. Box 2 provides an example of such a collaboration for a particularly vulnerable patient.

Box 2: Fostering Links with Community Supports to Improve Patient Outcomes

Background: *"Amy"* is a woman in her mid-50s whose experience of severe childhood abuse contributed to her extreme vulnerability, resulting in a life of continual trauma from family and domestic violence, sexual and physical assaults and chronic rough sleeping. Amy describes using alcohol as a coping mechanism to manage her distress, without any formal support network to help her navigate her many challenges. Amy was frequently brought to RPH ED by ambulance from the streets due to concerns about her health or safety. She was invariably heavily intoxicated and often injured. While in ED, her intoxication and any injuries were managed but the underlying drivers of her frequent ED presentations, rough sleeping and severe psychological trauma were not, and she often returned to the streets following discharge.

Support Provided: A psychiatrist working in a mental health outreach program engaged with Amy on the street and was able to build enough trust to begin unravelling the details of her traumatic past. This resulted in Amy's first mental health inpatient admission for management of her complex c-PTSD.

Accessing housing and supports to end Amy's street-present homelessness was complicated by her heavy alcohol use. Due to her ongoing lack of safe stable accommodation, she suffered extensive assaults and abuse from partners, leading to hospital presentations for injuries. To protect her from exploitation and abuse, an application for guardianship was made. However, this process was made challenging by the difficulties of demonstrating Amy's vulnerability to exploitation, which cannot be measured by the tools routinely used to support guardianship applications.

The Homeless Team's Clinical Lead pulled together evidence from the psychiatrist who had worked with her on the street, mental health admission information and observations from Amy's many ED presentations. This evidence was submitted at a State Administrative Tribunal hearing, accepted in full and guardianship granted. Due to Amy's vulnerability and history of trauma, she was appointed an experienced female guardian to manage this complex situation. This was followed by allocation of a public housing property. Unfortunately, without the wrap around support services Amy needed to improve her dire situation, the allocation of this property did not resolve her struggles.

Current Situation: Due to ongoing exposure to domestic violence from a partner, and exploitation by others, Amy's harmful use of alcohol has continued, contributing to repeated hospital admissions. Attempts to obtain NDIS support funding have been rejected on the grounds that vulnerability and exploitation do not constitute a disability. Nonetheless, throughout these ongoing, complex challenges, the Homeless Team continues to support Amy whenever she presents to hospital, having established rapport and gained her trust over the years. The Team also continues to liaise with Amy's external support network to improve her quality of life and reduce her hospital presentations.

Notes: **cPTSD** = Complex post-traumatic stress disorder, **NDIS** = National Disability Insurance Scheme (Australian Government)

3.3 HOW DO PATIENTS GET SEEN?

This section describes the various pathways by which patients come to be seen by the Homeless Team and the activities undertaken by the Team to obtain and review patients' histories and link them with primary care supports via its collaboration with HHC.

3.3.1 IDENTIFYING HOMELESS PATIENTS AT RPH

The Homeless Team aims to review all homeless patients within RPH. This is proactively approached, since:

- Not all patients self-identify as experiencing homelessness or see themselves as homeless (e.g., a patient living in an unsafe, FDV relationship or couch surfing with friends/family), and
- The hospital nomenclature of NFA has been shown to significantly under-recognise the number of patients who are in homeless circumstances.[51] This occurs for many reasons, including the provision of a non-current residential address, an address where postage is sent, a family members' address or rural/remote addresses patients are not currently living.

Exemplifying this issue, only just over half of all patients seen by the Homeless Team who presented to ED in the 1-year period prior to being seen (n=1,073 out of 1,935, 55%) had at least one presentation during that period where they were identified/coded as having NFA:

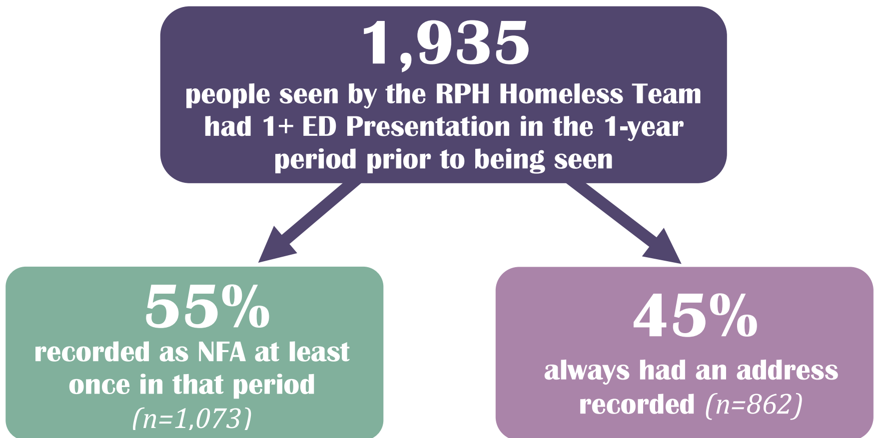


Figure 16: Homeless Team Patients Coded as NFA in Hospital

Note: **NFA** = no fixed address.

The Homeless Team therefore utilises multiple strategies to identify homeless patients at RPH:

1. RPH's Business Intelligence Unit produces a **daily list of identified homeless patients in RPH**, drawn from the hospital census which is taken at midnight. This census identifies patients with NFA or who have given addresses for homeless facilities such as Homeless Drop-In Centres and Transitional accommodation facilities such as St Bart's and The Beacon.
2. The Administrative Assistant performs a **manual search of the hospital patient database** each weekday morning, examining hospital areas where homeless patients are most frequently to be found, e.g., the ED, the Emergency Medical Ward (EMW), the ED Observation ward, the Acute Medical Unit and the State Trauma Unit. The manual search is particularly valuable for identifying patients who entered the hospital after the midnight census, patients known to the Homeless Team and HHC patients.
3. **Staff referrals:** information about how to refer individuals to the Homeless Team is displayed on colourful posters placed in RPH wards and ED (Figure 17). Any RPH staff member can refer a patient for Homeless Team review via the contact phone number provided on the poster. However, a

referral is not required to trigger a review by the Homeless Team, with any patient identified as homeless during round hours being reviewed.

4. **Routine visits to the ED and EMW,** which are the most common locations within RPH where homeless patients are to be found, generally at the start of each day's round.

Figure 17: RPH Homeless Team Poster

The identification process includes an informed assessment of eligibility for Homeless Team support, as described in Figure 18. This figure also outlines typical patient pathways to contact with the Team and usual patient flow during episodes of care.

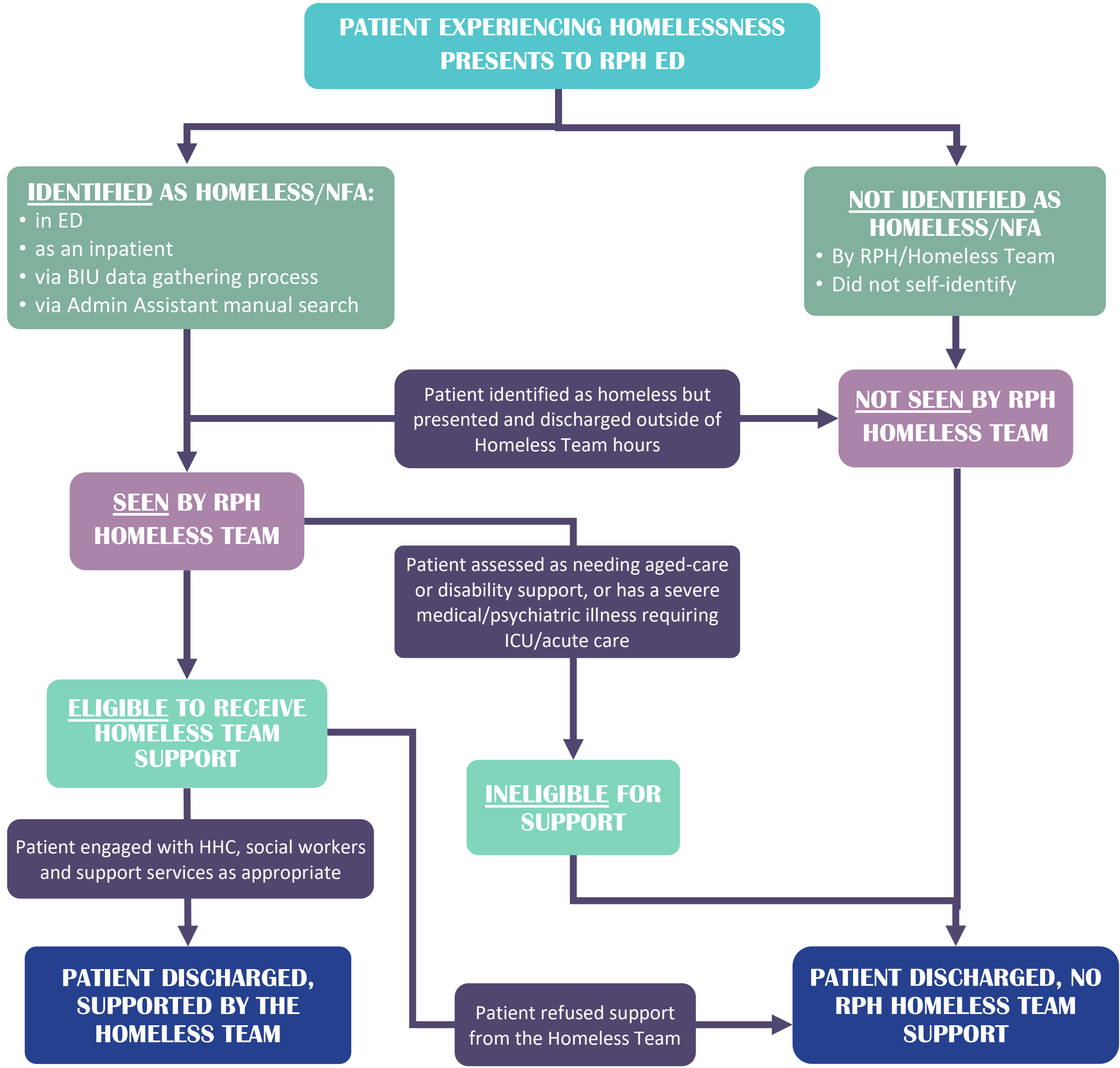


Figure 18: RPH Homeless Team Patient Flow

Note: **NFA** = no fixed address, **RPH** = Royal Perth Hospital, **ED** = Emergency Department, **HHC** = Homeless Healthcare, **BIU** = Business Intelligence Unit, **ICU** = Intensive Care Unit

3.3.2 HOMELESS TEAM ROUNDS

Homeless Team rounds involve a HHC registered nurse and two community case workers on weekdays and a HHC Nurse and one community caseworker on weekend days and Public Holidays. The hospital rounds, encompassing ED and inpatient wards, occur daily Monday to Sunday between 9am and 4pm. The full-time Administrative Assistant provides logistical support to the Homeless Team on weekdays, and the Clinical Lead provides advice and problem solving to the Homeless Team on weekdays in addition to her wider advocacy role.

The Homeless Team rounds are used to review patients' medical and psychosocial needs. The team works with the patient to identify their needs and priorities and develop an individualised discharge plan that supports continuity of care. If a patient is deemed suitable for reception of support from the Homeless Team, the community case worker reviews their housing needs, looks for suitable accommodation options and assists them with applications to housing and any other community-

based supports they require. This contact with the Homeless Team during rounds is often the first step in linking highly disengaged patients with the support services that can assist them in exiting homelessness.

This daily presence of the Homeless Team at RPH and its proactive efforts to identify and support patients experiencing homelessness demonstrates strong alignment with Strategy 4 identified in the Sustainable Health Review Final Report, with explicit mention of the need to put:

> "*people at the centre of care and ensuring people have access to care when they need it*".[40, p.75]

The clinical encounters by the HHC nurses during the Homeless Team round are recorded in the HHC database, and printed copies of their consultation notes are added to patients' medical files. Meanwhile, the case workers record their information from patient contacts in their parent community service database and write directly in the patients' notes. This ensures that information discussed during the Homeless Team consultation is readily available to the treating hospital team. There are usually discussions with members of the treating team at the time of the Homeless Team consultation. Other referrals or consultations that may be required, e.g., medical, nursing, pharmacy, allied health, or social work referrals, are facilitated by the Homeless Team staff, or by the Clinical Lead of the Homeless Team when needed.

Image 5: RPH Homeless Team Staff Discussing Care Plans Post-Patient Rounds

3.3.3 PATIENTS INELIGIBLE FOR SUPPORT

Occasionally, the Homeless Team is asked to review patients who are not suitable for support from homelessness services, generally due to requiring support from aged care or disability services rather than from the Homeless Team. Other times, the Homeless Team may not be able to assist due to the patient being in active psychosis or too acutely unwell at the time. Table 4 lists the types of reasons and provides some examples of patients who were deemed ineligible for Homeless Team support. Reasons for ineligible referrals also include RPH staff sometimes not understanding the remit of the Homeless Team or not looking beyond their patients' homelessness to understand other issues they are experiencing, e.g., disability and aged-care issues, and thereby not first attempting referral to mental health, aged-care or disability services that would better suit their needs.

Table 4: Examples of Unsuitable Referrals

Reason ^	Example
Patient required National Disability Insurance Scheme (NDIS) and disability support	A man in his late 30s was referred who had paranoid schizophrenia and who had been disengaged from mental health treatment and refusing to take antipsychotic medication for many months. This led to increasingly severe psychosis and to the patient secluding himself in squalid conditions in a budget hotel. After a period, he was removed from the hotel by police and brought to RPH, at which time he was emaciated and dehydrated and required urgent medical care before antipsychotic treatment could be re-started. Once stabilised, he was transferred to a psychiatric ward and determined to have a complex mix of severe schizophrenia, poor mobility, and high falls risk. Unfortunately, due to a lack of insight into his condition and reasons for frequent aggressive behaviour, applications to multiple supported mental health supported facilities were rejected. He required nearly a year-long hospital stay to obtain the comprehensive NDIS package he needed to be discharged. He was seen only once by the Homeless Team, 10 days into this lengthy admission, at which time he was deemed unsuitable for Homeless Team support as he clearly required high-level, supported mental health accommodation rather than homelessness services.
Patient in active psychosis or too acutely unwell currently	A man in his late 40s was referred who was living in precarious and insalubrious housing was admitted to RPH with complications from neglected wounds sustained after falling down a well a few months previously. On admission, he had large, infected, open wounds on both legs with infected bone visible at the base of the wounds. This led to him developing severe sepsis requiring ICU admission and amputation of one leg. He had multiple hospital stays between surgical and rehabilitation wards for ongoing wound infection over a period of months. The Homeless Team were asked to assess him multiple times by hospital staff, but on each occasion gave advice that he was not suitable for homelessness services due to his level of disability, and that he required funded disability accommodation to meet his needs.
Patient required aged-care accommodation	A man in his 60s was referred who had been sleeping rough for many years with untreated schizophrenia that masked the development of dementia as he aged. He was admitted to hospital very unwell with severe sepsis from a chronic leg wound. After a four-week stay in a tertiary hospital he was transferred to a geriatric mental health unit for ongoing treatment of his schizophrenia. Once his psychosis abated, it became clear he also had dementia, and he was placed in a nursing home. He was seen only once by the Homeless Team, four days into his admission, once his condition had stabilised, at which time he was deemed unsuitable for Homeless Team support due to his clear psychiatric and aged-care needs.

^ Note: these patients may fit more than one of the listed 'reasons' for being deemed unsuitable for Homeless Team support

3.3.4 DAY IN THE LIFE OF THE HOMELESS TEAM

The following pages describe a typical day in the life of the Homeless Team, from the identification of patients experiencing homelessness through emergency and inpatient ward rounds, engagement with patients, patient case conferences between the Homeless Team and HHC, development of individualised patient care plans, and supporting safe discharge to some form of at least temporary accommodation where possible.

RPH HOMELESS TEAM - A TYPICAL DAY

IDENTIFY RPH PATIENTS EXPERIENCING HOMELESSNESS

- Each night the RPH Data Unit produces a list flagging all patients recorded as "NFA" on their midnight hospital bed census, including people with addresses known to be homeless drop-in centres, crisis accommodation, etc.
- Each morning the HT administrative assistant collates a list of patients identified as homeless from several sources, including the nightly hospital census, a manual review of ward lists to identify patients known to the HT, plus any e-referrals and telephone referrals to the Team

HOMELESS TEAM DAILY WARD ROUND

Emergency Department

- HT caseworkers and the HHC nurse conduct a ward round of ED and short stay wards, to see patients identified as homeless. Ward rounds commence in ED to engage with patients before they are discharged (or self-discharge)
- Interact with staff to provide background information about patient's circumstances where applicable
- HT presence in ED gives the medical/ED staff the opportunity to refer other patients who may be at risk of homelessness. The HT check-in with anyone who has been referred and assess whether they are suitable for HT input and requiring support

Inpatient wards

- HT visit wards to see patients identified by the daily list, or to follow-up patients already engaged with team
- HHC nurse reviews most recent medical notes, discusses updates with case workers including likely duration of admission and potential medical needs on discharge
- Interact with medical, nursing, allied health and other staff to provide relevant patient background and help the hospital team to adapt care around realistic goals.
- HT liaise with medical team and ward social worker to coordinate a discharge plan encompassing medical, housing and psychosocial needs
- HT advocate for patients to not be discharged to the streets, exploring all other options available
- HT assesses patient suitability for MRC post-discharge and discusses this option with patient. Advocate for MRC referral if suitable. If patient ineligible for MRC or declining referral, HT advocate for patient to remain in hospital until stable enough for discharge and until sufficient discharge plans can be made

INITIAL ENGAGEMENT WITH PATIENT

Patient awake/able to engage

- Review if suitable for HT engagement
- HT check in with patients:
  - Many patients will already know the HT from previous engagement in the hospital or through the community HHC clinics
  - Explain the role of the team if the patient has not been seen before by the HT
  - Ask if they want support/input from the team and gain consent to engage
  - Discuss patient's priorities and advocate for them to the medical team as needed
- HHC nurse liaises with medical team to see whether patient to be discharged or admitted. Communicate this to patient as appropriate

* Homeless Team abbreviated to HT

DAILY CASE CONFERENCE BETWEEN HOMELESS TEAM & HOMELESS HEALTHCARE

Each morning after the team completes an initial ward round there is a case conference via Teams between the HT staff on the ward round and HHC's Medical Director, Nursing Director, and Director of Residential services at the MRC. This includes:

- Review of patients where GP input required
- Potential MRC referrals discussed
- HHC can identify any of its patients known to be in RPH who would benefit from HT Team follow up, e.g., clients referred by Street Health team
- HT can update broader HHC Team on patients well known to them who have presented to ED or been admitted, arrange follow-up GP appointment, flag test results for HHC to look out for

RESPONDING TO ENQUIRIES AND REQUESTS FOR ADVICE ACROSS THE HOSPITAL

INDIVIDUALISED PATIENT/CLIENT PLAN IS DEVELOPED

The aim is to address immediate discharge needs to facilitate timely & safe discharge with an ongoing plan. Patient needs are highly variable hence importance of an individual plan. This can include:

- Liaising with medical staff to provide relevant information relating to healthcare needs
- Strategies to encourage patient to not discharge themselves prematurely (e.g., connecting TV)
- Supporting patients to be connected to assessments where required e.g., for Mental Health, AOD Service, Occupational Therapist, Physiotherapy, Specialist Inpatient Teams
- Assess housing and accommodation needs, referrals, arranging suitable short-term accommodation where longer-term options not available

Note: there are many contact points with RPH staff, medical, nursing, and allied health to develop and action the individualised plans. This may be completed in a single visit or over multiple visits, depending on patients' length of stay in hospital.

ACTIONING PATIENT SUPPORT PLANS

- Case workers liaise with accommodation and other services as required by individual plan
- Case workers use brokerage funding to support safe discharge (i.e., provision of SmartRider cards, organise short-term accommodation for further recovery, essential clothing and toiletries as needed).
- Liaise with HT Clinical Lead where additional medical advice or patient advocacy needed

REGULAR CHECKING IN WITH PATIENT

- Touching base with patients to see how they are, update them on accommodation options for discharge etc.
- Advocacy on behalf of patient where needed to medical or other hospital staff

SUPPORTING SAFE DISCHARGE & PREVENTING RE-PRESENTATION TO HOSPITAL

- Liaise with social work as needed regarding patient discharge planning, especially in relation to issues concerning FDV or child protection
- Ensuring patient will be able to undertake post hospital medical advice given their homeless or temporary accommodation circumstances e.g., changing dressings, rest, elevating limbs, storing medications, and organising HHC GP follow ups
- Identifying factors to increase likelihood of presentation (e.g., lack of transport to follow ups at GP or outpatient appointments and organising supports)
- Connecting patients to HHC if do not have a regular GP, other support services as needed

PATIENT DISCHARGED BY RPH TO AVAILABLE COMMUNITY SUPPORTS

3.3.5 INTERACTIONS WITH PATIENTS KNOWN TO HHC

Most patients seen by the Homeless Team have substantial vulnerabilities and are often highly disengaged from homeless health support services. Therefore, the Homeless Team routinely records the degree to which each patient it sees is already known to, or engaged with, HHC (via its extensive network of community clinics). This is achieved through searching the HHC database for relevant GP records at the time of each patient's first contact with the Homeless Team, with each patient subsequently being classified as 'Well Known', 'Little Known' or 'Not Known' to HHC (Figure 19). For patients who are not well known to HHC, contact with the Homeless Team at RPH represents one of few opportunities to engage this highly vulnerable group.

Figure 19: Degree to Which Known to HHC

Figure 20 shows the proportion of the Homeless Team patients who were 'Well Known', 'Little Known' or 'Not Known' to HHC at first contact with the Team, by financial year (FY) between 2016/17 and 2020/21. The proportion of patients who were 'Little Known' to HHC trended upwards over time, increasing from 50% in 2016/17 to 71% in 2020/21, while the proportion of patients Not Known to HHC decreased from 29% to 12% over the same period. This is positive, because the Homeless Team can build on a given patient's even brief, low-level contact with HHC during a hospital visit. Further, it demonstrates the increase in HHC community contact points through the addition of new clinics and increased outreach over time, which enables the Homeless Team to provide continuity of care in the hospital setting. Finally, it reflects the fact that the Homeless Team continues to see previously disengaged patients.

Meanwhile, the proportion of Homeless Team patients who were Well Known to HHC has remained relatively constant over time, varying between 24% and 17% over the five-year period. This reflects the fact that **the Homeless Team does not, and has not previously, predominantly seen patients who are Well Known to HHC, but rather those with little or no previous contact.**

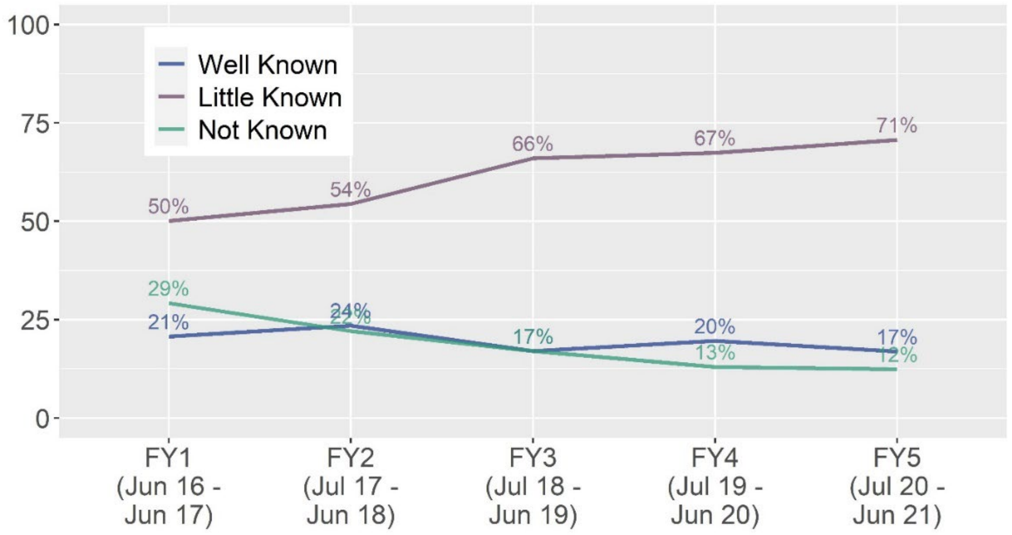


Figure 20: Proportion of Patients Known to HHC at First Contact

Note: **FY** = financial year.

4 WHO WAS SUPPORTED & WHAT WERE THEIR NEEDS?

4.1 PATIENT DEMOGRAPHICS

The mean age of the 1,946 patients seen by the RPH Homeless Team over its first five years of operation was 42 years (Table 5). Most patients were born in Australia (85%), followed by the UK (5%), New Zealand and South Pacific (3%, of which most were from New Zealand) and Africa (2%, of which about a quarter were from Sudan). The majority (65%) of patients were male, consistent with the over-representation of males more generally in the Australian homeless population.[1] Females comprised 34% of the cohort, and 1% identified as transgender. Overall, 33% of Homeless Team patients identified as being Aboriginal and/or Torres Strait Islander (hereafter 'Aboriginal'), a substantial over-representation given that only 3.3% of the Australian population identifies as Aboriginal.[52] This over-representation is consistent with what is seen in the Australian homeless population more generally.[1]

Table 5: Homeless Team Patient Demographics

RPH Homeless Team Patients		N (%)
Gender	Male	1,272 (65%)
	Female	660 (34%)
	Transgender	14 (1%)
Age	Mean age at first contact(years)	42
	Range	17 – 85
Indigenous Status	Non-Aboriginal and/or Torres Strait Islander	1,305 (67%)
	Aboriginal and/or Torres Strait Islander	641 (33%)
Country of Birth^	Australia	1,660 (85%)
	United Kingdom	106 (5%)
	New Zealand and South Pacific	65 (3%)
	Other	111 (6%)

Note: ^ Country of birth was unknown for 1 patient.

4.1.1 INDIGENOUS STATUS

As shown in Figure 21, the proportion of Homeless Team patients who identify as Aboriginal increased by 37% over time from 30% in 2016/17 to 41% in 2020/21. The increase has been equally split between males and females, with the rate of increase in the proportion of patients identifying as Aboriginal being 2.9% per year among males and 2.7% per year among females (Figure 65; Appendix C).

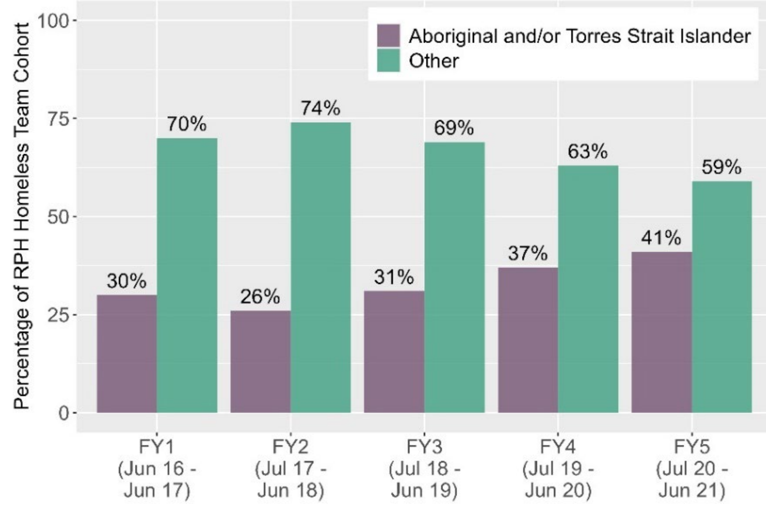


Figure 21: Indigenous Status of Homeless Team Patients

4.1.2 AGE DISTRIBUTION OVER TIME

Figure 22 shows the age distribution of the cohort, stratified by sub-period of operation first seen by the Homeless Team (first 2.5 years or second 2.5 years). The ages of patients seen changed only marginally over time. Over the entire period, 57% of patients were aged 35-54 years, while just 9% were aged either 15-24 years or >65 years. No patients were aged younger than 15 years, reflecting the fact that RPH is an adults-only hospital (15+ years old). Equally, there are few older people (>65 years old) due to factors such as the harshness of homeless life, access to aged-care accommodation and the markedly reduced life expectancy of the homeless population, with the median age at death amongst the Perth homeless population being approximately 50 years,[53] over 30 years younger than the current median life expectancy of the general Australian population.[54]

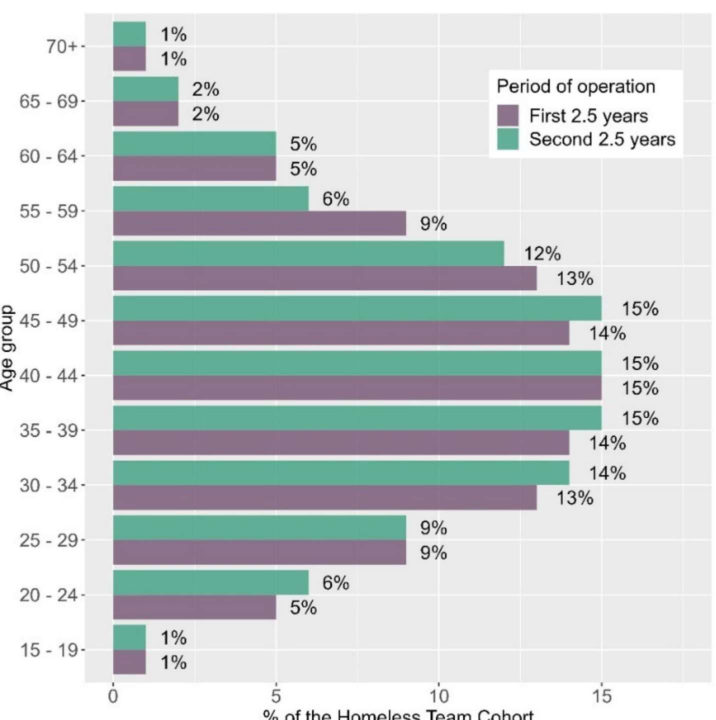


Figure 22: Age Distribution of Homeless Team Patients

4.1.3 AGE BY GENDER

Female patients seen by the Homeless Team were slightly younger, on average, than their male counterparts (40 years versus 44 years), with a higher proportion of females being aged 15-39 years old and a markedly reduced proportion being aged 55+ years old (Figure 23). The latter observation is thought to be due to Homeless Team patients being primarily rough sleepers and a combination of premature mortality and a tendency of older females to avoid inner-city homelessness services due to their physical vulnerability. In Perth, the usual supports for women experiencing homelessness are through FDV shelters, but many women of child-bearing age seen by the Homeless Team are largely excluded from such services as they have not recently experienced FDV, have not had children, have had children who have been removed from them and placed in state care, or have active substance use. As noted by the Clinical Lead of the Homeless Team, all these factors disqualify them from the few FDV refuges available.

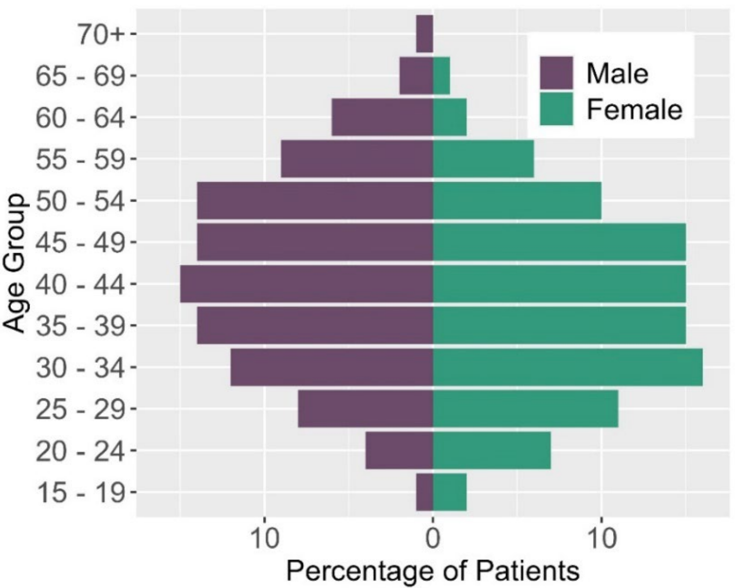


Figure 23: Age Distribution, by Gender

4.2 PATIENT CONSULTATIONS

Over the first five years of its operation, the Homeless Team provided 5,874 separate consultations during 4,454 episodes of care to 1,946 unique patients. During each episode of care, patients could be seen multiple times, particularly during lengthy inpatient admissions.

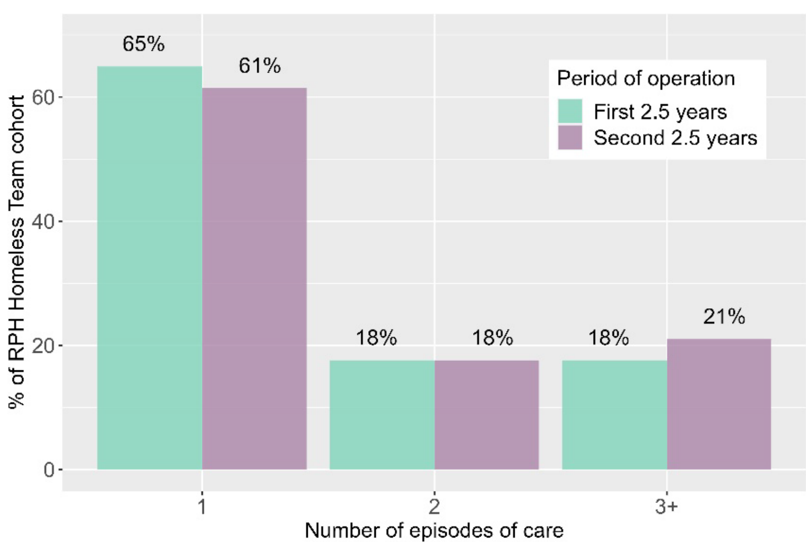


Figure 24: Episodes of Care Per Person

Over 60% of patients seen over the five-year period had only a single episode of care, with almost 20% having only two (Figure 24). Further, these percentages varied only slightly over time (between the first and second 2.5-year periods of operation). These figures provide **evidence to the contrary to some suggestions that the existence of the Homeless Team 'encourages' people experiencing homelessness to frequent the RPH ED**. If this were the case, a greater proportion of the cohort could be expected to have been seen multiple times by the Team.

4.2.1 LOCATIONS OF CONSULTATIONS WITHIN RPH

Patients are seen by the Homeless Team across all areas of RPH, with the most common location being the ED, where 51% of consultations occurred (20% in the Main ED and 31% in the ED Observation Ward) (Figure 25). The next most common consultation locations were the Medical and Surgical Inpatient Wards (26% and 16% of consultations, respectively). Only 6% of consultations occurred on the Psychiatric Ward (which has robust social work teams). The remaining 1% of consultations occurred in the Social Work Department, Outpatient Clinics, via Phone Call, with Hospital Visitors or in 'Other' locations in the hospital.

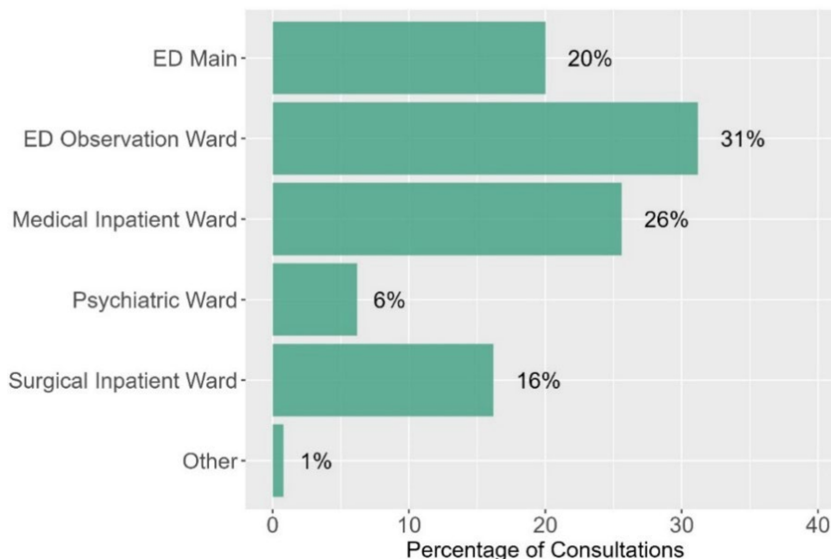


Figure 25: Consultation Locations within RPH

Note: 'Other' includes: the Social Work Department, Outpatient Clinics, via Phone Call, with Hospital Visitors or in various other locations in the hospital.

4.2.2 CHANGES IN CONSULTATIONS OVER TIME

Figure 26 and Figure 27 show, respectively, the number of consultations and unique patients seen by Homeless Team staff by month between June 2016 and December 2021. The activity of the Team increased over time from averages of approximately 75 consultations and 50 patients seen per month in 2016 to averages of approximately 125 consultations and 75 unique patients seen per month by end-2021. **Between its inception and the time of writing of this report, the Team saw approximately 2,900 unique patients at least once.**

Various factors have changed over time for the Team that have influenced their activity. For example, towards the end of 2021 the service was extended to offer weekend support at RPH (i.e., the service changed from a weekday to a 7-day per week service). Also, there was a dip in activity in early 2020 at the start of the COVID-19 pandemic, when it was extremely difficult for the Homeless Team to review patients on wards due to staff having to be in full personal protective equipment. However, once these measures were lifted, the upward trend in overall activity continued.

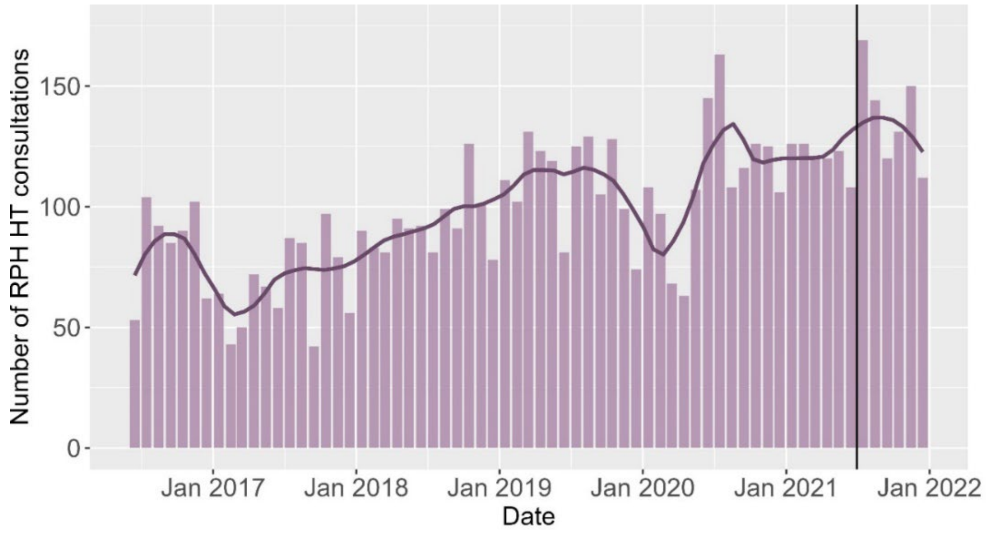


Figure 26: Monthly Homeless Team Consultations

Note: Bold lines: smoothed monthly consultation numbers and the end of the first 5 years of operation. **HT** = Homeless Team.

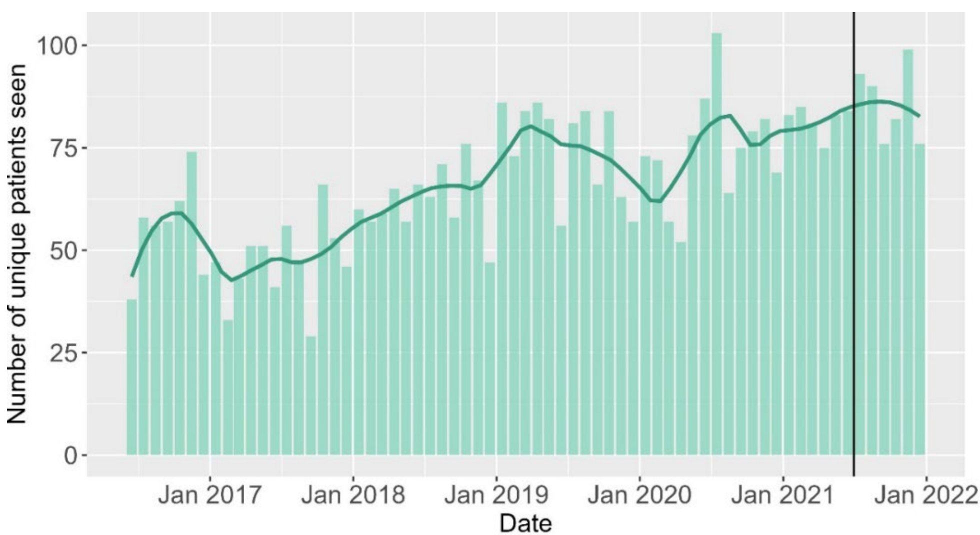


Figure 27: Monthly Unique Homeless Team Patients

Note: Bold lines show the smoothed monthly number of unique patients seen and the end of the first 5 years of operation.

4.3 HOMELESSNESS & HOUSING NEEDS

Patients seen by the Homeless Team are highly marginalised, with the majority experiencing primary homelessness (i.e., rough sleeping). Accordingly, reducing hospital discharge back into homelessness, and in particular back to the streets, is a primary aim. This is facilitated by early, collaborative discharge planning and enhanced care coordination for patients experiencing homelessness. However, the degree to which the Team can avoid such discharges is heavily impacted by the availability of suitable accommodation and the chronic shortage of public housing in Perth and WA. The difficulty of obtaining rapid and suitable housing remains a substantial barrier to improving the health of patients who are homeless, with rough sleeping being associated with deterioration in health and frequent re-admissions to hospital. Nevertheless, despite these challenges, the Homeless Team discharges patients to stable and safe accommodation wherever possible, as this chapter describes.

4.3.1 LIVING SITUATION AT FIRST CONTACT

Figure 28 shows the proportion of patients in different living situations at first contact with the Homeless Team. Most were rough sleeping at first contact (72%), while 8% were staying with family or friends, often in temporary couch-surfing arrangements. Although 7% were recorded as being in long-term housing, it should be noted that these were mostly patients of HHC, having been homeless previously and remaining vulnerable and at risk of returning to homelessness.

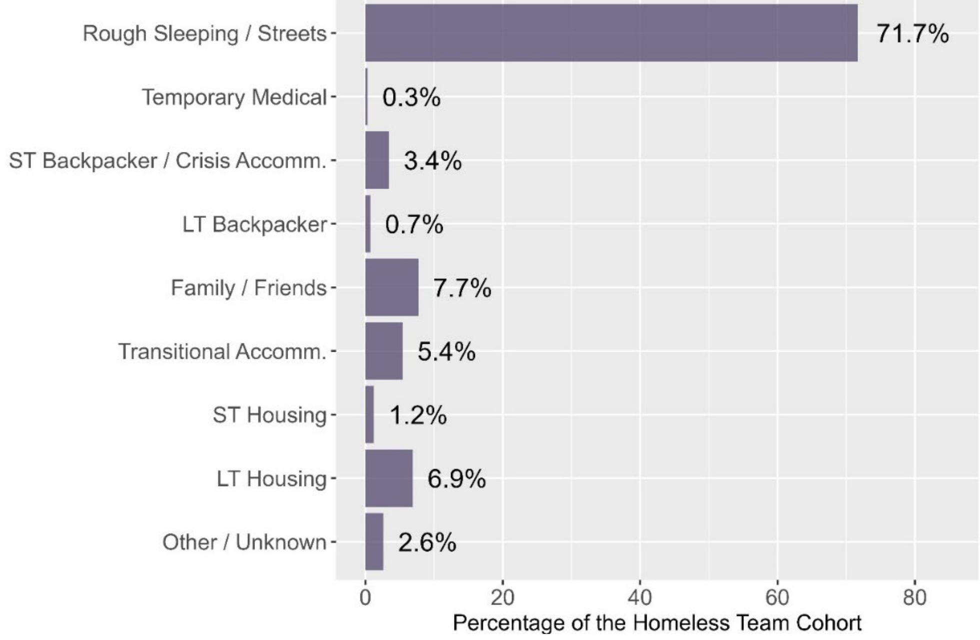


Figure 28: Living Situation at First Homeless Team Contact

Notes: Pre-first contact with the Homeless Team. Excludes data for one individual for whom living situation at first contact was not recorded. **Temporary Medical:** includes detox, rehab, hospice and palliative care, psychiatric facilities (voluntary and involuntary) and other medical facilities. **Other/Unknown:** includes prison, police custody, deaths, left Perth area and unknown. **ST:** short-term; **LT**: long-term.

Most patients who were rough sleeping at first contact were unknown to HHC, and similarly for patients who were in short-term backpacker or crisis accommodation, staying with family or friends, in long-term backpacker accommodation or in short-term housing, though the latter figures are based on small numbers (Figure 66, Appendix C). This result is consistent with the observation made previously that the Homeless Team does not predominantly see individuals who are already known to HHC (Section 3.3.5).

4.3.2 DISCHARGE DESTINATION POST-FIRST CONTACT

Figure 29 shows the proportion of patients discharged to different locations post-first contact with the Homeless Team. Whilst 72% of patients seen by the Homeless Team were rough sleeping at first contact, less than a third (32%) were discharged to rough sleeping following that contact. As noted previously, such discharges were driven primarily by the lack of suitable accommodation options. Nevertheless, they were avoided where possible. As previous evaluations of the Homeless Team and the WA Department of Health Homelessness Discharge Facilitation Fund have shown, even averting discharges to the streets for a few days or a week can help someone recover from hospital and buy time to help connect them to community-based services.[3,4,55] The fact that almost a quarter (22.4%) of discharges post-first contact with the Homeless Team were to short-term backpacker or crisis accommodation reflects the value of the Team's access to brokerage funds for that purpose (Section 3.2.7). Family or friends was the third most common discharge destination, but this situation still falls within the ABS definition of homelessness[1] and hence only represents an interim solution in the absence of longer-term housing and accommodation options. 'Temporary Medical' discharge destinations were primarily psychiatric facilities (voluntary and involuntary) but also detox, rehabilitation, hospice and palliative care, and other medical facilities.

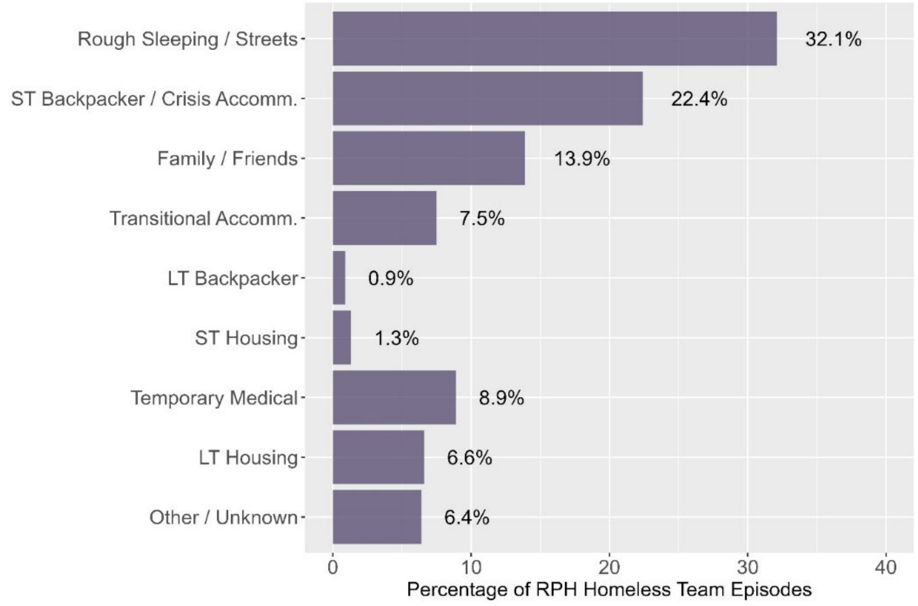


Figure 29: Discharge Destination After First Homeless Team Contact

Notes: Post-first contact with the Homeless Team. **Temporary Medical:** includes predominantly psychiatric facilities (voluntary and involuntary) but also detox, rehab, hospice and palliative care, and other medical facilities. **Other/Unknown:** includes prison, police custody, deaths, left Perth area and unknown. **ST:** short-term; **LT**: long-term.

Some temporal trends in discharge destination post-first Homeless Team contact were observed, e.g., the proportion of first episodes of care resulting in discharge to short-term backpacker or crisis accommodation increased from 12% in 2016/17 to 30% in 2020/21, and the proportion resulting in discharge to transitional accommodation decreased from 12% to 5% over the same period (Figure 30). These trends reflect the increase in wait times that have occurred even for transitional accommodation since the Homeless Team commenced, and the resulting increasing reliance of the Homeless Team on short-stay backpacker and low-cost motel accommodation that can be purchased using brokerage funds. The first evaluation of the Homeless Team presented case studies of patients being discharged directly into transitional supported accommodation such as The Beacon;[3] however, such discharges have become increasingly rare due to escalating demand on Perth's limited number of transitional accommodation premises. Encouragingly, **over the first five years of Homeless Team operation, the proportion of first episodes of care resulting in discharge to rough sleeping decreased from 37% in 2016/17 to 27% in 2020/21 (a 27% decrease)**.

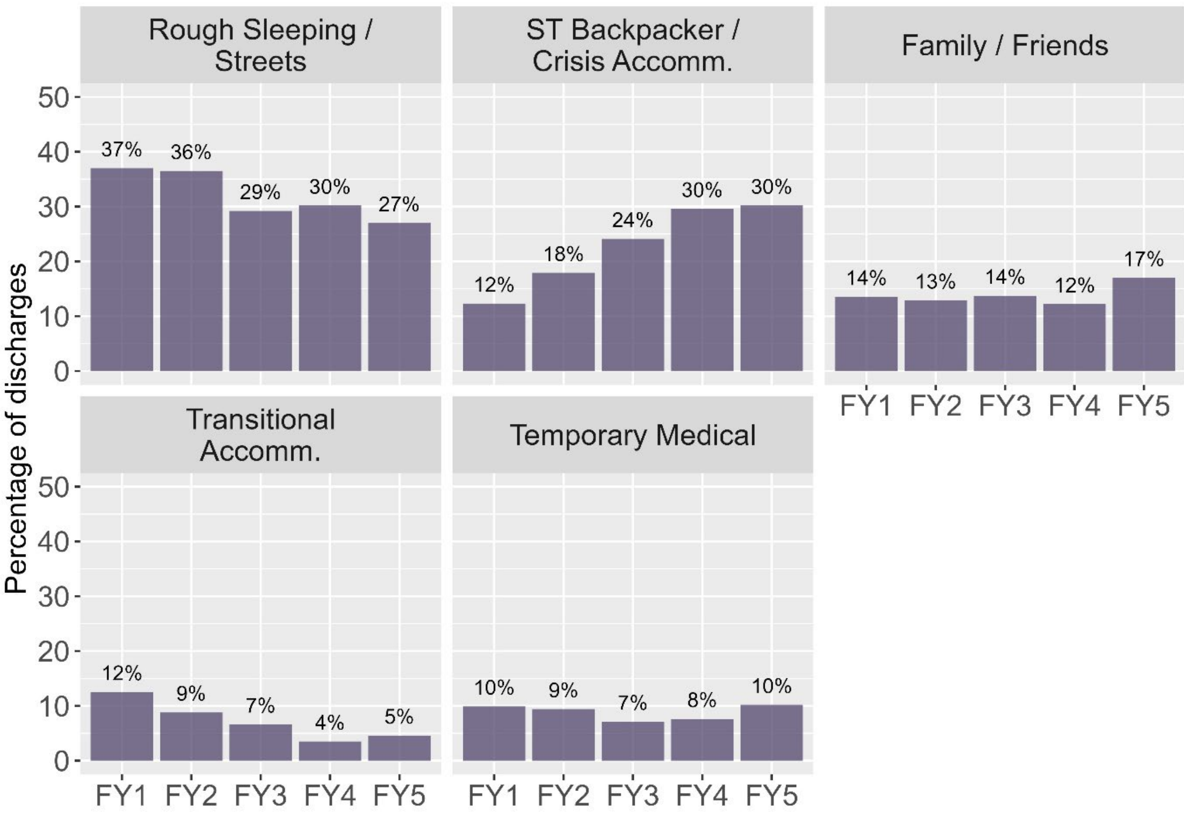


Figure 30: Temporal Patterns of Discharge Destination

Notes: **Temporary Medical:** includes detox, rehab, hospice and palliative care, psychiatric facilities (voluntary and involuntary) and other medical facilities. Data are shown only for destinations with at least 10 discharges in each financial year. **ST:** short-term; **FY:** financial year

Image 6: RPH Homeless Team Supporting a Patient in ED

4.3.3 CHANGES IN LIVING SITUATION: ADMISSION TO DISCHARGE

The figures presented in Section 4.3 are positive overall, with a substantial decrease in the proportion of patients who were sleeping rough being discharged back to the streets post-contact with the Homeless Team, including over the five-year period. However, securing long-term accommodation or permanent housing at discharge remains a huge challenge, with patients discharged to long-term housing predominantly being those who were already in such housing on admission (Figure 31). Similarly, many discharges to transitional accommodation or family/friends were to the same living situation patients were in at presentation or on admission. Nevertheless, Figure 31 demonstrates a positive impact of the Homeless Team in terms of its ability to direct discharges away from the streets, with more than half (57%) of patients who were rough sleeping on admission being supported by the Team into some form of accommodation.

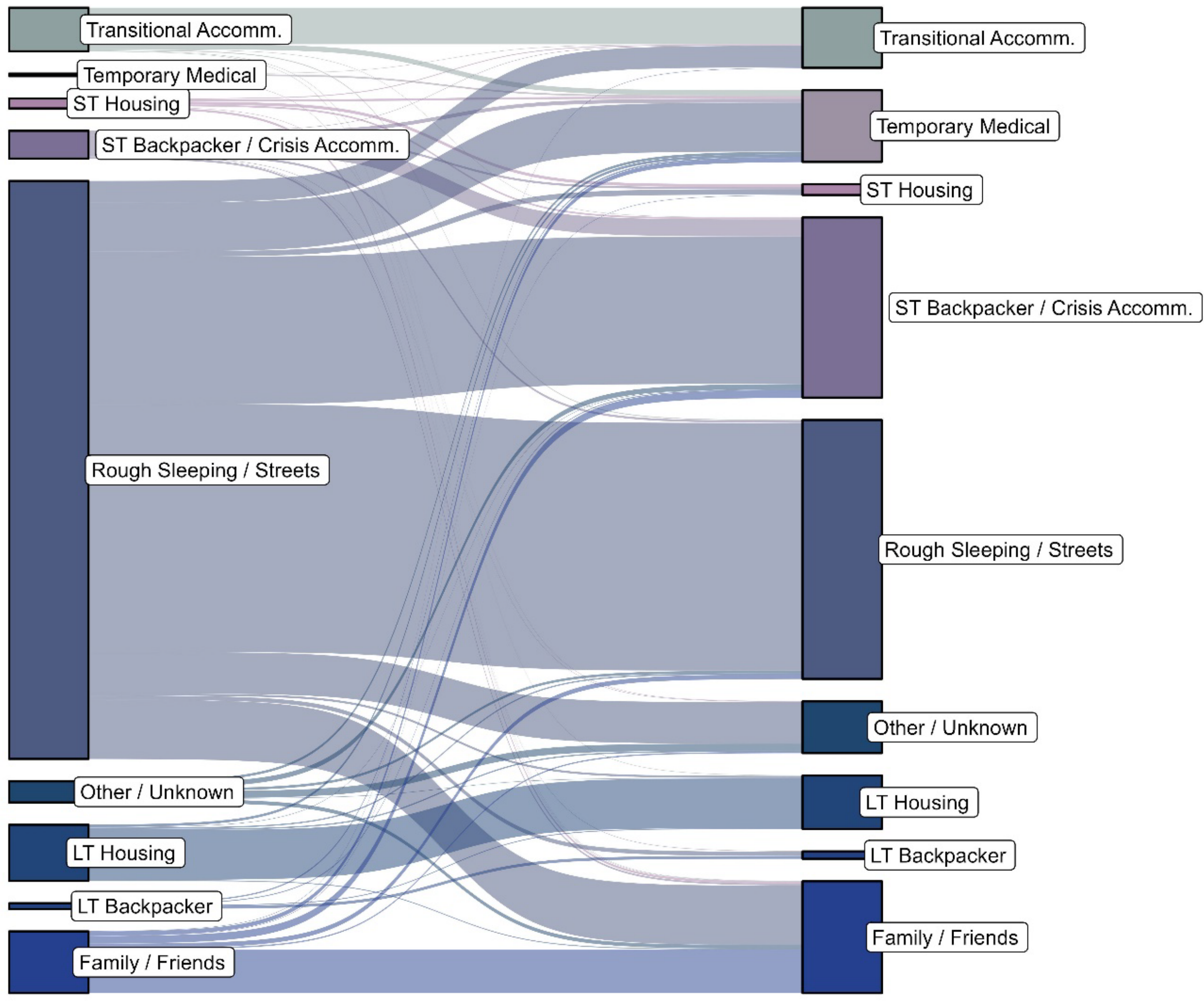


Figure 31: Living Situation: First Contact to Discharge

Notes: Pre/post first episode of care for each patient. **Temporary Medical:** includes detox, rehab, hospice and palliative care, psychiatric facilities (voluntary and involuntary) and other medical facilities. **Other/Unknown:** includes prison, police custody, deaths, left Perth area and unknown. **ST:** short-term; **LT**: long-term.

4.4 HEALTH NEEDS

4.4.1 CO-MORBIDITIES

The Homeless Team records the primary and up to two secondary diagnoses associated with each episode of care for each patient it sees. These diagnoses are classified as: “medical”, “injury”, “psychiatric”, “AOD” and “social” by the Homeless Team Clinical Lead. Across the 4,445 episodes of care provided by the Team over its first five years of operation, a primary diagnosis was recorded for all except four episodes, a second diagnosis was recorded for 4,312 episodes (97%) and a third diagnosis was recorded for 3,649 episodes (82%). The fact that just 3% of episodes of care provided by the Team had only a primary diagnosis recorded highlights the extreme vulnerability and complexity of care required for patients seen by the Team.

A medical primary diagnosis was recorded for almost half (46%) of all episodes of care, while a medical, injury or psychiatric primary diagnosis was recorded for most episodes (82%) and only 4% of episodes had a social primary diagnosis (Figure 32), e.g., accommodation needs. **These figures debunk the widespread myth that patients experiencing homelessness present to EDs primarily to obtain ‘a bed for the night’ or because of intoxication, rather than for ‘legitimate’ health concerns.** However, most second diagnoses (47%) were AOD-related and most third diagnoses (65%) were related to social issues, highlighting the fact that people experiencing homelessness, and especially rough sleepers who constitute most of the Homeless Team cohort, have complex factors underpinning their presentations. The high proportion of AOD-related second diagnoses reflects the most important secondary factor in these presentations: usually a substance use issue, e.g., alcohol dependence in someone with alcohol-related injury or illness. The high proportion of third diagnoses related to social issues reflects the major underlying issue driving the presentations, which in most cases is homelessness and often rough sleeping.

This complexity illustrates the need for a comprehensive, medico-psychosocial, rather than a purely medical response for this cohort, particularly for rough sleepers, a much higher proportion of whom had multiple diagnoses recorded at first contact than those who were not rough sleeping (Figure 67, Appendix C). The Homeless Team's work is to bring the additional supports from GP care, community agencies and homelessness services into RPH to address these issues alongside the medical care delivered by the hospital.

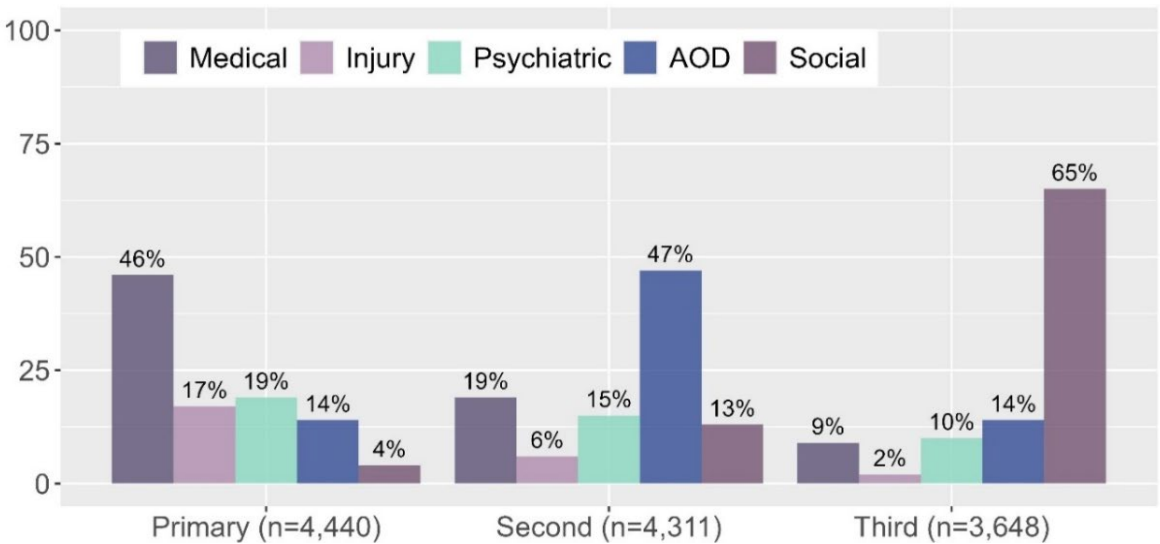


Figure 32: Primary, Secondary and Tertiary Diagnoses for Episodes of Care

4.4.2 PHYSICAL HEALTH CONDITIONS

The health burden experienced by the Homeless Team patients is also substantial when one looks beyond overall morbidity. When assessed at first contact with the Team, 25% had an injury (including wounds and fractures), 24% had hepatitis B or C and 16% had a respiratory condition (16%). Despite an average age of only 42 years, cardiovascular disease, including stroke and heart disease, was common (9%), and conditions affecting the brain (including brain injuries and epilepsy) impacted 9% of patients at first contact (Figure 33).

While the physical morbidity burden of the cohort largely remained constant over time, there were some noteworthy changes. For example, 19% of the cohort had some kind of injury at first contact in the first 2.5 years of operation, but this figure trebled to 30.5% in the second 2.5 years of operation (Figure 33). Similarly, 5% of the cohort had a domestic violence or sexual assault injury at first contact in the first 2.5 years of operation, but this figure trebled to 15% in the second 2.5 years of operation.

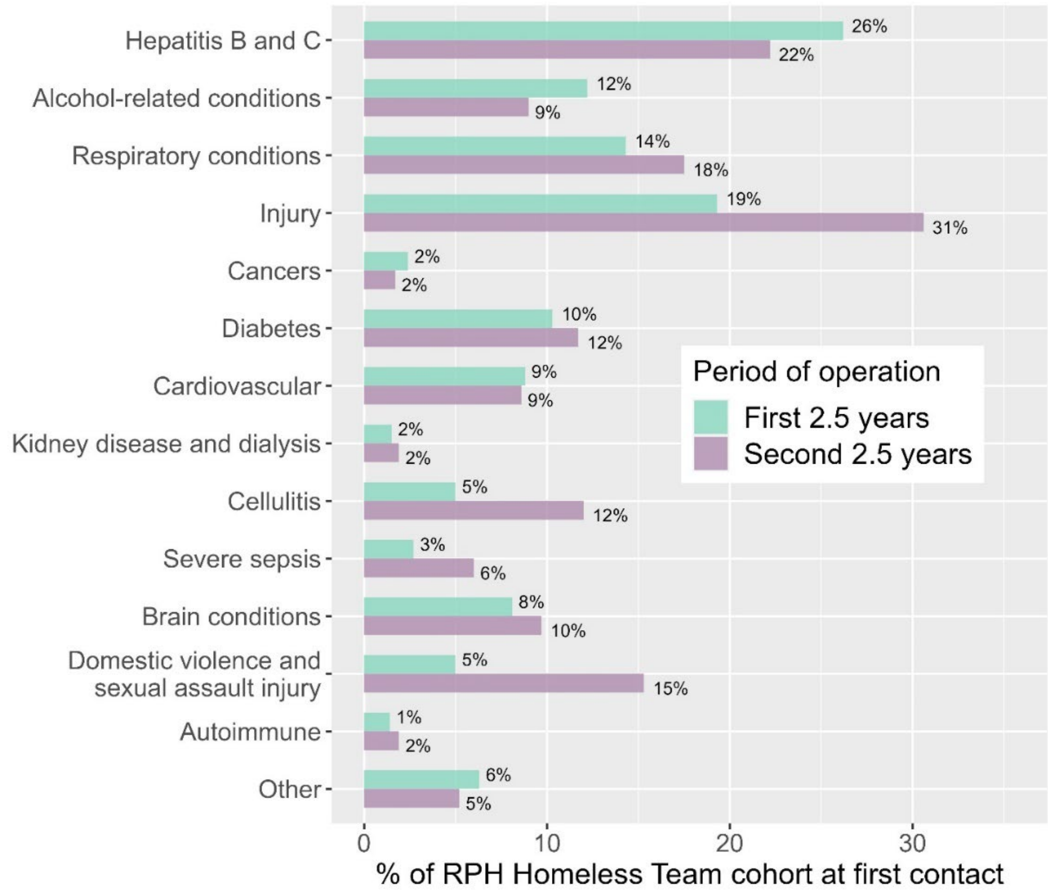


Figure 33: Physical Health Conditions

Notes: At first contact. Groups are not mutually exclusive. Data for two patients who did not have physical morbidity information recorded at first contact are excluded. **Injury** includes wounds and fractures. **Cardiovascular** includes heart disease. **Other** includes pregnancy, HIV/AIDS, dental, and other conditions.

4.4.3 PSYCHIATRIC CONDITIONS

People experiencing homelessness have a substantially higher prevalence of psychiatric morbidity than the general population,[26,27] and patients seen by the Homeless Team are no exception. Over the first five years of operation, over a quarter of the cohort (27%) had a history of depression at first contact, while 14% had deliberately self-harmed through either overdose or injury (Figure 34). The prevalence of PTSD was 11%, consistent with the high levels of trauma experienced by people

experiencing homelessness. It is important to note that these are likely significant underestimates, as mental health conditions have often gone undiagnosed in homeless populations.

Serious psychiatric conditions such as schizophrenia were also evident, with over 13% of patients seen having this condition, compared with only about 1% of the general population being diagnosed with schizophrenia.[56] These higher rates of serious psychiatric conditions among homeless populations has been observed also in other developed countries (such as USA, UK) where failings in the mental health system, including the closure of inpatient mental health facilities without compensatory investment in community mental health services, have notably affected people with schizophrenia. Without the necessary family or professional support to maintain treatment, the Homeless Team, like elsewhere, has seen patients who have relapsed into psychosis, dropped out of mainstream society and ended up on the streets.

Over time, the diagnosed prevalence of mental health conditions remained approximately constant over the first five years of Homeless Team operation, for the most part. However, there were some exceptions, e.g., drug-induced psychosis, likely due to the recently greater purity and increased IV use of methamphetamine, and autism spectrum disorders, which have become increasingly diagnosed in adults in recent years.

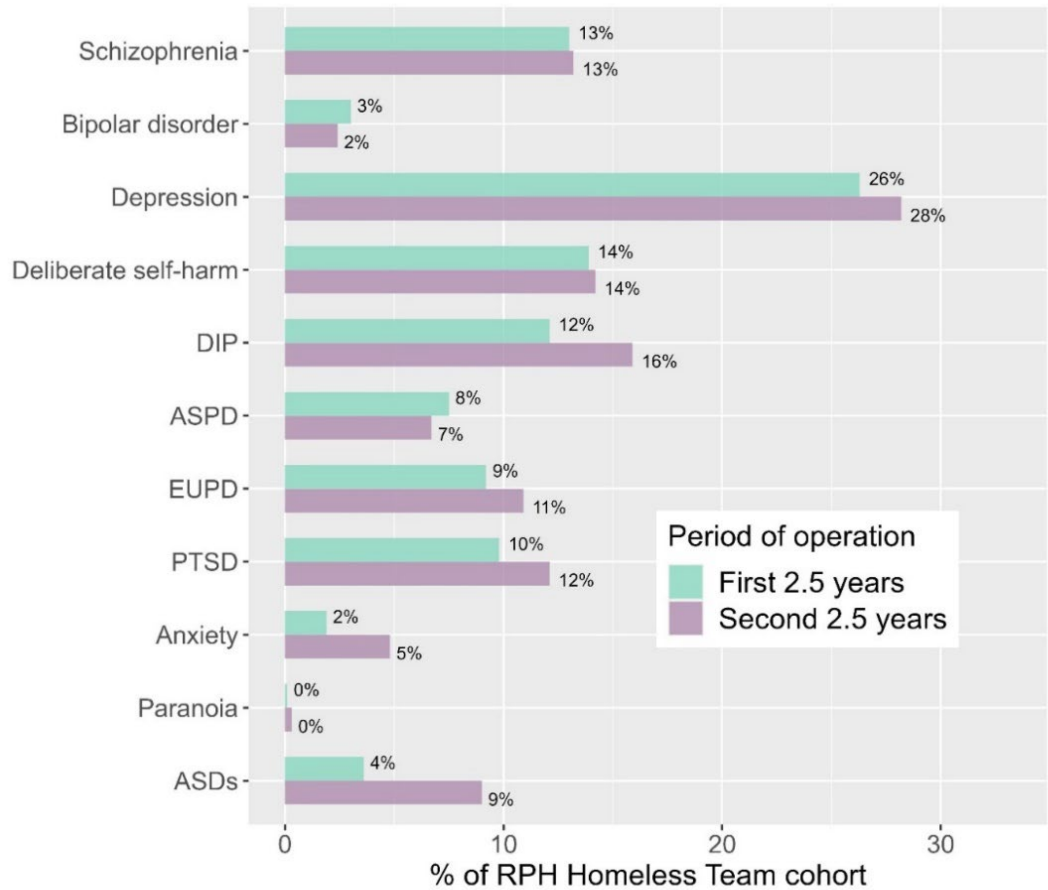


Figure 34: Psychiatric Morbidity Burden

Notes: At first contact. Groups are not mutually exclusive. The graph excludes data for one patient who did not have psychiatric morbidity information recorded at first contact with the RPH Homeless Team. **DIP:** Drug-induced psychosis; **ASPD**: Anti-social Personality Disorder; **EUPD:** Emotionally Unstable Personality Disorder; **PTSD**: Post-Traumatic Stress Disorder; **ASDs**: Autism Spectrum Disorders. **Deliberate self-harm** includes both overdose and injury.

Untreated or undertreated mental health conditions significantly impact upon health outcomes for people experiencing homelessness, since the effects of mental illness are often amplified by both substance use and adverse social circumstances, creating insurmountable barriers to stabilising

mental health. Consequently, it is important to note that the prevalences depicted in Figure 34 only represent the formally diagnosed burden of psychiatric illness amongst the Homeless Team cohort, which will significantly under-represent the true burden. This is because of people experiencing homelessness typically having minimal contact with specialist mental health services to have appropriate psychiatric assessments and to obtain formal diagnoses. Additionally, for Australia's Aboriginal populations, traumatic events (e.g., premature deaths, stolen generation effects, child removals, poverty, FDV and imprisonment) can be so pervasive that the resulting effects on mental health may be considered 'normal' rather than as a flag for a psychiatric illness. The same can be true of refugee populations exposed to severe trauma in their country of origin. Consequently, the prevalence of AOD use and dual diagnosis amongst the cohort, described in Section 4.4.4, is arguably a better indication of the mental health effects of trauma.

4.4.4 SUBSTANCE USE

Rates of substance use amongst people experiencing homelessness, and especially rough sleepers, who comprise most of the Homeless Team cohort, are typically extremely high. As such, it is unsurprising that nearly 80% of the cohort were recorded as having problematic AOD use at first contact (Figure 35), where categorisation as 'problematic' required evidence of:

- a direct association between the use and hospital presentations and/or admissions,
- frequent, ongoing, or heavy use, and/or
- high-risk practices such as intravenous drug use (IVDU).

The prevalence of problematic AOD was also consistent over time, as was a correspondingly high prevalence of drug injection within the previous year (46% overall) and daily consumption of alcohol over the previous month (21% overall). However, these figures likely represent minimum levels, as the stigma surrounding AOD use can lead to under-reporting of the severity and/or type of use. This is particularly true for substances with effects that are relatively inconspicuous, or relatively unlikely to result in hospital presentation, e.g., THC, and of popular prescription medications such as benzodiazepines, pregabalin and quetiapine, which can be obtained both legally and illegally.

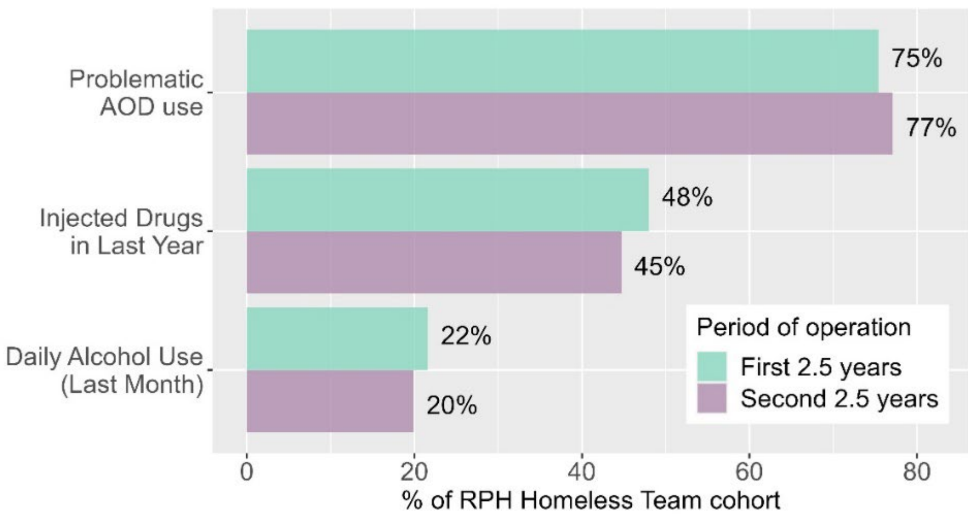


Figure 35: Problematic AOD Use

Notes: At first contact. Groups are not mutually exclusive.

In terms of substances being used at first contact, methamphetamine and alcohol were most common (50% and 45%, respectively), followed by THC (26%) and street opiates (13%) (Figure 36). However, these figures likely underestimate the true prevalence of use due to associated stigma.

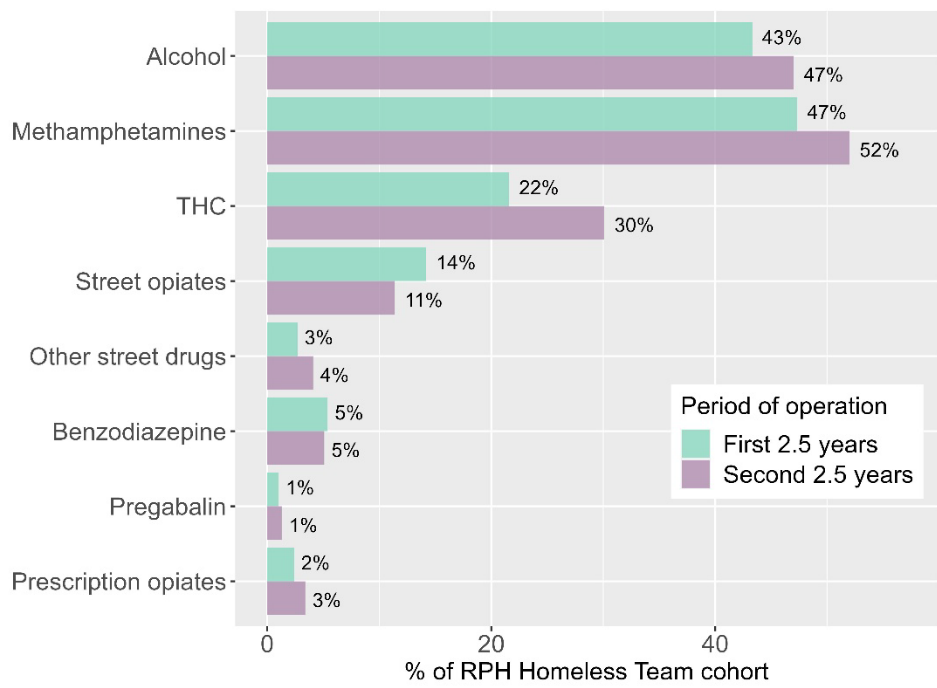


Figure 36: AOD Use at First Contact

Notes: Patients could be using >1 drug. Excludes 1 patient who did not have street AOD use and 2 without pharmacy AOD use recorded. **THC** = Tetrahydrocannabinol. Prescription opiates include Oxycodone, Morphine, Fentanyl, Buprenorphine, Methadone, Codeine and other opiates. **Other street drugs** include synthetic THC, hallucinogens, new psychoactive drugs, solvents, Gamma Hydroxybutyrate (GHB) and others. **Atypical antipsychotics** are a separate category but are not shown due to small numbers.

Table 6 shows the proportions of the cohort who were using one or more substance at first contact, stratified by classification as having problematic AOD use (yes/no). They represent the prevalence of polysubstance use amongst the cohort, with 40% of the cohort using 1+ substance, 24% using 2+, 12% using 3+ and some using up to seven. Corresponding proportions amongst individuals with problematic AOD use were higher, with close to one in every three (30%) using 2+.

Alcohol and methamphetamines were the most common substances used concurrently (22%), followed by methamphetamines and THC (19%).

Table 6: Prevalence of Polysubstance Use

Substances used (n)	Problematic AOD use Yes n (% of Yes)	 No n (% of No)	Total n (% of cohort)
0	0 (0%)	366 (79%)	366 (19%)
1+	716 (48%)	66 (14%)	782 (40%)
2+	443 (30%)	19 (4%)	462 (24%)
3+	232 (16%)	7 (2%)	239 (12%)
4+	66 (4%)	2 (0%)	68 (3%)
5+	16 (1%)	1 (0%)	17 (1%)
6+	8 (1%)	0 (0%)	8 (0%)
7+	2 (0%)	0 (0%)	2 (0%)
Total	**1,483 (76%)**	**461 (24%)**	**1,944**

Notes: At first contact with the Homeless Team. Excludes two patients whose classification as having problematic AOD use was not recorded and one who with problematic AOD use for whom no use of drugs was identified.

The use of substances also varied based on individuals' living situation at first contact with the Homeless Team. Particularly, rough sleepers, compared to others, were more commonly:

- classified as having problematic AOD use (81% versus 65%),
- identified as having injected drugs in the previous year (51% versus 34%), and
- users of one or more of the individual substances listed in Figure 36 (85% versus 70).

In total, 86% of rough sleepers were identified as using substances at first contact via one or more of the above, compared to 70% of those were not rough sleeping. These figures poignantly reflect the fact that amongst people experiencing homelessness, rough sleeping is particularly associated with close to universal AOD use of some kind.

Table 7: Proportion with Problematic AOD Use (Past Year)

n (%)	Living Situation at First Contact		Total
	Rough Sleeping	Other	
Problematic AOD use	1,127 (81%)	357 (65%)	**1,484 (76%)**
Injected Drugs in Previous Year	717 (51%)	186 (34%)	**903 (46%)**
Using ANY of the Individual Substances	1,191 (85%)	386 (70%)	**1,577 (81%)**
[Problematic AOD use] OR [IVDU in Previous Year] OR [Using ANY of the Individual Substances]	1,193 (86%)	386 (70%)	**1,579 (81%)**
Total	**1394 (72%)**	**551 (28%)**	**1,945**

Notes: Data excluded for one patient whose classification as having problematic AOD use at first contact was not recorded

4.4.5 DUAL DIAGNOSIS AND TRI-MORBIDITY

'Dual diagnosis', i.e., AOD use and mental health issues, is common amongst homeless populations, and patients seen by the Homeless Team are no exception. Using the definitions of physical and mental health conditions and AOD use underlying the prevalences reported in sections 4.4.2, 4.4.3 and 4.4.4, data for the cohort showed that, at first contact with the Homeless Team, 70% of patients seen had at least one physical morbidity (n=1,357), 56% had at least one mental health condition (n=1,094) and 81% had a substance-use disorder or had recently used a substance (n=1,578) (Figure 37). Further, almost half (49%) could be considered to have dual diagnoses and one in three (33%) tri-morbidity. These figures are consistent with those reported previously for other sub-populations of people experiencing homelessness in Perth, e.g., a cohort of HHC patients amongst whom multi-morbidity was examined in 2021.[31] However, they likely underestimate the true prevalences amongst the cohort, as they are based only on data recorded by the Homeless Team at first contact.

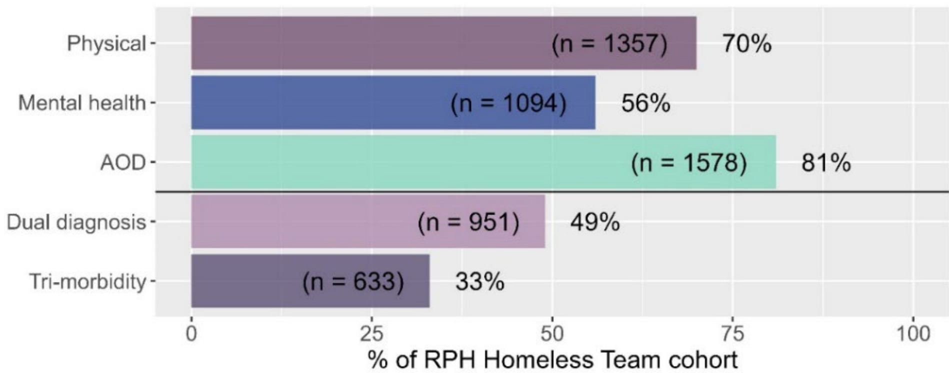


Figure 37: Prevalence of Physical or Mental Health Conditions, and AOD Use

Notes: Prevalences are based on physical and mental health conditions and AOD use recorded by the Homeless Team at first contact, and likely underestimate the true prevalences amongst the cohort.

Box 3 provides an example of an individual who was consistently presenting to hospital for a combination of mental health, substance use and chronic health conditions prior to seeing the Homeless Team. Unfortunately, this pattern of use is all too common amongst the homeless and particularly those who are rough sleeping.

Box 3: Tri-Morbidity in the Homeless Team Cohort

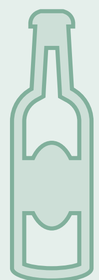
Background: *"Brian"* is a 60-year-old male who had been sleeping rough for 12 months after becoming estranged from his family. His lack of safe accommodation and situational crisis contributed to a significant deterioration in his mental health and subsequent heavy alcohol use. Over a 14-month period, Brian presented to ED 13 times, for a combination of mental health, substance use and chronic health conditions. Brian's street present homelessness and worsening alcohol use contributed to deterioration of his chronic cardiac condition, further increasing his hospital usage. Brian was admitted for 15 inpatient days over this period.

Hospital Use: 13 ED presentations over 14 months, with 15 inpatient days. Equating to an estimated cost to the health system of $52,000.

Support Provided: The Homeless Team first met with Brian in the ED waiting room and supported him during a subsequent inpatient admission to address his physical and mental health and substance-use challenges. The Homeless Team worked collaboratively with hospital staff including the psych and AOD teams to ensure a solid discharge and transition plan from hospital, which connected Brian to community support services.

On discharge, brokerage funds were used to prevent discharge to the streets and support Brian in budget hotel accommodation, to facilitate additional rest and safety. The Homeless Team linked Brian in with a HHC GP who was able to visit Brian at the hotel, along with a support worker. This enabled the team to support Brian into an admission at a community drug and alcohol service, to assist him with his goal of recovery from heavy alcohol use. Referrals were also made for longer-term accommodation to end Brian's cycle of homelessness.

Current Situation: Brian continues to see a HHC GP in the community, and to engage with the drug and alcohol service. He rapidly secured accommodation through a supported accommodation service, providing specialised support for individuals with a homelessness history and challenges with mental health and substance use. Brian remained sober for 4 months but, for the next 2.5 years, he struggled with this and had 8 ED presentations and 5 admissions in 2021. In early 2022, he transitioned into his own social housing unit but without sufficient supports and meaningful activity, he again had 8 ED presentations and 5 admissions, adding up to a month of hospitalisation. In early 2023, he achieved stable sobriety and has not presented to a hospital for 6 months although is seeing his GP regularly.



Notes: ^ Estimated costs based on figures listed in Table 2.

4.5 MORTALITY

Poor health and premature death are, unfortunately, ever-present realities for people experiencing homelessness and particularly rough sleepers. As such, it is unsurprising that:

- 7% of the cohort died within two years of first contact (123/1,764 patients with 2 years follow up),
- 10% died within three years of first contact (136/1,394 patients with 3 years follow up), and
- 13% (258 of 1,946 individuals) were known to be deceased at the time of writing of this report.

The mean and median ages at death of the deceased were just 48 years (range 17 – 84 years), >3 decades younger than the current mean life expectancy of the general Australian population.[54] These figures emphasise the urgent need for improved provision of services and housing to a cohort of individuals who are some of the most vulnerable in our society.

Table 8: Deaths of Homeless Team Patients

		N (%) deceased
All		**258 (100%)**
Gender	Male	178 (69%)
	Female	76 (29%)
	Transgender	4 (2%)
Indigenous Status	Aboriginal and/or Torres Strait Islander	70 (27%)
	Non-Aboriginal and/or Torres Strait Islander	188 (73%)

Due to the high mortality rate of people experiencing homelessness, the Homeless Team (along with other homelessness organisations and service providers) are involved in assisting with and helping coordinate end-of-life care planning for individuals, including through facilitating links with palliative care. An example of this is 'Greg' in Box 2, who first saw the Homeless Team in mid-2017 during a period of multiple ED presentations and admissions, mostly associated with alcohol dependence. During that period, he was assessed as palliative due to a severe lung infection, aged only 37. Incredibly, his condition and situation substantially improved over a period of years, with the Homeless Team playing a role in contributing to supporting him to see HHC GPs in the community. Unfortunately, he ultimately died aged 40 from advanced liver disease. Box 4 provides another example of an individual whose heavy smoking led to unavoidable health complications that ultimately could not be resolved but whose pathway to death was made easier through the support and concern provided to him by the Homeless Team.

Box 4: Role of the RPH Homeless Team in Helping Coordinate End-of-Life Care Planning

"Lyndon" was a 63-year-old man who lived on the steps of a church for over 10 years. He was a heavy smoker for most of his adult life but rarely sought any medical care. In mid-2020, he developed a cough, difficulty breathing and some weight loss, and, for the first time in his adult life, presented to the RPH ED. He was diagnosed with pneumonia and chronic smoking-related lung disease and admitted to a medical ward where he made contact with the Homeless Team. His chest symptoms improved rapidly with inhalers and antibiotics, and he was discharged to a week's homelessness respite and then to longer term accommodation at a low cost hostel. However, his breathing difficulties worsened over the next month and he was readmitted to hospital where investigations now showed lung cancer and lung clots. He was discharged back to the hostel with treatments in place and received support from the HHC outreach nurse and case workers who supported him to reconnect with long lost family, providing him with much comfort. His breathing difficulties markedly increased about 3 weeks after his last admission, and he was again admitted to RPH and supported by the Homeless Team as it became apparent that the cancer was progressing rapidly. The Palliative Care team at RPH provided relief for pain and breathing difficulty and planned for him to be transferred to a hospice for end-of-life care. However, he died peacefully at RPH before this could happen.

5 HEALTH SERVICE UTILISATION

This chapter presents hospital use and associated cost figures for the cohort pre-to-post first contact with the RPH Homeless Team. As noted in Section 2.3.4, the figures are calculated relative to individuals' **dates of discharge from hospital,** since changes in hospital use cannot be measured until individuals leave hospital. However, for convenience and interpretability, the terminology used still refers to periods of hospital use 'pre/post first contact with the Team'. The adjustment affected 43% of the cohort (828/1,946 individuals), with mean and median periods of 7.9 and 2 days between the dates of first contact and discharge (range 1-327 days). As noted in Section 2.3.3, data were available for all eleven public hospitals for adults in metropolitan Perth but not WA country hospitals or the three Perth public-private partnership hospitals. Therefore, they largely but incompletely represent the hospital use profile of patients experiencing homelessness seen by the Homeless Team.

Beyond these findings, the impact of the Homeless Team on the hospital use of the cohort is perhaps best captured by the dramatic change from steep upward trajectories to overall downward trends, sustained for multiple years post-contact, to levels similar to or slightly higher than those seen previously. These patterns of hospital use are consistent with those observed for cohorts of people experiencing homelessness elsewhere, e.g., amongst a cohort of people experiencing homelessness pre-to-post first homelessness assessment in the 2018 Scottish study *Health and Homelessness*.[57]

To set the scene of the high hospital use of people experiencing homelessness, the first sub-section in this chapter describes the proportion of most frequent presenters to RPH ED who were homeless.

5.1 HOMELESSNESS IN FREQUENT RPH ED PRESENTERS

Figure 38 shows the proportion of the top 50 most frequent presenters to RPH ED who were experiencing homeless, by year between 2016 and 2022. While data presented in previous evaluations of the Homeless Team suggested that the proportion of frequent RPH ED presenters who were homeless was decreasing over time,[3,4] the present data, which cover a wider period, suggest that the proportion has in fact remained relatively constant, with 2018 and 2022 being anomalous years in which the presence of NFA individuals amongst the most frequent RPH ED presenters was diluted by particularly frequent presenting by housed individuals.

Only data for the top 50 most frequent presenters are presented to avoid issues related to small cohort sizes. However, additional data showed that some of the top 20 and top 10 most frequent presenters to RPH ED in all years were homeless. This does not reflect poorly on the Homeless Team. Rather, these data, combined with: **(a)** data provided in Section 3.3.4, which showed that the proportion of patients seen by the Team who were well known to HHC remained relatively constant over time, **(b)** the recently released 2021 Australian Census figures on homelessness, which indicate a substantial increase in the number of people

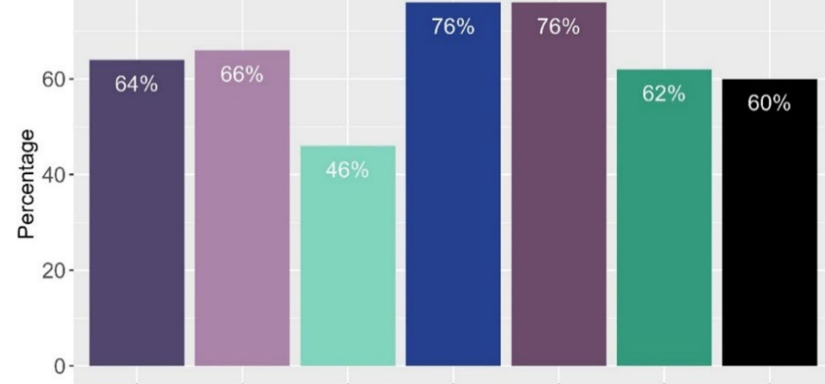


Figure 38: Proportion of NFA Patients Amongst Top 50 RPH Frequent Presenters

Note: RPH ED frequent presenter statistics used with permission of RPH Homeless Team

experiencing homelessness in WA since the last census (see Section 1.1), and **(c)** data in Section 4.2, which show that most people seen by the Homeless Team had only one or two episodes of care, reflect the fact that there are constantly new people who are becoming homeless in WA and Perth, a subset of whom present to RPH ED and are seen by the Homeless Team. In fact, given the overall rise in homelessness indicated by the 2021 Census data (Section 1.1), **the lack of any marked increase** in the proportion of NFA individuals amongst the most frequent RPH ED presenters potentially positively reflects upon the Homeless Team.

5.2 HEALTH SERVICE USE PRE-HOMELESS TEAM CONTACT

This section describes the hospital use of the cohort, i.e., ED presentations, ambulance arrivals, inpatient admissions and bed days, and associated costs to the health system in the 3-year period leading up to first contact with the Homeless Team.

5.2.1 ED PRESENTATIONS

Prior to first contact with the Homeless Team, both the number of people presenting to ED and the total number of ED presentations trended upwards, with the highest use observed in the year immediately prior to contact (Table 9). This pattern is congruent with other research and evaluations undertaken by Home2Health, which have consistently demonstrated increasing use of hospital services by people experiencing homelessness leading up to reception of support, associated with the steady deterioration in their health the longer they remain homeless. Almost the entire cohort presented to an ED at least once over the three-year pre-contact period (n=1,940; 99.7%), for a total of 21,401 presentations or almost four presentations per person, per year over that period.

Table 9: ED Presentations 3 Years Pre-First Contact

	3 Years Pre	2 Years pre	1 Year Pre	Total
N (%) People with 1+ Presentation	993 (51%)	1,116 (57%)	1,935 (99%)	**1,940 (100%)**
Total ED Presentations	4,590	5,423	11,388	**21,401**
Mean^ (SD)	2.4 (4.8)	2.8 (5.1)	5.9 (6.5)	**11 (13.4)**
Range	0 - 45	0 - 50	0 - 70	**0 - 112**
N (%) Presentations Resulting in Leave Event^^	389 (8%)	479 (9%)	1,019 (9%)	**1,887 (9%)**

Notes: ^ Calculated per person based on the cohort of n=1,946 individuals seen by the Homeless Team over its first five years of operation. ^^ E.g., did not wait, DAMA.

People experiencing homelessness have a relatively high likelihood of leaving ED before being seen or treated,[58,59] and this is evident in patients seen by the Homeless Team, with 9% of ED presentations amongst the cohort over the three-year pre-first contact period being leave events (e.g., presentations classified as 'did not wait', discharged against medical advice; Table 9). This is unsurprising, given the ED environment can be challenging for people experiencing homelessness. Factors identified in the literature as contributing to the likelihood of leave events amongst people experiencing homelessness include experiences of psychological trauma, actual and perceived stigma, competing priorities, and worry about unattended possessions, all of which can trigger people to leave ED without waiting to be seen or against the advice of medical professionals, despite being unwell. Leaving without being seen or treated contributes to the cycle of frequent ED re-presentation by this population.[60]

5.2.2 AMBULANCE ARRIVALS TO ED

Previous Australian research has shown that people experiencing homelessness are more likely than the general population to present to ED via ambulance.[51] In many cases, it is not the person experiencing homelessness who has called the ambulance, but rather bystanders or police who are concerned about the individual. Overall, in the three years prior to first contact with the Homeless Team, 80% of the cohort travelled to ED via ambulance at least once, with one individual doing so 44

times in the year directly prior to contact (Table 10). On average, individuals had nearly five ambulance arrivals to ED over the three-year pre-contact period, for 9,096 arrivals in total.

Table 10: Ambulance Arrivals 3 Years Pre-First Contact

	3 Years Pre	2 Years Pre	1 Year Pre	Total
N (%) People with 1+ Arrival	602 (31%)	733 (38%)	1,387 (71%)	**1,557 (80%)**
Total Ambulance Arrivals	1,829	2,407	4,860	**9,096**
Mean^ (SD)	0.9 (2.5)	1.2 (3)	2.5 (4.1)	**4.7 (8.2)**
Range	0 - 32	0 - 37	0 - 44	**0 - 91**

Note: ^ Calculated per person based on the cohort of n=1,946 individuals seen by the Homeless Team over its first five years.

5.2.3 INPATIENT ADMISSIONS

People experiencing homelessness utilise hospital healthcare differently to the general population. Often they have more unplanned inpatient admissions, are more likely to be re-admitted, and have longer stays. This is a consistent finding in international[61] and Australian[47,62,63] research and is evidenced again here, with over 96% of the Homeless Team cohort having at least one inpatient admission in the three-year pre-first contact period, for a total of 9,006 admissions spanning 55,534 bed days admitted (Table 11). Further, in the year directly prior to first contact, both the number of admitted individuals and the total number of admissions increased dramatically. This increase was reflected primarily in non-psychiatric bed days but also in psychiatric bed days.

Table 11: Inpatient Admissions 3 Years Pre-First Contact

n (%)	3 Years Prior	2 Years Prior	1 Year Prior	Total
Admissions				
N (%) People with 1+ Admission	708 (36%)	804 (4%1)	1,806 (93%)	**1,866 (96%)**
Total Admissions	1,853	2,133	5,020	**9,006**
Mean^ (SD)	1 (2)	1.1 (2.1)	2.6 (2.6)	**4.6 (5.3)**
Range	0 - 28	0 - 23	0 - 36	**0 - 46**
N (%) Admissions Ending in DAMA	188 (10%)	219 (10%)	649 (13%)	**1,056 (12%)**
Days Admitted				
Psychiatric Days	7,009	6,347	11,774	**25,130**
Non-Psychiatric Days	6,666	7,021	16,717	**30,404**
Total Bed Days	**13,675**	**13,368**	**28,491**	**55,534**
Mean (SD) LOS (Days) ^	8.3 (16.6)	6.8 (13.4)	6.4 (14.9)	**6.5 (11.5)**
Range in Days Per Admission	1 - 253	1 - 182	1 - 338	**1 - 338**

Note: ^ Calculated per person based on the cohort of n=1,946 individuals seen by the Homeless Team over Its First Five Years.

Patients who discharge against medical advice (DAMA) have a higher risk of adverse health outcomes and are more likely to be re-admitted. Here, DAMA discharges included those 'whilst on leave', 'against advice' and 'at own risk'. The DAMA rate amongst the cohort was 12% over the three-year period prior to first contact with the Team (Table 11).

5.2.3.1 Reasons for Inpatient Admission

As noted in Section 4.4, the health profiles of patient seen by the Homeless Team were complex, with mental health and AOD issues featuring prominently. This complexity is also reflected in the coded diagnoses of inpatient admissions of the cohort in the three-year period prior to first contact with the Team. Specifically, examining both principal and additional diagnoses:

- 84% of the cohort had at least one physical health diagnosis,
- 72% had at least one AOD diagnosis, and
- 42% had at least one mental health diagnosis (Figure 39).

Further, around one in every three individuals (32%) had at least one mental health, AOD and physical health inpatient diagnosis over the period, while 35% had dual diagnosis, i.e., at least one mental health and AOD diagnosis.

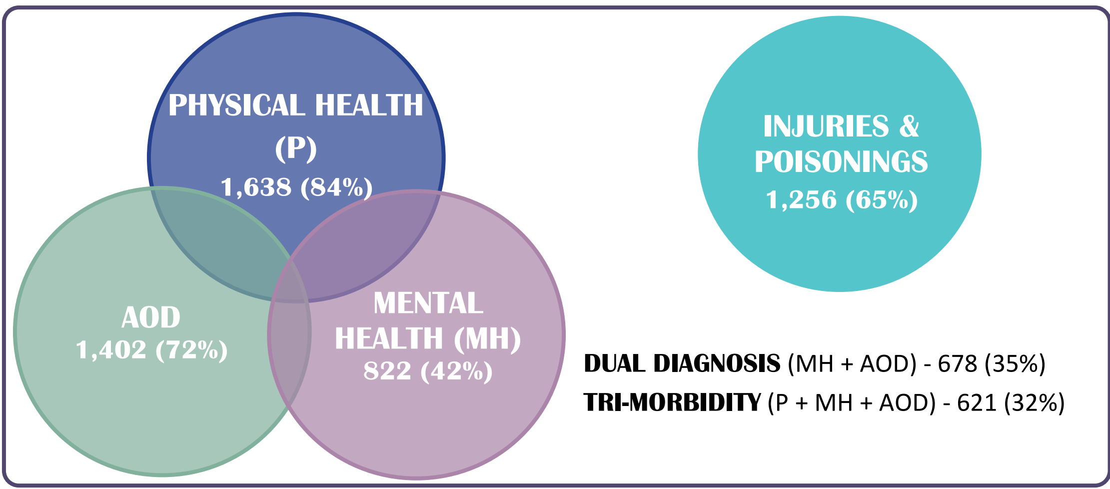


Figure 39: Physical, Mental Health and AOD Inpatient Diagnoses Pre-First Contact

Notes: ICD codes: **Mental Health:** F00-F09, F20-F99; **AOD:** F10-F19; **Physical Health:** A-E, G-R; **Injuries and Poisonings:** S-T. U-Z codes are excluded. **AOD =** alcohol and other drug (use disorders).

These figures reflect the high complexity of health conditions and diagnoses amongst the cohort, and are consistent with the prevalences of dual diagnosis and tri-morbidity indicated in the Homeless Team data (Section 4.4) and with reports of high levels of tri-morbidity amongst homeless populations both locally and internationally.[31,64]

Figure 40 depicts some of the most common principal inpatient and ED diagnoses of the cohort over the period. Consistent with the above results, mental health and AOD diagnoses feature prominently.

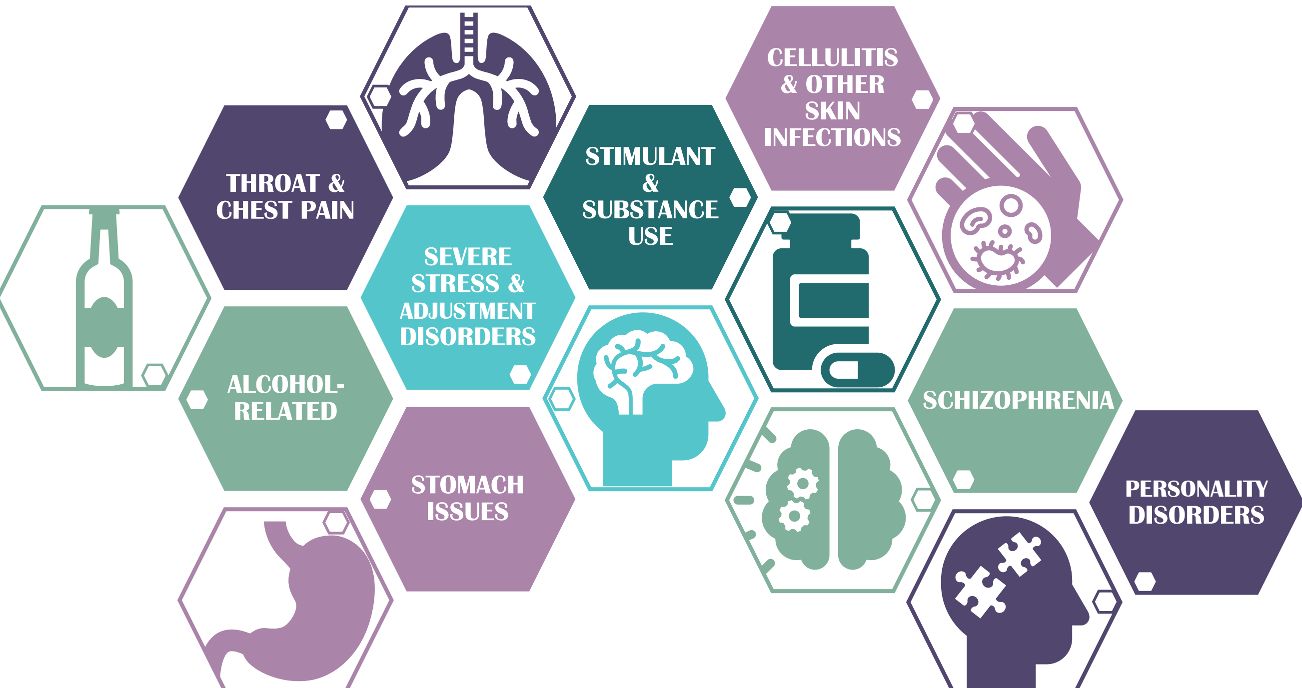


Figure 40: Common Inpatient and ED Diagnoses Pre-Contact with the Homeless Team

5.2.4 OUTPATIENT APPOINTMENTS

Table 12 describes the outpatient appointments scheduled for cohort over the three-year period pre-first contact with the Homeless Team. Both the total number of scheduled appointments and the proportion of the cohort with at least one appointment increased over time. However, it is pertinent to note that a high proportion of scheduled appointments were not attended (29% over the period, ranging between 25% in the year immediately prior and 34% in the third year prior). This result is consistent with the literature, which notes that people experiencing homelessness face substantial barriers to outpatient attendance and have higher non-attendance rates than the general population.[65-67]

Table 12: Outpatient Appointments 3 Years Pre-First Contact

n (%)	3 Years Prior	2 Years Prior	1 Year Prior	Total
N (%) People with 1+ Appointment	754 (39%)	820 (42%)	1,022 (53%)	**1,395 (72%)**
Total Outpatient Appointments	4,704	4,952	6,437	**16,093**
Mean (SD)	2.4 (6.9)	2.5 (6.6)	3.3 (7.4)	**8.3 (16.6)**
Range	0 - 136	0 - 102	0 - 97	**0 - 259**
N (%) of Appointments Not Attended	1,583 (34%)	1,516 (31%)	1,581 (25%)	**4,680 (29%)**

5.3 CHANGES IN HOSPITAL USE POST-HOMELESS TEAM CONTACT

This section examines the hospital use of the cohort pre-to-post first contact with the Homeless Team. As described in Section 5.1, the relevant figures are calculated pre/post the **date of discharge of the ED presentation or inpatient admission during which each patient first saw the Homeless Team,** since the follow up period only started once the patient was discharged from hospital. However, for simplicity, the pre/post periods are still referred to as being relative to 'first contact with the Homeless Team'.

Based on available follow up (Table 1, Chapter 2), three follow up time periods are examined:

- Six months and one-year pre/post (data available for 100% of the cohort; n=1,946), to examine the hospital use of the cohort over a short period post-contact with the Team, and
- Three years pre/post (data available for 72% of the cohort, n=1,394), to examine the long-term hospital use of the cohort post-contact with the Team while still capturing a relatively large proportion of the cohort.

Given the relatively high mortality of the cohort (Section 4.5), the analyses are supplemented by additional results that account for death, to avoid reporting potentially misleading results.

5.3.1 CHANGES IN ED PRESENTATIONS

Reductions of 24% and 17% in the numbers of individuals presenting at least once to ED were observed 6-months and one-year pre-to-post first contact with the Homeless Team (Table 13). However, while the total number of ED presentations reduced by 4% 6-months pre-to-post first contact, an increase of 7% was observed one-year pre-to-post first contact.

Table 13: ED Presentations 6 Months & 1 Year Pre/Post First Contact

	Pre	Post	% change
Six-months pre/post			
N (%) People with 1+ Presentation	1,930 (99%)	1,459 (75%)	-24%
Total ED Presentations	7,938	7,596	-4%
Mean^ (SD)	4.1 (4.3)	3.9 (6.5)	
Range	0 - 49	0 - 93	
N (%) Presentations Resulting in Leave Events^^	675 (9%)	791 (10%)	
One-year pre/post			
N (%) People with 1+ Presentation	1,935 (99%)	1,603 (82%)	-17%
Total ED Presentations	11,388	12,227	7%
Mean^ (SD)	5.9 (6.5)	6.3 (10.1)	
Range	0 - 70	0 - 156	
N (%) Presentations Resulting in Leave Events^^	1,019 (9%)	1,304 (11%)	

Notes: ^ calculated based on the five-year RPH Homeless Team cohort (n=1,946). ^^ calculated based on the total number of ED presentations

Pre-to-post first contact, more individuals had reduced presentations than had increased presentations (56% and 53% versus 30% and 36% of the 6-month and 1-year cohorts, respectively) (Figure 41), including after adjusting for death (Figure 68 and Figure 69, Appendix C). These findings are consistent with those of the second Homeless Team evaluation[4] and indicate that, while the proportion of individuals who presented to ED decreased post-contact with the Homeless Team, those who did present did so more frequently than before on average. This is not surprising, given that the Homeless Team is not an accommodation service and primarily (but importantly) links patients to homelessness services to avoid discharges back to the street where possible. Further, the overall increase in the one-year post period could be driven by patients seeking care after having built trust and rapport with the Team.

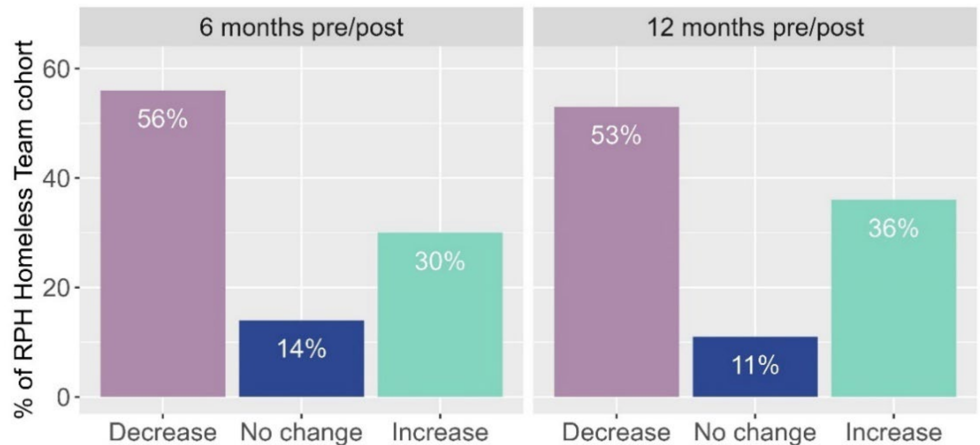


Figure 41: Proportion with Changes in ED Presentations Pre/Post First Contact

The impact of the Homeless Team on the ED use of the cohort is perhaps best captured by the dramatic change from a steep upward trajectory to an overall downward trend that continued for at least three years post-contact (Figure 42), even after adjusting for death (Figure 70; Appendix C).

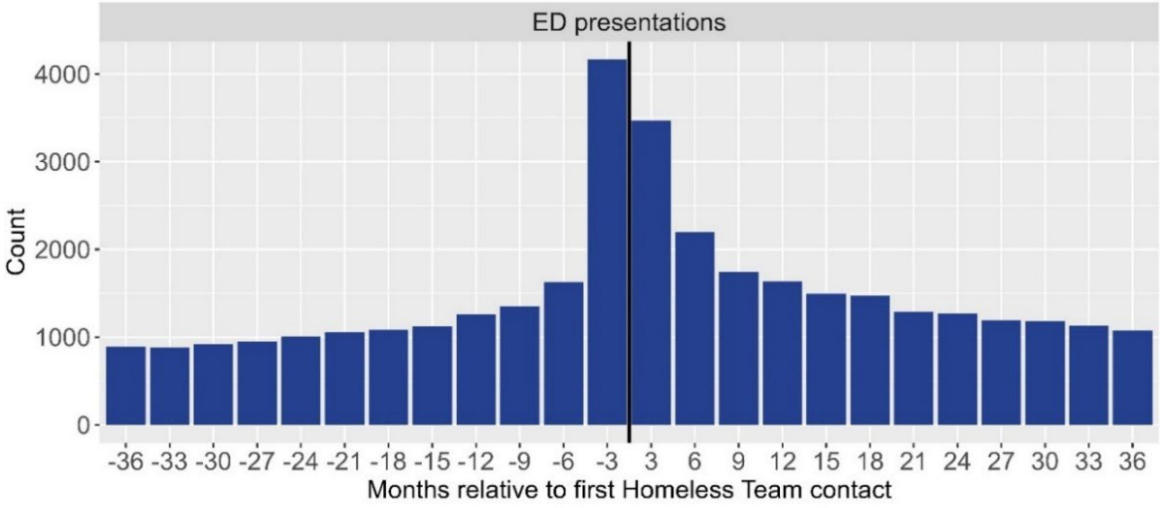


Figure 42: Quarterly ED Presentations 3 Years Pre/Post First Contact

Note: data are for the cohort of 1,394 individuals who had at least three years of follow up post-first contact, and should not be directly compared with those in Table 13, which are for the full cohort (n=1,946)

Box 5 provides a case study of an individual who experienced a large reduction in their ED presentations post-contact with the Team, largely driven by the support the Team provided with respect to personal hygiene and referrals to both temporary (i.e., hotel) and transitional accommodation.

Box 5: Changes in ED Utilisation Post-Engagement with the Homeless Team

Background: *"Horatio"* is a male in his early forties with a diagnosis of schizophrenia, and a long history of homelessness. Since 2005, Horatio had been admitted to mental health wards 19 times in the ensuing 15 years. Despite these engagements with the mental health system, Horatio reported that he only but had consistent psychiatric treatment when in either hospital or jail. Horatio's difficulty managing his mental health diagnosis resulted in ongoing psychosis, made more intimidating to others by his imposing physical stature. These factors combined made it challenging for Horatio to access supported accommodation, despite engaging with workers in the homelessness sector. He had not been welcome to stay with family members for over 20 years due to his illness and once stated that, apart from incarceration, he could not recall the last time he lived in an appropriate accommodation setting.

Support Provided: In mid-2021, Horatio was released from another prison sentence into homelessness. His mental health quickly deterioration, Horatio began regularly presenting to EDs to ask for help to get off the streets. The Homeless Team supported Horatio by connecting him to a community mental health outreach team, for ongoing review and treatment of his schizophrenia. Horatio was also connected with ongoing case management to aid in finding suitable accommodation.

The Homeless Team further supported Horatio to attend to his personal hygiene, which had deteriorated significantly since release from prison and was acting as a barrier to accessing housing. The team supported Horatio with clean clothes, shoes that actually fit him, and toiletries to help him regain a sense of his dignity. Brokerage funding was used to support Horatio temporarily in budget hotel accommodation, while transitional accommodation referrals were commenced.

Current Situation: In mid-2022, a year after Horatio's release from prison, he entered a well-supported transitional accommodation, and has remained there for the last 18 months.

Horatio is thriving in this accommodation, demonstrated by a significant decrease in his hospital presentations. In the 18 months prior to entering this accommodation, Horatio presented to ED 62 times. In the 18 months since accessing accommodation, Horatio has only had 11 ED presentations.

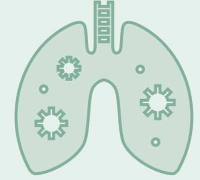
Pre-to-post Homeless Team contact, the proportion of ED presentations that resulted in leave events (e.g., without being seen) remained approximately constant. This reflects the enduring complex health and psychosocial profiles of patients seen by the Team, an example of which is provided in the case study in Box 6. This case study describes a man whose frequent use of the ED, primarily for alcohol use, drastically reduced after receiving support from the Team but who continued to frequently leave the ED without being seen.

Box 6: Homeless Team Patient with a Large Decrease in Hospital Use but Frequent Leave Events

Background: *"Cameron"* is a male in his earlier fifties with a long history of struggling with alcohol use. Cameron's substance use contributed to his journey to becoming homeless in June of 2020. Based on his lack of stable accommodation and problematic alcohol use, he began frequently presenting to ED due to intoxication, deteriorating health and situational crisis. In December of 2020, he had a fall while intoxicated, sustaining a neck fracture for which he required a neck and body brace for eight weeks. Over the subsequent months, Cameron presented frequently to emergency departments at several metro hospitals, primarily due to other falls and assaults on the street, contributed to by his increased vulnerability while wearing his brace. His alcohol use presented a barrier to accessing accommodation and he remained on the streets, struggling to manage his health and address his substance use. Motivated to change, Cameron accessed residential rehabilitation in June of 2021. Unfortunately, he was asked to leave the facility soon after arriving, which led to a spiral of increased alcohol use while on the streets again. His mental health deteriorated due to his circumstance and separation from his children. Cameron began using prescription medications alongside alcohol, self-reporting this as a way of coping with his emotional distress.

Hospital Use: In 2021 alone, Cameron presented to ED 179 times and had 22 overnight hospital stays. Further, over half of his presentations resulted in leave events (92 of 179 presentations, or 51%).

Support Provided: In late 2021, Cameron was admitted to RPH with pneumonia. During this two-day admission, the Homeless Team was able to spend time with Cameron, building rapport in order to begin the process of supporting him out of homelessness. During five further RPH ED presentations among 14 in total to all hospitals in January 2022, the Homeless Team worked hard to provide support. In February 2022 Cameron received transitional accommodation, where he received support for his mental and physical health.



Current Situation: Since being accommodated, Cameron has been seen regularly by a HHC's GP at their weekly Hub clinic. His ED presentations have dropped dramatically. Whereas in the 6 months July-December 2021 (pre-housing) Cameron presented to EDs 103 times, the figure for the same period in 2022 was only 20 ED presentations. This represents a 5-fold reduction in ED use. Additionally, Cameron only had three admissions in 2022 for a total of five bed days, and his 2023 hospital use remains low. However, he continues to frequently leave ED without being seen, with 15 of his 20 Jul-Dec 2022 ED presentations resulting in leave events (75%). Together, these figures demonstrate the effect of housing stability and community supports on hospital healthcare usage, even in the absence of sobriety. Cameron continues to work on his alcohol use, significantly reducing his intake with the support of HHC.

5.3.2 CHANGES IN ED RE-PRESENTATIONS

People experiencing homelessness often cycle between the hospital and the streets, repeatedly using the ED and being admitted to hospital. Reflecting this, Table 14 shows the proportion of the cohort who had at least one 7-, 28- and 90-day ED re-presentation six months pre-to-post their first contact with the Team. For example, in the six-month period pre-first contact, 45% of the cohort had at least one 7-day re-presentation (n=880) while 60% had at least one 90-day re-presentation (n=1,348). However, positively, small reductions were observed pre-to-post first contact, regardless of the re-presentation period (7-, 28- or 90-day) and despite the overall number of re-presentations increasing. Further, the proportions of re-presentations that resulted in inpatient admission reduced substantially by 19%, 15% and 17%, respectively. This pattern likely reflects earlier help-seeking for health issues,

which allows them to be dealt with in ED rather than requiring costly hospital admission, and results in considerable healthcare cost savings.

Table 14: ED Re-presentations 6 Months Pre/Post First Contact

	Pre	Post	% change
N (%) individuals with 1+ ED re-presentations within 7 days^	880 (45)	841 (43)	-4%
Total number of 7-day ED re-presentations	2,802	3,660	
N (%) of 7-day re-presentations resulting in admission	1,033 (37)	1,098 (30)	-19%
N (%) individuals with 1+ ED re-presentations within 28 days^	1,147 (59)	1,138 (58)	-2%
Total number of 28-day ED re-presentations	4,612	5,930	
N (%) of 28-day re-presentations resulting in admission	1,790 (39)	1,959 (33)	-15%
N (%) individuals with 1+ ED re-presentations within 90 days^	1,348 (69)	1,326 (68)	-1%
Total number of 90-day ED re-presentations	5,986	7,170	
N (%) of 90-day re-presentations resulting in admission	2,448 (41)	2,446 (34)	-17%

Notes: ^ calculated based on the five-year RPH Homeless Team cohort (n=1,946)

Box 7 provides a case study of an individual who was frequently re-presenting to ED for a range of issues but driven by frequent intoxication. Fortunately, the advocacy of the Homeless Team resulted in a lengthy hospital admission that broke his cycle of substance use and repeated hospital presentation and ultimately resulted in acquisition of appropriate supports and a dramatic reduction in hospital use.

Box 7: Changes in Hospital Utilisation Following Homeless Team Engagement

Background: *"Colin"* is male in his mid-forties who prior to a serious assault in mid-2019, had minimal hospital service use. The assault resulted in Colin sustaining a serious head injury, requiring a 12-day ICU admission in an induced coma a further 74-day rehabilitation admission. Colin was left with ongoing cognitive issues, short-term memory loss, and epilepsy, requiring daily medication to prevent seizure. Adhering to his vital medication regime was challenging due to the cognitive impairment. Unfortunately, on discharge, Colin was assessed as capable of *"managing his medication independently"* and was not considered for supported accommodation. Colin was discharged to group accommodation with low levels of support, where his pre-existing struggle with alcohol use deteriorated. Within two months Colin was rough sleeping again. In the following two years, Colin remained rough sleeping, amassing 70 ED presentations and 35 admissions related to intoxication, falls, and seizures. These presentations lead to 35 hospital admissions. His heavy alcohol use prevented him from accessing accommodation services, almost all of which required tenants to cease substance use. Achieving and sustaining sobriety was an insurmountable challenge for Colin while sleeping rough, particularly due to his brain injury which left him impulsive and unable to make long-term plans.

Support Provided: The Homeless Team advocated for Colin to receive a long hospital admission to comprehensively address his many complex health and psychosocial issues, necessary for breaking his harmful cycle of substance use and repeated hospital presentation. The Homeless Team also advocated for the exploration of more suitable, supported accommodation, in order to prevent a return to homelessness, as had happened previously.

Current Situation: Subsequent to a further 53-day hospital admission in which guardianship, an NDIS package and DSP access were all achieved, Colin was discharged to a group facility with support package sufficient for his care needs. In the subsequent two-years, he has only had six ED presentations and had five hospital admissions (9 days total). Otherwise, his health is managed by his GP. This represents a massive reduction in hospital use post Homeless Team engagement, compared to his pre-contact use.

5.3.3 CHANGES IN AMBULANCE ARRIVALS

Similar patterns to ED presentations were observed for ambulance arrivals (Table 15), with the number of individuals with at least one arrival decreasing both six months and one-year pre/post first contact. However, the total number of arrivals increased between the one-year pre/post periods.

Table 15: Ambulance Arrivals to ED Pre/Post First Contact

	Pre	Post	% change
6 months pre/post			
N (%) People with 1+ Arrival	1,272 (65%)	963 (49%)	-24%
Total Ambulance Arrivals	3,339	3,185	-5%
Mean^ (SD)	1.7 (2.7)	1.6 (3.9)	
Range	0 - 33	0 - 70	
1 year pre/post			
N (%) People with 1+ Arrival	1,387 (71%)	1,152 (59%)	-17%
Total Ambulance Arrivals	4,860	5,312	+9%
Mean^ (SD)	2.5 (4.1)	2.7 (6)	
Range	0 - 44	0 - 83	

Notes: ^ calculated based on the five-year RPH Homeless Team cohort (n=1,946)

Most individuals had reduced numbers of ambulance arrivals post-first contact with the Homeless Team. However, a quarter of the cohort had more arrivals in the six-months post-first contact (Figure 43), indicating that those who used ambulance services did so more frequently than pre-contact, on average.

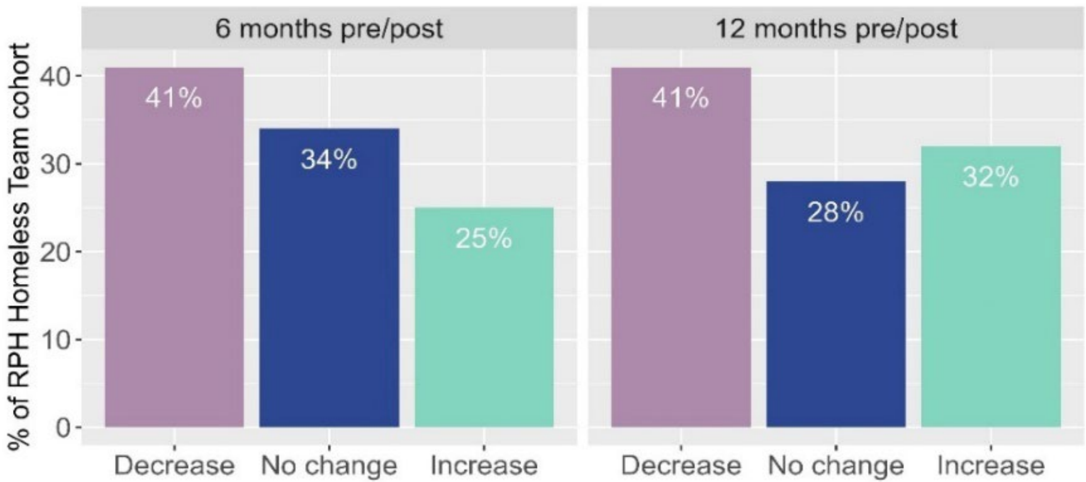


Figure 43: Proportion with Changes in Ambulance Arrivals

The patterns of ambulance use of the cohort pre-to-post first contact with the Homeless Team largely reflects their ED use, with a steep upward trajectory pre-first contact changing to a downward trend that is sustained for at least three years post-contact (Figure 44), even after adjusting for death (Figure 70, Appendix C).

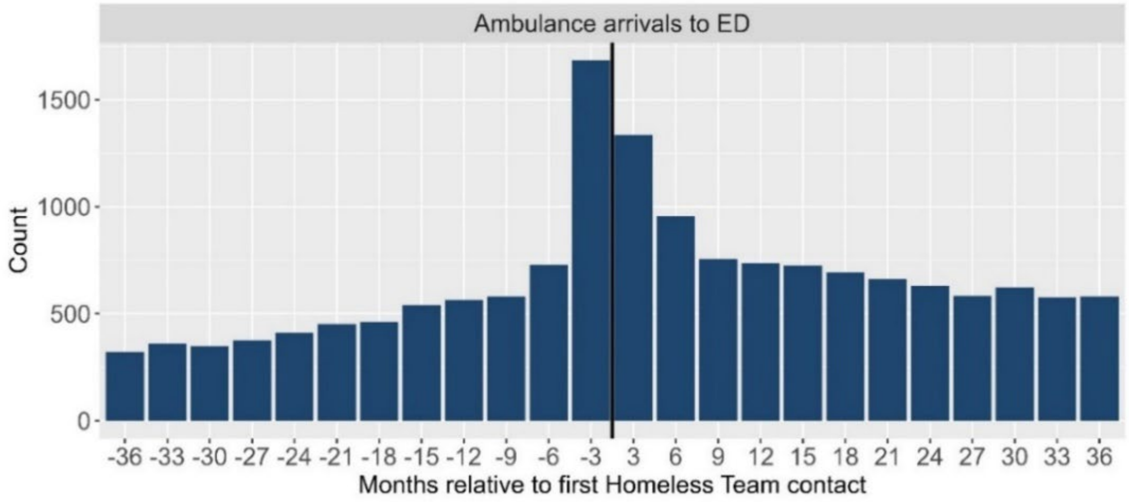


Figure 44: Quarterly Ambulance Arrivals Pre/Post First Contact

Note: data are for the cohort of 1,394 individuals who had at least three years of follow up post-first contact, and should not be directly compared with those in Table 15, which are for the full cohort (n=1,946)

5.3.4 CHANGES IN INPATIENT ADMISSIONS & DAYS ADMITTED

Reductions in the number of individuals admitted at least once to RPH were observed both six months and one year pre-to-post first contact with the Homeless Team (38% and 28%, respectively; Table 16). Further, these reductions were reflected in lower overall numbers of admissions and bed days. However, they also masked some increases, with the number of psychiatric bed days increasing by 19% and 7% six months and one year pre-to-post first contact, respectively, and the mean LOS being higher in both 'post' periods.

Table 16: Inpatient Admissions 6 Months & 1 Year Pre/Post First Contact

	6 months pre/post			1 year pre/post		
	Pre	Post	% change	Pre	Post	% change
Admissions						
N (%) People with 1+ Admission	1,761 (90%)	1,099 (56%)	-38%	1,806 (93%)	1,300 (67%)	-28%
Total Admissions	3,683	2,880	-22%	5,020	4,685	-7%
Mean^ (SD)	1.9 (1.8)	1.5 (2.3)		2.6 (2.6)	2.4 (3.7)	
Range	0 - 24	0 - 23		0 - 36	0 - 44	
N (%) Admissions Ending in DAMA	473 (13%)	388 (13%)	-18%	649 (13%)	620 (13%)	-4%
Days Admitted						
Total Psychiatric Days	6,511	7,731	19%	11,774	12,620	7%
Total Non-Psychiatric Days	12,549	9,943	-21%	16,717	16,567	-1%
Total Bed Days	19,060	17,674	-7%	28,491	29,187	2%
Mean (SD) LOS (Days)	5.8 (9.9)	7.5 (17.8)		6.4 (14.9)	7.3 (17.4)	
Range in Days Per Admission ^^	1 - 159	1 - 725		1 - 338	1 - 725	

Notes: ^ calculated based on the 5-year Homeless Team cohort (n=1,946). ^^ calculated based on the LOS for every admission beginning during the relevant period rather than the number of days that fell within that period; thus, the maximum can be longer than the period for which it is reported

Over 50% of patients seen by the Homeless Team experienced reductions in their numbers of inpatient admissions, and 60% experienced a reduction in non-psychiatric bed days, one-year pre-to-post first contact with the Team (Figure 45).

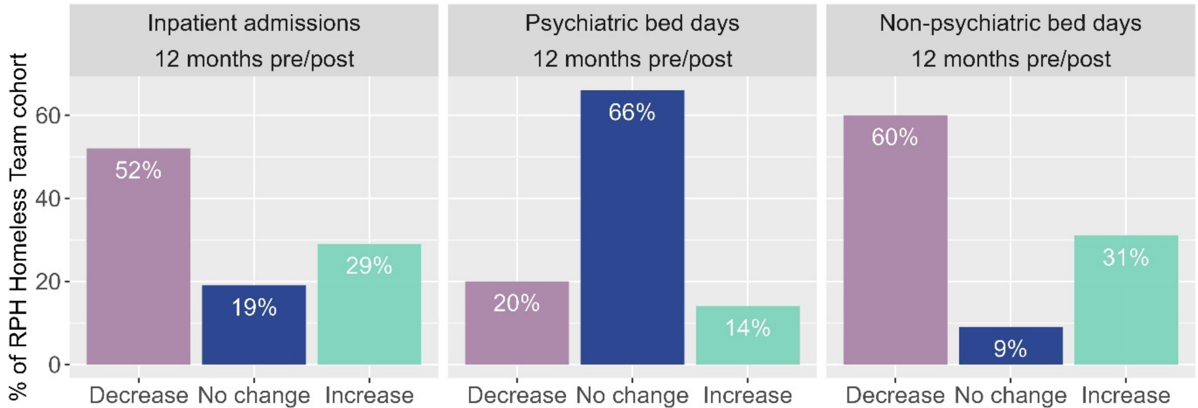


Figure 45: Proportion with Changes in Admissions & Bed Days Post-First Contact

Further, the reduction in bed days continued for at least three years post-contact (Figure 46), even after adjusting for death (Figure 70, Appendix C).

Figure 46: Quarterly Inpatient Bed Days Pre/Post First Contact

Notes: data are for the cohort of 1,394 individuals who had at least three years of follow up post-first contact and should not be directly compared with those in Table 16, which are for the full cohort (n=1,946)

These results indicate that, while contact with the Homeless Team generally led to reductions in use of inpatient services, in some cases increases in use occurred, likely reflecting improved engagement, appropriate treatment and instances where the Team may have, for example, encouraged and advocated for extended hospital admissions to enable proper mental health diagnosis and care.

Box 8 exemplifies this situation, providing an example of a patient who initially experienced no change in use post-contact with the Team before eventually being effectively supported in a community setting, admitted to hospital for an extensive, nine-month psychiatric admission and supported into NDIS accommodation, after which they experienced no further hospital use.

Box 8: Example: Increased Hospital Use Post-Contact with the Homeless Team

Background: *"Lachie"* was a male in his mid-forties who had been experiencing psychotic illness since his early twenties, with this illness historically being deemed drug induced psychosis (DIP). After around a decade, this diagnosis was revised to schizophrenia. With no family support and increasing experiences of psychosis, he ended up on the streets, where he remained for over 15 years, punctuated only by psychiatric admissions and incarceration. His experiences while street present involved heavy IV methamphetamine and alcohol use, deteriorating health, and increasingly violent behaviour. He struggled to adhere to a prescribed medication regime to manage his mental health. By 2013, he was having frequent, short psychiatric admissions (generally <1 week). Due to his unstable mental health and resultant violence, he was unable to access housing services.

From 2015, he was supported by a mobile psychiatric service, receiving a depot antipsychotic injection. He received the lowest potency medication with the longest duration due to the difficulty of administering this medication and long breaks between contact. This medication regime did not adequately control his psychosis and he continued to deteriorate.

Support Provided: Lachie was first seen by the Homeless Team in mid-2020, after being admitted to hospital for severe pneumonia. Unfortunately, he was unable to be supported into crisis accommodation at this time due to his history of violence, substance misuse, and mental health, and his hospital use continued. It was not until early 2021 that he was placed under the mental health act by a community team and admitted to hospital with the aim of effectively treating his psychosis and ending his cycle of homelessness and periodic incarceration.

Current Situation: After a lengthy, nine-month inpatient stay, Lachie received NDIS supported accommodation, with regular community mental health review, where he remains at present, with no further ED presentations or hospital admissions since that time.

Image 7: The RPH Homeless Team Heading off on a Ward Round

5.4 THE IMPACT OF DISCHARGE DESTINATION ON HOSPITAL USE

As noted by Sir Michael Marmot in his seminal work on the social determinants of health:

> *"It is futile to treat homeless patients in hospitals then discharge them back to the abysmal social conditions that made them sick in the first place: to do so perpetuates a revolving door between the hospital and the street or between the hospital and precarious housing"*[68]

Reflecting this, a key focus for the Homeless Team is reducing the number of patients experiencing homelessness discharged back into homelessness, and particularly into rough sleeping or to the streets. As observed in Section 4.3, this ideal is often severely hindered by the lack of suitable accommodation options. Nevertheless, in many instances the Team has been able to connect people to at least short-term, transitional, or other forms of temporary accommodation. To capture this effort's impact, this section stratifies the pre/post hospital use analyses by discharge destination, with discharge destination dichotomised as a) **'Rough Sleeping'**, or b) **'Accommodation'** *(includes all remaining discharge destinations listed in Section 4.3.2 except death, prison, left Perth and unknown, which were excluded from the analysis).*

For conciseness, the 6-month pre/post cohort results are presented, with data for the 1-year pre/post cohort provided in Table 27 and Table 28 (Appendix C). It was hypothesised that greater reductions in hospital use would be observed for patients discharged to accommodation than for those discharged to rough sleeping.

5.4.1 DIFFERENCES IN PRE/POST HOSPITAL USE

The results of the analysis are stark. For all outcomes, **substantially greater reductions in hospital use were observed for individuals discharged to accommodation** and **greater proportions of those individuals had reduced hospital use** (Figure 47; Table 29, Appendix C). For example:

- An overall 4% reduction in total ED presentations (Table 13) masked a 3% **increase** for individuals discharged to rough sleeping and an 6% **decrease** for others, and
- An overall 7% reduction in bed days (Table 16) masked a 36% **increase** for individuals discharged to rough sleeping and a 22% **decrease** for others.

As demonstrated in Figure 47, the findings validate the sheer extent of effort that is frequently expended by the Homeless Team to support individuals into even some degree of short-term accommodation, which can bridge the gap to help people stay off the streets while waiting for Centrelink payments, flights back to country, entry into transitional or other accommodation, etc. More broadly, the findings show that not discharging patients to the street can act as an important circuit breaker to hospital re-presentation.

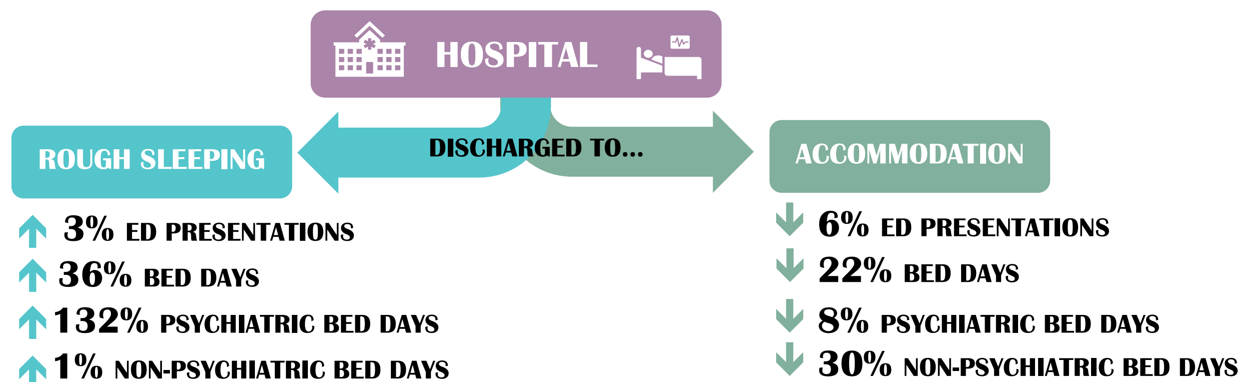


Figure 47: Summary: Pre/Post Hospital Use Differences by Discharge Destination

Notes: results for **Accommodation** exclude data for individuals whose discharge destination following first contact was Died, Left Perth / Returned to Country, Prison / Police Custody, Other or Unknown (n=125, 6%).

The role of discharge destination in helping stabilise individuals' lives is illustrated in Box 9, which describes the story of a woman who was experiencing extreme vulnerability underscored by severe abuse as a child. Fortunately, facilitated by the support of the Team over an extended period, she was ultimately able to secure NDIS support and her previously high hospital use plummeted. Her story also demonstrates that the support provided by the Homeless Team not only has a measurable impact on hospital use but also a meaningful impact on the lives of the individuals concerned.

Box 9: Contribution of Discharge Destination to Stabilising Individuals' Lives

Background: *"Paula"* is a woman in her mid-40s who was fostered as an infant due to physical abuse from her parents and adopted. She had a difficult childhood and was identified early as having trauma-related mental health issues. While still a teenager, she had a child who was taken into DCPFS care. Four years later, she was living in a caravan park, experiencing FDV and actively seeking medications to self-sooth. She was then further destabilised by a severe sexual assault and loss of her accommodation, which resulted in six admissions to mental health wards that year. After this, she had a period of relative stability, living in social housing with a partner, though both were struggling with harmful substance use. Subsequently, both she and her partner were involved in a significant motor vehicle accident while under the influence, suffering significant injuries. Paula sustained major fractures to both legs.

After the accident, Paula and her partner struggled with pain, resulting in worsening substance use. A year later, Paula's partner died of a drug overdose.

After this, Paula maintained another period of relative stability in rental accommodation until her brother died and she was simultaneously evicted from her property. This led to 8 ED presentations over 2 weeks. Paula then suffered another sexual assault by three men on hospital grounds when discharged from an ED during the night with no safe place to go. A period of frequent hospital use followed: 18 ED presentations and 11 inpatient bed days in 2 months. When she presented to hospitals, she was increasingly seen as unstable, manipulative and drug seeking, which acted as a barrier to her receiving the care she needed for her intense psychological distress.

Support Provided: In her brief presentations to RPH ED after her eviction from her rental, the Homeless Team began engaging with Paula, slowly working to build rapport and trust, a significant challenge due to her history of trauma. Through this engagement, Paula was assisted to access supported accommodation, despite the complexities in her support needs. This resulted in a significant decrease in her ED presentations in the following 12 months. Unfortunately, Paula then moved out of this supported accommodation into an unsupported, short-term accommodation service. Without supports, her mental and physical health deteriorated, resulting in 15 ED presentations and four inpatient admissions totalling 28 days over three months. During this period of crisis, the Homeless Team continued to support Paula, utilising brokerage funding to access short term accommodation, clothes and food. The case workers provided her with psychosocial support, and drove the challenging process of obtaining a NDIS housing and support package for her complex physical and mental health conditions. In February of 2020, Paula secured a $250,000 NDIS package in recognition of her extremely high needs, ending her homelessness and instability.

Current Situation: Since receiving the NDIS package, Paula's use of hospital healthcare has plummeted. In the remainder of 2020, she had 9 ED presentations, but this dropped to only 5 in 2021 and 3 in 2022.

Paula's case is a stark demonstration of how a lack of safe housing and supports leads to hospital use, but conversely, how the relatively low cost of social housing and supports can save significant costs for both the health system and vulnerable individuals.

Notes: **DCPFS=** Department for Child Protection and Family Support; **NDIS=** National Disability Insurance Scheme; **FDV=** family domestic violence.

The poignant human face of Homeless Team impact is also reflected in unsolicited feedback and gratitude expressed by patients the Team has supported, as captured in the following quotes from patients:

> *"I thought I was going to die before meeting you guys, I couldn't have known people out there that would give me the time of day without wanting something in return. So really thank you all, you have saved my life."*
>
> *"I don't know what I would've done without you, you have given me a second chance and gotten my family back, I don't know how I could thank you."*
>
> *"I appreciate that you always are looking out for me, even when nobody's asked you. Thank you all for helping me get here, I will make the most of this."*

5.4.2 DIFFERENCES IN PRE/POST ED RE-PRESENTATIONS

Like for ED presentations, ambulance arrivals and inpatient admissions (Section 5.4.1), differences in rates of ED re-presentations and the proportions of those re-presentations that resulted in inpatient admission were observed depending on discharge destination, with patients discharged to rough sleeping experiencing substantially higher rates of re-presentation and subsequent admission. For example, the overall 4% decrease in the proportion of the cohort who had at least one 7-day ED re-presentation in the 6-month period post-first contact with the Homeless Team was driven by an 8% **increase** amongst patients discharged to rough sleeping combined with a 9% **decrease** amongst patients discharged to accommodation (which included family/friends, transitional accommodation, short- and long-term housing) (Table 17). These results emphasise the importance of the extensive work the Homeless Team undertakes trying to source even temporary or short-term accommodation for patients it sees, and the associated benefits to the health system.

Table 17: ED Re-presentation Statistics 6 Months Pre/Post First Contact

	Rough Sleeping (n=625; 32%)			**Accom.** (n=1,196; 61%)		
	Pre	Post	change	Pre	Post	change
N (%) individuals re-presenting within 7 days^	305 (49%)	329 (53%)	8%	525 (44%)	473 (40%)	-9%
Total N of 7-day ED re-presentations	1,076	1,514		1,598	2,046	
N (%) resulting in admission	372 (35%)	475 (31)	-11%	612 (38)	584 (29)	-24%
N (%) individuals re-presenting within 28 days^	399 (64%)	432 (69%)	8%	684 (57%)	649 (54%)	-5%
Total N of 28-day ED re-presentations	1,733	2,367		2,673	3,359	
N (%) resulting in admission	629 (36%)	810 (34%)	-6%	1,073 (40%)	1,074 (32%)	-20%
N (%) individuals re-presenting within 90 days^	467 (75%)	478 (76%)	1%	803 (67%)	778 (65%)	-3%
Total N of 90-day ED re-presentations	2,210	2,787		3,492	4,117	
N (%) resulting in admission	851 (39%)	974 (35%)	-10%	1,466 (42%)	1,375 (33%)	-21%

Notes: ^calculated as % of the relevant sub-cohort. Results for "Accommodation" exclude data for individuals whose discharge destination following first contact was died, left Perth/returned to Country, prison, other or unknown (n=125, 6%).

5.4.3 ONE-YEAR PRE/POST FIGURES

Pre/post hospital use figures for the one-year cohort stratified by discharge destination are provided in Table 27 and Table 28 (Appendix C). Broadly, these results conveyed similar findings, with reductions in hospital use and associated costs observed for the one-year cohort discharged to accommodation and increases observed for the one-year cohort discharged to the streets.

However, some differences were also observed. Particularly, for individuals discharged to accommodation, decreases were lower when examining a one-year pre/post period than when examining a 6-month pre/post period. This suggests that the temporary accommodation found for individuals may have served to positively impact upon hospital use in the short-term, but that the experience of homelessness has a longer-term impact that it is difficult for individuals to overcome.

5.5 CONTRIBUTING FACTORS FOR INCREASES IN HOSPITAL USE POST-HOMELESS TEAM CONTACT

While many people supported by the Homeless Team had observable decreases in hospital use pre/post first contact with the Homeless Team (e.g., 56% for ED presentations, 41% for ambulance arrivals and 52% for inpatient admissions 6-months pre/post first contact), the pattern of use for some patients remained the same or increased. This phenomenon is not unique to the Homeless Team, and, drawing on available literature and observations of the evaluation team, there are some cogent, evidence-based explanations:

- Health has already deteriorated prior to escalating hospital use: As observed by Field et al.: *"Unplanned hospital admission marks a threshold in deteriorating health, increasing the probability of further acute admissions. Achieving sustained improvements in the health of homeless people needs investment in a range of community health, housing, care and support services."*[64] This grim reality for many people experiencing homelessness and particularly rough sleepers is that reductions in hospital use should not be expected given the advanced level of poor health people experiencing homelessness are often experiencing. Thus, whilst stalling or halting the trajectory of increasing hospital use is in and of itself a significant and positive outcome, the 'value' of this prevention of future hospital use is harder to quantify. This idea is examined further in Chapter 9.
- Impact of the Broader Housing Crisis in WA: There is only so much the Homeless Team can do in an environment of stark increases in homelessness and ongoing, worsening shortages of accommodation and public housing (see Section 1.1). While the Homeless Team links people to available accommodation options where possible and has been proactive in encouraging accommodation providers to take in people who have experienced homelessness, the consensus in the WA homelessness sector is that the scarce availability of crisis, short-term and long-term affordable housing in Perth has worsened considerably since the RPH Homeless Team commenced in mid-2016.
- Time Taken for Support to Impact: In practice, support provided to people experiencing homelessness should not be expected to immediately positively impact, as it often takes extended periods of time to engage and build rapport with individuals to the point where their chronic and frequently long-term issues can be effectively addressed. This situation is exemplified by the case study in Box 8 (Section 5.3.4), which describes an individual who experienced no change in their hospital use until they were eventually effectively engaged in the community and admitted for an extensive, nine-month hospital stay.
- Wider Health and Psychosocial Challenges: While the Homeless Team expends substantial effort identifying underlying drivers of recurrent hospital use amongst people experiencing homelessness, and signposting means of addressing these drivers where possible, its scope to tackle them swiftly is limited. As such, post-contact with the Team, many of the core drivers of individuals' poor health and repeated hospital use remain (these challenges, which include both health and psychosocial factors, are discussed in detail in Chapter 8). As illustrated in Box 10, there are instances where, despite the most comprehensive care of the Homeless Team, there is no simplistic translation of this care into reduced hospital use for people with an extensive history of trauma and adversity. Nonetheless, these case study accounts must be told, as this is the day-to-day real world in which the Homeless Team operates, and ideologically the Team is focused on person-centred quality health and social care as the primary outcome, and is not beholden to decreases in hospital use as a simplistic holy grail.

Box 10: Example of Increased Hospital Use Post-Contact with the Homeless Team

Background: *"Graham" is* a 30-year-old transgender (female to male) individual who, in early 2021, relocated to Perth due to significant trauma, including severe sexual abuse from multiple family members as a child and a violent sexual assault as an adult. Interstate, he had been well known to psychiatric support services, but when starting over in Perth had to rapidly access accommodation, support services and mental health care. This proved highly stressful, resulting in escalating anxiety, suicidality and severe self-harm which led to multiple ED presentations and psychiatric admissions. A contributing factor was the difficulty of accessing safe and supported accommodation.

Hospital Usage: Altogether over the one-year period following his very first contact with the Homeless Team, Graham presented to ED 28 times, including 18 times via ambulance, and had nine inpatient admissions for a total of 146 bed days, including 120 psychiatric bed days.

Support Provided: The Homeless Team saw Graham in April 2021 on his first presentation to ED after arriving in Perth. Initially the Team identified that due to his extreme vulnerability and precarious mental health Graham was unsuitable for congregate homelessness services at the time. He was supported by the Team whenever he presented to ED, with the Team also advocating for mental health services to take a primary role in his care.

Current Situation: Graham sadly does not yet permanent stable safe accommodation, and the legacy of his trauma is pervasive. He has continued to present to regularly present to an ED, often for suicidal ideation. This has resulted in regular admissions to a mental health inpatient ward. This pattern of hospital use attests to the severe, lifelong impacts of childhood sexual abuse particularly.

In addition to the factors influencing some of the observed increases in hospital for some patients described above, it is important to also draw attention to a data limitation whereby, as described in Section 3.3.3, the Homeless Team data includes information for some individuals seen by the Team who were ultimately deemed ineligible for support, e.g., due to being severely medically or mentally unwell or due to requiring aged care or disability services support. Consequently, the cohort-level post-Homeless Team contact hospital use figures are biased upwards. Accordingly, a recommendation has been made that such individuals/ consultations be identified in the Homeless Team database going forwards, so that this bias can be accounted for in future evaluations.

Image 8: Homeless Team Supporting a Patient

5.6 ECONOMIC IMPLICATIONS ON THE HEALTH SYSTEM

The often-revolving hospital door experience of many homeless patients has significant cost and resource implications for hospitals and the wider health system. This is by no means unique to RPH or Western Australia, and has been emphasised in the recent UK National Institute for Health and Care Excellence guideline entitled 'Integrated health and social care for people experiencing homelessness'.[69]

> *In addition to a moral responsibility, there is an economic imperative to tackle homelessness. The costs of homelessness to society are significant… Given the financial implications of homelessness to society and the far worse health and social care outcomes, most interventions that address homelessness are likely to be cost effective or even cost saving from the wider public sector perspective.[69]*
>
> ***- UK National Institute for Health and Care***

In addition to the quantifiable costs attributed to inpatient bed days or ED presentations,[5] there are substantial challenges to the optimal use of strained health system resources associated with ED wait-times, ambulance arrivals, patient flow, bed occupancy, management of long-stay patients,[70] discharge planning and staffing. The higher rates of homeless patients leaving ED without being seen or discharging against medical advice is also a suboptimal use of hospital resources and is associated in turn with often inevitable representations to hospital.

This section describes some of the economic implications of the hospital use of patients experiencing homelessness seen by the Homeless Team. Four sub-sections are presented, examining:

- Estimated costs associated with an increasing pattern of hospital use of the cohort **leading up to first contact with the Homeless Team**,
- Estimated costs associated with changes in the hospital use of the cohort **pre/post first contact with the Homeless Team**,
- **Differences** in pre/post costs **based on individuals' discharge destination**, and
- A comparison of estimated costs of hospital use of the cohort to **operating costs of the Homeless Team**.

As described in Section 2.3, estimated costs presented throughout this section are calculated based on the most recently released:

- **average ED presentation and non-psychiatric inpatient bed day costs** for WA public hospitals, reported in the National Hospital Cost Data Collection (NHCDC) Public Hospitals Round 25 (2020-21) Infographic Report published by the Independent Health and Aged Care Pricing Authority (IHACPA),[5]
- **average psychiatric bed day cost** for WA public hospitals, calculated based on data attached to the *Expenditure on mental health-related services* sub-section of the AIHW Mental health report 2023,[7] and
- **average cost of an ambulance arrival** in WA, calculated based on data attached to the 2023 Report on Government Services of the Productivity Commission.[6]

5.6.1 COSTS ASSOCIATED WITH HOSPITAL USE PRE-FIRST HOMELESS TEAM CONTACT

Based on the data in Section 5.1, Table 18 shows the estimated 'costs to the health system' associated with the hospital use of the cohort over the three-year period prior to first contact with the Homeless Team. The total estimated cost over that period was **over $156 million**, or over $80,000 per person or over $26,500 per person, per year. **Over half of this cost (53%, or over $42,000 per person) was incurred in the year immediately prior to first contact**. These figures suggest that earlier intervention with this cohort of patients might result in substantial cost savings to the health system.

Table 18: Estimated Health Service Costs 3 Years Pre-First Contact

	Days/ Presentations	Unit Price	Aggregate Cost	Cost p/person	Cost p/person p/yr
ED Presentations^	21,401	$894	$19,132,494	$9,832	$3,277
Ambulance Arrivals^^	9,096	$1,034	$9,405,264	$4,833	$1,611
Psychiatric Days Admitted^^^	25,130	$1,596	$40,107,480	$20,610	$6,870
Non-Psychiatric Days Admitted^	30,404	$2,879	$87,533,116	$44,981	$14,994
Total			**$156,178,354**	**$80,256**	**$26,752**

Notes: ^ Average ED presentation cost and admitted acute care weighted separation cost for WA sourced from 2023 *NHCDC Public Hospitals Round 25 Report.*[5] ^^ Average ambulance arrival cost in WA sourced from 2023 Report on Government Services.[6] ^^^ Average psychiatric inpatient bed day cost for WA sourced from 2023 AIHW *Mental health report.*[7]

5.6.2 CHANGES IN COSTS ASSOCIATED WITH HOSPITAL USE

The over-representation of people experiencing homelessness in hospital (ED and inpatient) data is common across Australian hospitals, and, as reflected in Recommendation 13 of the WA Sustainable Health Review, there is a need for a:

> *system-wide approach to identifying and supporting people who are frequent users of health services including emergency and outpatient services to improve pathways of care and reduce presentations.*[1 p.16]

For example, as seen in the literature[17,18] and previous evaluations of the Homeless Team[13] and HHC,[14] the ED is frequently used by people experiencing homelessness for issues that could be better and more efficiently addressed in a primary health care setting or by social services.

With this in mind, Table 19 estimates the changes in costs associated with the changes in hospital use six months and one year pre-to-post first contact with the Homeless Team. Six months pre-to-post first contact, a total reduction of over $7 million was observed, representing a 13% decrease in cost. The picture at the one-year pre/post mark is less clear, including the fact that the deterioration in health is hard to halt when many of the cohort remain homeless, and short reprieves in accommodation organised by the Homeless Team are not a longer-term panacea. Comparing the one-year pre/post periods, an estimated increase in cost of approximately 3% was calculated, driven by increases in psychiatric bed days, ED presentations and ambulance arrivals. Potential reasons for these increases are discussed in detail in Section 5.5, and it is important to note that this was the overall net effect and that there were many patients whose hospital use reduced. Further, it is worth noting that these cohort-wide figures mask differences observed between sub-cohorts based on discharge destination. These differences are examined in Section 5.4.

Table 19: Changes in Associated Hospital Use Costs Pre/Post First Contact

Follow up Period	Estimated cost change^	% cost change	Based on
6-months pre/ post first contact (n=1,946)	**- $7,246,266** (-$3,724 per person)	**- 13% reduction**	342 **fewer** ED presentations 154 **fewer** ambulance arrivals 452 **additional** psychiatric bed days 2,606 **fewer** non-psychiatric bed days
1-year pre/ post first contact (n=1,946)	**+ $2,135,800** (+1,098 per person)	**+ 3% increase**	839 **additional** ED presentations 452 **additional** ambulance arrivals 846 **additional** psychiatric bed days 150 **fewer** non-psychiatric bed days

Notes: ^ Estimated costs are based on figures listed in Table 2, Section 2.3.4

5.6.3 DIFFERENCES IN COST CHANGES PRE/POST HOMELESS TEAM CONTACT BASED ON DISCHARGE DESTINATION

This section describes the differences in health system costs associated with the differential pre/post changes in hospital use of the cohort following stratification by discharge destination (Table 29, Appendix C). The changes in hospital utilisation and associated costs according to discharge destination for the period 6-months pre-to-post first contact are presented in Table 20. The overall estimated cost reduction of 13% for the whole cohort in the 6-months pre-to-post first contact (Table 19) masked a 20% **decrease** for patients discharged to accommodation and an 18% **increase** for patients for whom no accommodation could be sourced and who were discharged to rough sleeping or the streets.

Table 20: Costs Associated with Changes in Hospital Use 6-Months Pre/Post First Contact, by Discharge Destination

Discharge Destination	Estimated cost change^	% cost change	Based on
Rough Sleeping (n=625)	**+ $2,966,156** (+ $4,746 per person)	**+ 18.1%**	74 **additional** ED presentations 6 **additional** ambulance arrivals 1,741 **additional** psychiatric bed days 40 **additional** non-psychiatric bed days
Accommodation (n= 1,196)	**- $8,025,500** (- $6,710 per person)	**- 19.8%**	297 **fewer** ED presentations 119 **fewer** ambulance arrivals 398 **fewer** psychiatric bed days 2,432 **fewer** non-psychiatric bed days

Notes: ^ Estimated costs based on figures listed in Table 2. Results for Accommodation exclude data for individuals whose discharge destination following first contact was died, left Perth/returned to Country, prison, other or unknown (n=125, 6%)

Thus, by far, the greatest associated cost reductions were seen among patients supported by the Team who were able to be discharged to accommodation, with the reduction in ED presentations, ambulance arrivals and inpatient days for these 1,196 patients being over $8 million in a 6-month period alone. The same decrease was not evident among patients who were unavoidably discharged to the streets due to a lack of available accommodation, with these patients also being more likely to return to hospital within 28 days. The differences are depicted visually in Figure 48.

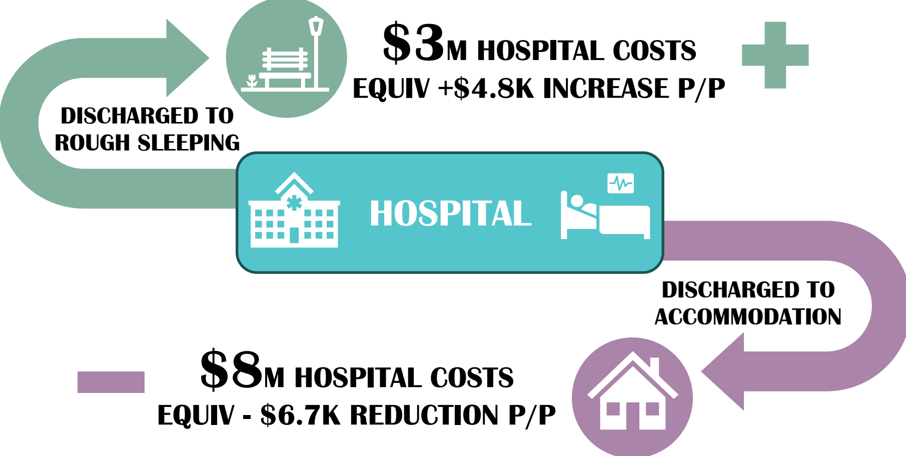


Figure 48: Impact of Discharge Destination on Costs Associated with Hospital Service Use

Additionally, costs associated with changes hospital use for the one-year pre/post cohort are presented in Table 30 (Appendix C).

5.6.4 COMPARISON OF ASSOCIATED HOSPITAL USE COSTS & HOMELESS TEAM OPERATING COSTS

It was beyond the scope of this evaluation and the available data to undertake a full return on investment or cost benefit analysis, and the costs associated with the observed reductions in hospital use of the cohort pre-to-post first contact with the Homeless Team are acknowledged to not literally be bankable cost savings per se. However, it is worth noting that those **reductions in costs are over three times greater than the operating staff costs of the Homeless Team**. This figure was calculated as the ratio of:

- the per-person estimated reduction in costs associated with hospital six-months pre-to-post first contact with the Homeless Team, calculated as: $\sim\$7.25 \text{ million} / 1,946 = \sim\$3,700$
- and the per-person operational cost of running the Homeless Team, based on the number of unique patients seen by the Team in the most recent six-month period for which data were available (Jan-Jun 2021, n=352): $\$390,250 / 352 = \sim\$1,109$

The staffing costs for the services provided by the Homeless Team totals **$780K per year** (Table 21).

Table 21: Operational Cost of Running the Homeless Team

Salary Item	FTE	Approximate Cost (per annum)
Homeless Team Clinical Lead – Salary	0.5	$138K
Homeless Team Administrative Assistant	1	$69K
Ruah weekday case workers ^	2	$278.5K
Weekend case workers	0.4 ^^	$110K
HHC in-reach nurse	1	$150K
HHC GP in-reach and consult advice	1 hour per day	$35K
Total		**$780.5K**

Notes: Based on annual operating/staffing costs 2021/2022. ^ includes overheads. ^^ corresponds to approximately 0.65 FTE cost-wise due to overtime.

5.6.5 LONGITUDINAL TRENDS IN COSTS ASSOCIATED WITH HOSPITAL USE

One of the most consistently observed findings in this and previous evaluations of the Homeless Team has been that hospital use tends to increase the longer people remain homeless and/or without targeted intervention. Hence, patterns of hospital use at the aggregate and often individual levels often increase significantly in the three years prior to first contact with the Homeless Team before initially increasing or plateauing as health and support needs start to get addressed and ultimately decreasing over time to levels the same as or slightly above those observed pre-contact. This trend is consistent with patterns of hospital use observed elsewhere for people experiencing homelessness,[57] and is observed here in patterns of use for ED, inpatient admissions (general and psychiatric) and ambulance arrivals, as reflected in the following four graphs, which show the hospital use of the present cohort and associated estimated costs to the health system by 6-month period three years pre-to-post-first contact with the Homeless Team.

The first two graphs relate to ED presentations. Overall ED presentations (Figure 49) and ambulance arrivals to ED (Figure 50) remained high in the 6-month period immediately following first contact with the Team, before decreasing to levels either the same as or slightly higher than seen pre-contact.

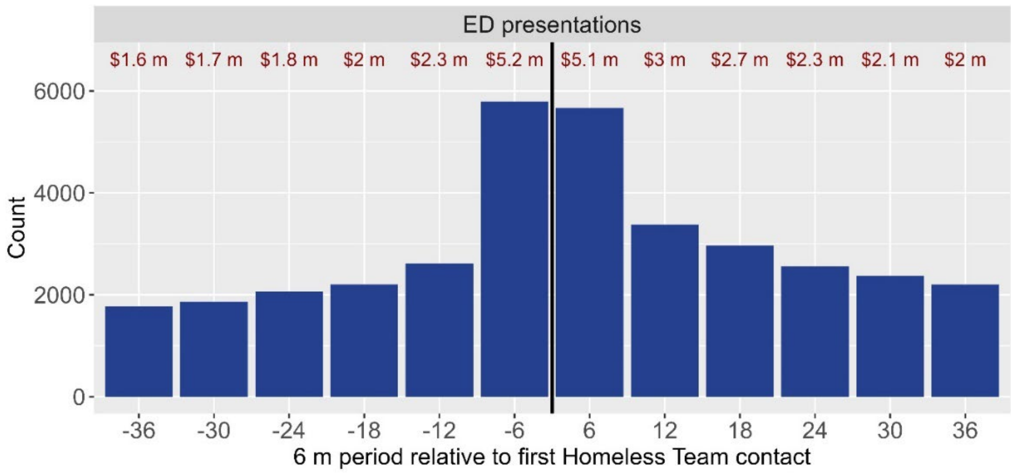


Figure 49: ED Presentations & Associated Costs Pre/Post First Contact

Notes: Costs estimated based on figures listed in Table 2.

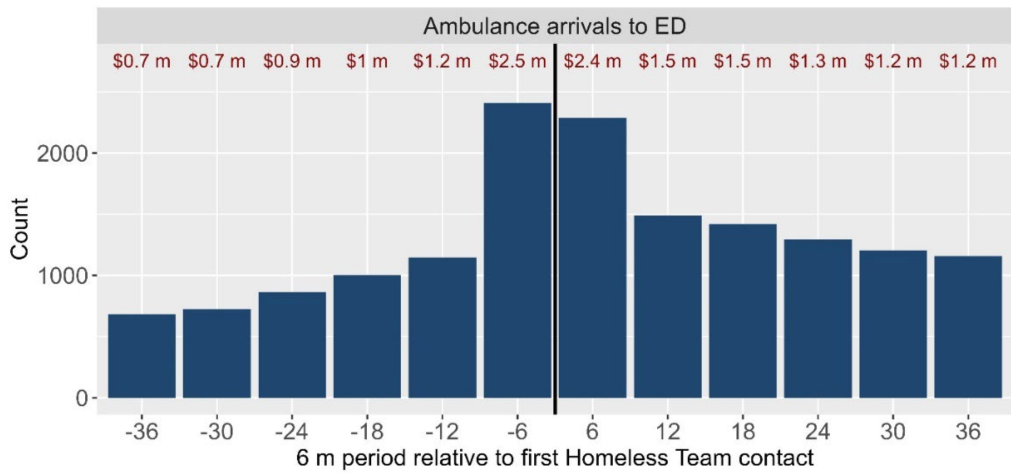


Figure 50: Ambulance Arrivals to ED & Associated Costs Pre/Post First Contact

Notes: Costs estimated based on figures listed in Table 2.

A similar pattern was observed for psychiatric (Figure 51) and non-psychiatric bed days (Figure 52), with the associated costs to the health system being substantial: a total cost of $42.4 million in the six months immediately prior to first contact and $36.9 in the six months immediately following.

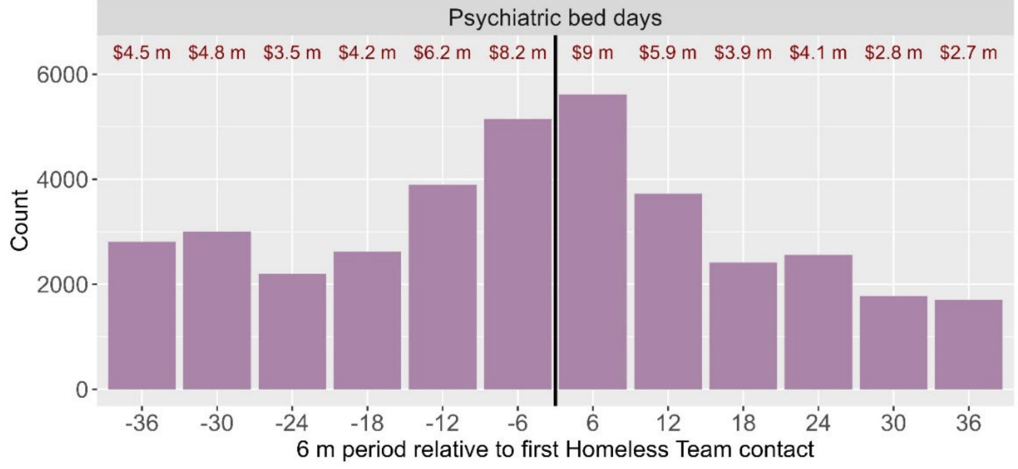


Figure 51: Psychiatric Bed Days & Associated Costs Pre/Post First Contact

Notes: Costs estimated based on figures listed in Table 2.

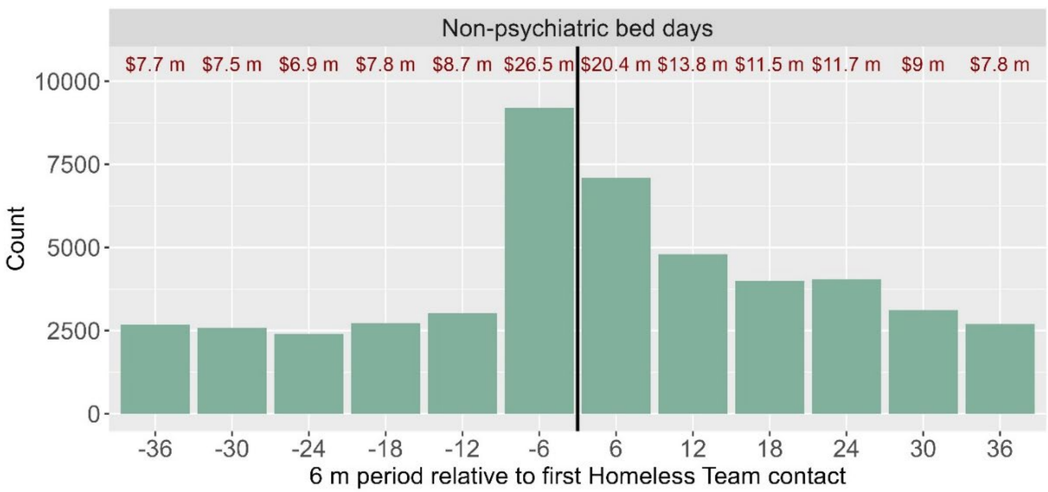


Figure 52: Non-Psychiatric Bed Days & Associated Costs Pre/Post First Contact

Notes: Costs estimated based on figures listed in Table 2.

In summary, this chapter has focused on the hospital use of the Homeless Team cohort and associated costs to the health system. However, the impact of the Homeless Team is broader. The following two chapters examine in turn the benefits of the Team as perceived by RPH staff and the wider contributions of the Team to addressing homelessness in WA.

Image 9: HHC Nurse & RPH Homeless Team Coordinating Patient Care

6 BENEFITS OF THE HOMELESS TEAM AS OBSERVED BY RPH STAFF

The benefits of having a dedicated Homeless Team at RPH are further reflected in the responses to a staff feedback survey, which was distributed by the evaluation team directly to relevant RPH staff or via senior RPH management. The purpose of the anonymous survey was to gain wider RPH staff insights into the role and impact of the Homeless Team, including the potential impact for patients, staff, and hospital and health system overall. There was a strong response to the survey, with 133 respondents across RPH. Due to the survey being sent via numerous group distribution email databases it was not possible to calculate the overall response rate. Key findings are summarised below.

6.1 HOW THE TEAM SUPPORTS & COMPLEMENTS OTHER STAFF

The majority of RPH staff respondents agreed with a series of five statements regarding the support the Homeless Team provides to the overall care provided to patients (Figure 53).

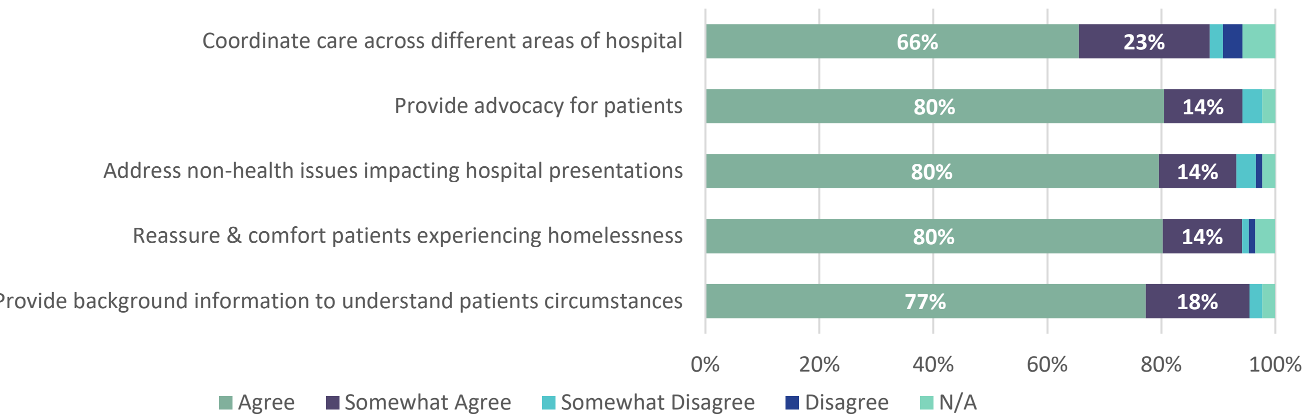


Figure 53: How the Homeless Team Supports and Complements Other RPH Staff

Common themes reflected in these survey responses included: the valuable role of the Team in providing information and links to support services/accommodation; knowledge of patient history; advocacy on behalf of patients and to community services; identifying and addressing non-medical discharge barriers; continuity of care; hospital staff education and upskilling; and skilled capacity to build trust and rapport with homeless patients. Collectively, these highlight ways in which the Homeless Team contributes to a greater level of care for RPH patients experiencing homelessness.

Table 22 provides some example quotes from RPH staff, elucidating the ways in which the Homeless Team complements and supports the work of other staff across the hospital. These quotes evidence the collaborative way in which the Team works with other hospital departments, thus enhancing the hospital's overall capacity to respond appropriately to homeless patients' medical and psychosocial needs and understanding of factors contributing to challenging behaviours in the hospital setting. In these situations, the Homeless Team can often broker improved understanding and therefore a better hospital experience for both staff and patients.

Table 22: Perceived Benefits of the Homeless Team, per RPH Staff

Benefit	Quoted examples from hospital staff
Coordinating care across the hospital	*"it's a 2-way linkage between HHC and the hospital, hospital staff know that these people can be followed up plus HHC can engage early with new clients or at least touch base with those that slip through the safety nets… it makes it a collaborative affair and that hospital care is not in isolation."* *"I have genuinely witnessed the team build a much-needed rapport bridge between behaviourally challenging, yet vulnerable ED consumers and ED staff. This resulted in great outcomes for these patients."* *"Collaborative practice with social work department, works well and good boundaries identifying social work issues and HHC issues."*
Supporting and comforting patients experiencing homelessness	*"The patients that I have seen, have benefited having a dedicated team that is aware of the services and supports available to people experiencing homelessness. Having a familiar face and team that are available to see patients again and again as they represent to hospital provides reassurance to the homeless person that there is someone that already knows their situation and is building rapport with the patient."* *"The [RPH HT] team brings a level of hope in providing quality care for those who are homeless, even if it is a warm bed and shelter for one night. They reduce antagonism toward health services and homeless patients have engaged more with care provided."* *"I have had many patients assisted by the [RPH Homeless Team]. For one patient, the team organised food vouchers and accommodation for two nights that was newly destitute and provided options for ongoing treatment requirements. That patient felt that someone cared, understood them and their outlook was one more of hope."*
Providing background information to help staff understand patients' psychosocial needs	*"They provide comprehensive information on a patient's psycho/social history to make it easier to identify potential issues medical or social that can be addressed in hospital or in the community. Their history allows us to develop a better rapport and nurse using a holistic approach addressing all factors that we can during the person's stay so they can discharge in a safe and supported way."* *"A patient experiencing FDV came in with injuries from an assault. The patient was very withdrawn, and it was hard to gain a history. The [RPH Homeless Team] provided a history to medical/nursing staff, also discussing the patients triggers/relievers around hospital admissions. They had an extensive conversation with the patient which sometimes time does not allow when nursing. The patient was more open to care after and was linked up with social work and supported into safe crisis accommodation."*
Educating RPH staff on homelessness	*"Providing education to other members of the multidisciplinary team to assist in reducing the stigma associated with being homeless."*
Provides additional staffing support and relieves pressure on other RPH staff	*"HHC team have been very helping in supporting our homeless patients and can often save [Social Workers] a lot of time during the day."* *"The existing service that we have with the RPH Homeless Team is fantastic. The team communicates well with all staff and patients. They provide an exceptional level of care and have time to put into patients that we do not currently have."* *"[The RPH Homeless Team] are able to spend more time with patients to facilitate access to social and primary care services. They understand the locally available services and are better able to articulate this knowledge [to the patient]."* *"… the Homeless Team make it an easier, less stressful admission for the patient by providing advocacy for their immediate needs, with planning for future needs."* *"It gives nursing staff a service to flag our concerns with. For example, I noticed one homeless man frequently presenting to ED at night but leaving before seeing the medical team. I could flag my concern with the team who responded back with information that reassured me he was receiving support through them".*

6.2 STAFF PERCEPTIONS OF THE HOMELESS TEAM'S IMPACT

This section examines RPH staff perceptions of the benefits of the embedded Homeless Team. A short survey was distributed to RPH staff, with a list of potential benefits of the Homeless Team. The proportions of staff who agreed they had observed the stated benefits of the Homeless Team are presented below (Figure 54).

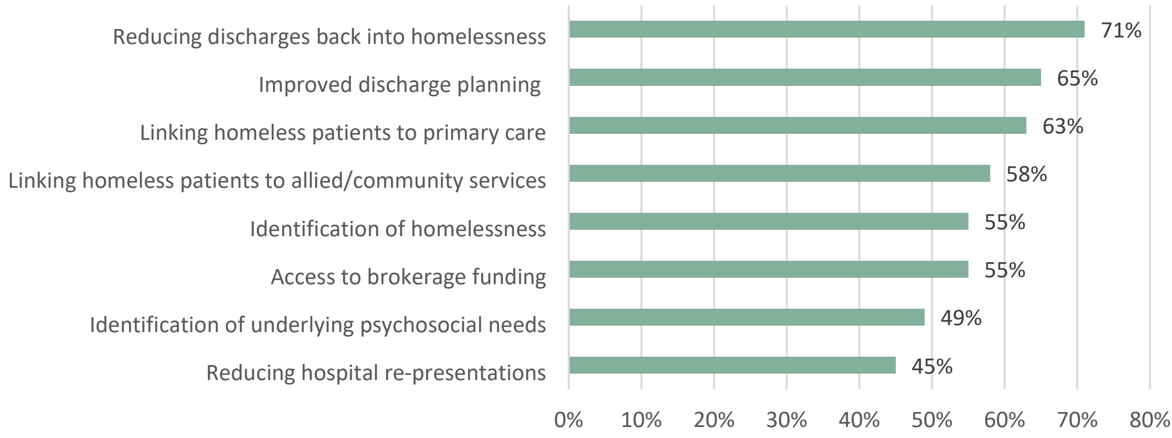


Figure 54: RPH Staff Perceptions of the Benefits of Having a Dedicated Homeless Team

Overall, a range of benefits of the Homeless Team have been observed by wider RPH staff, and the majority of survey responses were positive. Almost three quarters (71%) of survey respondents agreed that the Homeless Team connected patients to accommodation options which in-turn reduced overall discharges back onto the streets. Almost two thirds (65%) of staff agreed that having the Team at RPH improved discharge planning for homeless patients, and a similar proportion (63%) recognised the role of the Homeless Team in linking patients to GP and primary care (63%), as well as to allied health and community services (58%).

The following examples provided by RPH staff in the survey illustrate how the presence of the Homeless Team facilitated improved discharged planning for people experiencing homelessness:

> *"I have worked extensively with the RPH Homeless Team during my time as an employee at RPBG, mostly within the ED and acute medicine setting. Their support has been invaluable in assisting patients to discharge from hospital and reducing the likelihood of representation, secondary to psychosocial matters."* **– RPH staff member**
>
> *"They provide comprehensive information on a patient's psychosocial history to make it easier to identify potential issues medical or social that can be addressed in hospital or in the community. Their history allows us to develop a better rapport and nurse using a holistic approach addressing all factors that we can during the persons stay so they can discharge in a safe and supported way."* **– RPH staff member**
>
> *"HHC team entered observation ward in ED and rounded on homeless patients admitted the night before. They facilitated discharges by coordinating with street doctor, helping with accommodation and also clarifying which patients required help and which did not. Hugely streamlines the discharge process. In addition, indigenous patients are helped to get back to Country when there are funds available to improve health and wellbeing as well as get these patients back to a stable accommodation and community that supports them. Saves the department a huge amount of time and the health system so much money."* **– RPH staff member**

Other benefits of the Homeless Team reflected in staff survey responses included the value of access to brokerage funds to support patient discharge (55%), enhancing identification of homeless patients within the hospital (49%), underlying psychosocial factors contributing to patient hospital use (49%) and the reduction of patient re-presentation in the future (45%). The following quote from survey

open ended responses illustrates the valuable use of brokerage funding to fund short-term accommodation and essentials for a person experiencing homelessness who would otherwise have been discharged back to the streets:

> *"I liaised closely with the homeless health care team on the ward in order to facilitate safe discharges for homeless people back out into the community. By using the brokerage fund through homeless health care, we are able to fund short term accommodation for patient utilising PATS as well as providing them with essentials such as food vouchers, clothing and toiletries to assist them if they are sleeping rough."* **– RPH staff member**

Image 10: RPH Homeless Team Staff Coordinating with Other RPH Staff in ED

7 WIDER CONTRIBUTIONS TO ADDRESSING HOMELESSNESS

Beyond the direct work and impact of the RPH Homeless Team in the lives of individual patients, the RPH hospital setting, and the East Metropolitan Health Service more broadly, the Team have had a much wider influence and impact via its collaborations, capacity building, advocacy and engagement in the health, homelessness and community sectors.

CAPACITY BUILDING WITHIN THE WA HEALTH WORKFOCE	CONTRIBUTITING TO WIDER EFFORTS TO ADDRESS HOMELESSNESS IN WA	POLICY TRACTION & REFERENCING OF THE RPH HOMELESS TEAM
PARTICIPATION IN WA AND NATIONAL FORUMS RELATING TO HOMELESSNESS & HEALTH	COLLABORATIVE INVOLVEMENT IN OTHER INITIATIVES	WIDER INTEREST IN LEARNING FROM THE RPH HOMELESS TEAM MODEL

7.1 CAPACITY BUILDING WITHIN THE WA HEALTH WORKFORCE

In addition to the direct care provided to patients and its broader role within RPH, the Homeless Team has increasingly become a conduit for broader capacity building around homelessness within the WA public health system.

7.1.1 SUPPORTING OTHER HOSPITALS IN RESPONDING TO HOMELESSNESS

As the Homeless Team has become more well known, there has been a considerable increase over the years in requested advice and engagements with staff from other WA hospitals in relation to patients experiencing homelessness. This support has taken the form of:

- responses to requests for advice regarding care of specific patients,
- raising awareness and educating regarding responding homelessness, and
- providing advice and strategies for safer discharge of homeless patients (Table 23).

Table 23: Advice and Assistance to Other Hospitals

Activity	Metropolitan Area	Regional WA
Responding to requests for advice regarding care of specific patients	• Case conferences with staff at hospitals where a patient with complex issues including homelessness presented • Advice to support patient care, (*e.g., medication management, identifying case worker, organising appointments with HHC)* • Reconnecting patients to care where homelessness interrupted treatment *(e.g., cancer treatment, bypass surgery)*	• Collaboration with Return to Country programs for Aboriginal patients who have exited hospital without a pathway to get home • Liaison with regional hospital staff where a patient has moved to Perth or moved from Perth to regional area
Awareness raising and education for staff on responding to homelessness	• Invited talks to ED medical staff at other public hospitals • Grand Round presentations that are accessed by staff at other hospitals	• Invited presentation to WACHS staff in Bunbury and Geraldton to connect them with community homelessness services in areas where there are BNL projects
Advice & strategies for safer discharge for homeless patients	• Advice and template examples for other hospitals participating in the Department of Health Homelessness Discharge Facilitation Fund *(FSH, SCGH, RGH, KEMH, BRH)*	

A visit by the Homeless Team Clinical Lead, Dr Amanda Stafford to Bunbury Regional Hospital (BRH) ED in April 2023 exemplified the support provided to other hospitals. While at RPH the collaboration between the hospital and local community homelessness services is well developed via the Homeless Team's work, this is not seen in most hospitals, especially in rural areas. The WA Alliance to End Homelessness (WAAEH) has been working to establish By Name Lists (BNLs) in large rural centres; however, local community homelessness services struggle to get a foothold in their local hospitals to assist their homeless clients. In Bunbury, WA's third largest regional centre with a population of over 90,000, this lack of connection was impeding efforts to assist the local homeless population.

At the WAAEH's request, Dr Stafford contacted the Head of the BRH ED to request a face-to-face meeting of senior ED staff and representatives from Bunbury's community homelessness services (Zero Project Bunbury and Kenyi Mia). The goal was to facilitate a collaboration between the hospital and Bunbury's Housing First outreach service to better serve frequent ED presenters among the local homeless population. A successful meeting took place at the BRH ED, facilitated by Dr Stafford and attended by ED senior staff, Social Workers and two community homelessness service representatives, exploring the mutual benefits possible with a collaboration. An ED Consultant champion for Homelessness and point of contact was identified, along with an initial project to identify the five most frequent homeless BRH ED presenters and work collaboratively to resolve their homelessness. One of the ED Consultants commented *"I had no idea these services existed in Bunbury"*, and Anna Janickova, Community Impact Advisor, WAAEH noted there has already been at least one good news story arising from the visit.

> *"An individual was flagged who had presented twice to ED in June for reasons relating to mental health and AOD use. After checking if the person was already on the By Name List, the local Kenyi Mia Housing First Support Team prioritised him for support and assisted him to get into rehab in Perth. It is a very good outcome for this person, that hopefully led to ending his frequent ED presentation cycle and will save a bed for someone in need at the hospital."* – **Anna Janickova, Community Impact Advisor, WAAEH**

7.1.2 HEALTH WORKFORCE CAPACITY BUILDING

7.1.2.1 Medical Student & GP Registrar Placements with Homeless Healthcare

Supervision and support to future members of the WA medical workforce through providing medical student and GP registrar placements is an integral part of the Homeless Team's collaboration with HHC. Since inception of the Homeless Team, a total of 71 medical students and eight registrars have been provided placements by HHC that included ward rounds with the Homeless Team at RPH.

> *"An important part of medical student and registrar placements with Homeless Healthcare is the time they spend with the Homeless Team at RPH, as they get to see firsthand, how challenging navigation of the health system can be for patients experiencing homelessness, particularly when there is often a history of trauma and past negatives experiences of feeling stigmatised by health professionals. These placements also encourage students and registrars to think more about the ways in which we can improve access to primary care for the Perth homeless population, and they get to see the crucial difference that stable housing makes to health."* - **Dr Andrew Davies, HHC Medical Director**

The Sustainable Health Review[14] highlights the need to improve the health of vulnerable population groups, hence the value of student and registrar exposure to the needs of patients experiencing homelessness and the work of the Homeless Team in the formative years of their careers as health professionals.

"My placement at Homeless Healthcare has opened my eyes to the medical needs of some of our most health-vulnerable members of society. Participating in Homeless Team ward rounds was part of this placement. The exposure to the clinical complexity involved in the care of people experiencing homelessness has proved invaluable to my development as a medical professional and has reminded me of why I chose to do medicine in the first place." **– 4th year Medical Student, Practical Placement with HHC**

7.1.2.2 RPH Capacity Building Opportunities for New Health Workforce Graduates

In addition to exposure to the Homeless Team by GP registrars doing placements with HHC, many other registrars and graduate nurses and allied health professionals undertaking rotations through RPH have incidental opportunities to gain a greater understanding of how to relate to and support homeless patients. These opportunities are enhanced by the fact that the Clinical Lead of the Homeless Team is a senior ED consultant at RPH in the other half of her full-time role. As people experiencing homelessness constitute a (5-10%) significant proportion of the people presenting to RPH ED, **early career health professionals gain exposure and skills around**:

- Better understanding the underlying causes and drivers of homelessness,
- Challenging stereotypes and beliefs about homelessness and people experiencing homelessness,
- Adjusting the clinical approach when talking with and caring for patients experiencing homelessness,
- Looking beyond the immediate presenting issue and recognising the high levels of co-morbidity and how homelessness drives health deterioration,
- The value for patient care in collaborating with the Homeless Team, Aboriginal Liaison Workers and Community Homelessness Services,
- Improved deliberation and reflexion around discharge planning,
- Modifying discharge planning around homelessness to improve outcomes,
- Measuring patient risk on discharge differently when it is a person experiencing homelessness, e.g., nighttime discharges, and
- Improving staff self-awareness of their attitudes to people experiencing homelessness and how to re-frame these more positively.

Image 11: RPH Homeless Team Staff and Ruah Case Worker on the ED Ward

7.2 CONTRIBUTIONS TO EFFORTS ADDRESSING HOMELESSNESS

This subchapter describes the involvement of the Homeless Team in wider efforts to address homelessness in WA, including collaborating on new initiatives, advocacy, and roles on key advisory groups and committees.

Since its inception, the Homeless Team has rapidly become recognised as an important voice at the table in collective efforts to respond to homelessness in WA. This has included invited roles held by the Homeless Team Clinical Lead on various key advisory groups and committees (Figure 55). Through these roles, the Homeless Team is able to provide a strong health focus for both policy development and practical issues in gaining and retaining housing for the most vulnerable rough sleepers in Perth.

Whilst a number of these roles have been within the health sector, the Homeless Team has also anchored itself as an important health representative in wider homelessness advisory committees and steering groups, including ones initiated by the Department of Communities, the City of Perth, and non-government homelessness organisations.

> *"When the Homeless Team commenced, health sector representation or even mention of 'health' were typically missing or very sparse across the homelessness system and within key homelessness policies in WA. This has changed significantly over the past six years, with the Homeless Team now seen as a key voice at the table."* **– Dr Amanda Stafford, Clinical Lead, RPH Homeless Team**

This cross-sectional involvement is vital to meeting the needs of people experiencing homelessness, as social determinants of health (such as socioeconomic status, living conditions, and lifestyle factors) are major drivers of poor health, but, as demonstrated through Maslow's Hierarchy of Needs, health often becomes secondary to more immediate needs such as lack of shelter. So, purely "health focused" or purely "housing focused" approaches have, and will be, ineffective on their own in improving the health and reducing hospital usage of people experiencing homelessness.

The recently released Department of Health research summary *Integrated primary health care for adults who have experienced homelessness*[71] notes that coordinating critical elements of homeless health responses and alignment and coordination of services and funders to avoid duplication are critical factors to support the health of people experiencing homelessness.

The contribution of the Homeless Team to addressing homelessness in WA was recently recognised when the Clinical Lead, Dr Amanda Stafford, was jointly awarded the Shelter WA Sector Advocate Award, 2023. This Award recognises "*an individual who has been a strong voice on homelessness and community housing issues in WA. Someone who has made an extraordinary contribution of time, leadership and resources to positively impact and bring homelessness and community housing issues to the forefront, with a strong push for solutions and investment.*"

Image 12: Dr Stafford Receiving Award

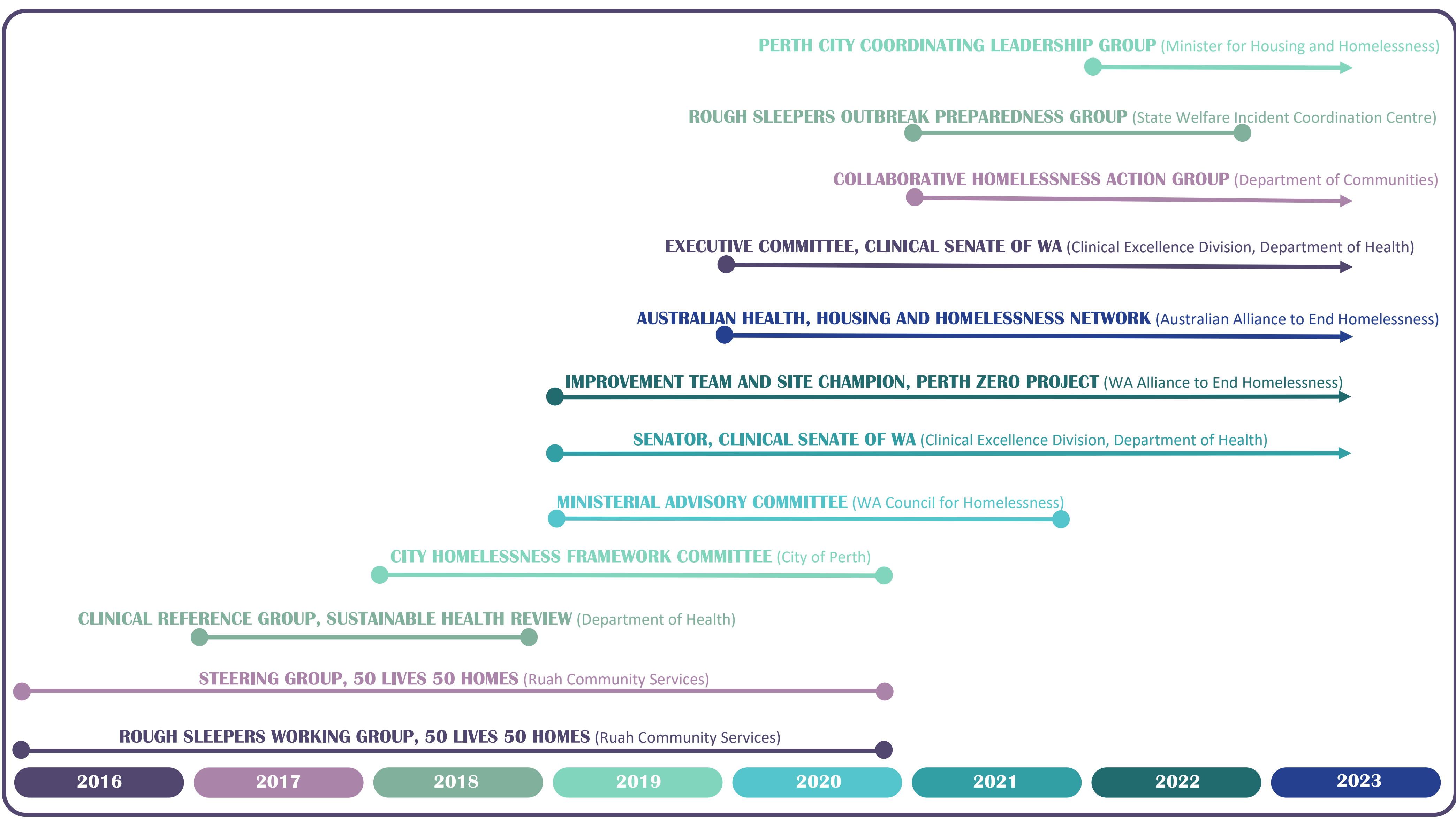


Figure 55: Timeline of Advisory Group and Committee Involvement

7.3 POLICY TRACTION

Since its establishment, the Homeless Team has been explicitly referenced in a number of significant national and State policy documents and strategies. This includes three policies, papers & strategy mentions at a federal level, four at a state level and two other governmental report mentions or recommendations (Table 24). These references reflect how the Team, its model of care and its impact for people experiencing homelessness have contributed to positive homeless health outcomes, policy change and advocacy of its model both nationally and internationally.

Table 24: Policy Traction, Papers, and Strategy Mentions of the RPH Homeless Team

Federal Policy Traction, Papers, and Strategy Mentions of the Homeless Team
• **Productivity Commission.** *Innovations in Care for Chronic Health Conditions* (2021) - Case study highlighting the importance of the Homeless Team in supporting those experiencing homelessness to decrease inpatient and ED admissions.[49] • **Productivity Commission.** *Implementing innovation across the health system. Information Paper* (2021) - Case study regarding the Homeless Team's composition of staff (GP's, hospital doctors, practice nurses and case workers) and benefits of the team's experience. Key recommendations also referred to the Homeless Team model and potential extension of this model to other large public acute hospitals.[72] • **Productivity Commission.** *Inquiry Report - Mental Health* (2020) - Used as an exemplar hospital program that avoids discharging patients into homelessness through extensive staff training and procedures.[73]
State Policy Traction, Papers, and Strategy Mentions of the Homeless Team
• **Parliament of WA.** Inquiry into the financial administration of homelessness services in WA. (2021-2023) - a submission made by EMHS[74] refers proudly to the work of the RPH Homless Team and notes that innovative programs to address the health of people experiencing homelessness are cost effective alternatives to acute hospital care, and can assist with breaking the cycle of chronic homelessness. Other Inquiry submissions made by Homeless Healthcare, the UNDA Home2Health Research Team and the Australian Alliance to End Homelessness also cite the the importance of the Homeless Team's work and its impact on reducing discharges into homelessness. There are several references to the Homeless Team in the final report of the Inquiry released in June 2023.[75] • **WA Department of Health.** Sustainable Health Review (2019) - The Sustainable Health Review discussed the partnership between HHC, the Homeless Team, and the Home2Health research team, and referenced the combined impact on reducing hospital use and creating a more cost-effective health system.[40] • **WA Department of Communities.** All Paths Lead to a Home (2020) - Report highlighted the collaboration between HHC and the RPH Homeless Team, referred to key RPH Homeless Team statistics, and provided an overview of the team support it provides to patients.[76] • **Parliament of Victoria.** Homelessness in Victoria. Orygen Submission (2020) - The Homeless Team was mentioned as an exemplary transition program for mental health care of persons experiencing homelessness.[77]
Other Policy Traction, Report Mentions and Recommendations of the Homeless Team
• **Consumers of Mental Health WA.** Alternatives to Emergency Departments Project Report (2019) - A sub-chapter in the report that outlined the Homeless Team service, how the team links to other services, and final evaluation outcomes of Homeless Team in the first 3 years of operation.[78] • **AHURI.** Trajectories between mental health & housing pathways. Policy priorities (2021) - The Homeless Team is mentioned as case study of a service that improves transitions out of institutional care, with reference to the Homeless Team model of care, as well as hospitalisation and homeless health improvements since conception.[79]

7.4 DISSEMINATION LEARNINGS & OUTCOMES

Beyond the dissemination of the Homeless Team model and is impact in formal policies and reports, there is a proactive commitment to sharing information about the model of care, evaluation findings and potential implications for other service providers and settings. This is undertaken both directly by Homeless Team staff and indirectly through its evaluation and service delivery partners, namely Home2Health, based at UNDA, and HHC.

Dissemination outputs related to the activity of the Homeless Team include the following, further details of which are provided in Appendix D:

- **Peer-reviewed journal articles** on the work of the Homeless Team, its impact or wider learnings about homelessness and health,
- **Invited presentations and conferences** and in WA, nationally and international,
- **Media mentions** of the Team or quoting the Clinical Lead on homelessness issues, and
- **Participation in forums** on health and homelessness in WA and nationally.

7 **PUBLISHED JOURNAL ARTICLES**
(on the work of the Homeless Team, its impact on health and homelessness more broadly)

28 **CONFERENCE & INVITED PRESENTATIONS**
(WA, national, and international)

10 **MEDIA MENTIONS & OUTPUTS**
(including radio, newspapers, and podcasts)

Image 13: Dr Jim O'Connell from the Boston Health Care for the Homeless Program with Home2Health Researchers Lisa Wood & Shannen Vallesi

"The RPH Homeless Team has a strong backbone of data and evaluation research which has led to significant contributions to the development of an Australian evidence base around the best-practise provision of healthcare for people who are homeless. Moreover, its commitment to evaluation has generated concrete evidence on how the health system can save money and free up hospital beds when people experiencing homelessness receive trauma informed care and are connected to primary care and community health services and essentially, accommodation and housing. The willingness of the Homeless Team to share its experiences and learnings with other health professionals coupled with the dissemination of evidence through evaluation reports and papers has been invaluable to health services across Australia. The integrated model of care being implemented by the Homeless Team serves as a leading example to follow." – **Stephanie Macfarlane, former Homelessness Health Program Manager, SESLHD**

7.5 COLLABORATIVE INVOLVEMENT IN OTHER INITIATIVES

A variety of programs and initiatives have been associated with the Homeless Team over the years. A selection of these is shown in Figure 56. Each of these initiatives and the relevant involvement of the Homeless Team is described briefly throughout the subchapter.

PILOTS OF NEW SERVICES TO IMPROVE HEALTH OF PEOPLE EXPERIENCING HOMELESSNESS

The Medical Respite Centre (Oct 2021 – present)

- Australia's first fully medical (24/7) residential service for PEH discharged from hospital

Stay Witch's Non-medical Respite (April 2021 – April 2023)

- Provides 10 non-medical beds where residents can stay for a period of up to 14 days

Homeless Discharge Facilitation Fund Project (Jul 2018 - Jul 2022)

- Provided discharge facilitation funds to each of the participating hospitals to support safe discharge and reduce discharges to homelessness

Mental Health Homeless Pathways (May 2019 – Oct 2022)

- Provides discharge planning advice and intervention for multiple long stay complex PEH patients

Homeless Outreach Dual Diagnosis Service (Feb 2019 – Feb 2020)

- Outreach service for PEH in Perth who have a dual diagnosis of mental health and alcohol and other drug issues

HEALTH SECTOR WIDE RESPONSES TO PRIORITY ISSUES

- Support for PEH during the COVID-19 pandemic
- Expanded Syphilis testing program

HOMELESSNESS SECTOR NEW INITIATIVES

Safe Night Space for women

- A place for women to rest, access basic facilities, seek support and connect to other services in a safe and secure environment at night

Figure 56: Programs and Initiatives that have been Associated with the RPH Homeless Team

Note: **PEH=** people experiencing homelessness.

7.5.1 THE MEDICAL RESPITE CENTRE

The MRC is Australia's first medical respite care service for people experiencing homelessness who are being discharged from hospital. It provides medically supported, short-term accommodation, allowing individuals the opportunity to rest and recover in a safe and therapeutic environment following hospital discharge, whilst linking them to community health, social and support services and housing/accommodation. The MRC was established as a recommendation of the WA Sustainable Health Review and commenced operation in inner city North Perth on 25 October 2021 as an initial two-year pilot that has since received an additional year of funding. The MRC is a collaboration between HHC and Uniting WA, with the Homeless Team being an integral part of the patient referral pathway in the original tender for the MRC. However, it is available to all public hospital patients.

The reasonably **close proximity of the MRC to RPH** has proven valuable because many of the MRC referrals and transported patients come from RPH, and because some HHC GPs and nurses provide primary care-led in-reach in RPH under the Homeless Team. This enhances synergies between the respective roles of the Homeless Team and the MRC, particularly in relation to homeless patients at RPH being discharged to the MRC or needing to return to hospital when their health deteriorates.

> *"The MRC has completed a circle of medical care for hospitalised rough sleepers at RPH. Now, the Homeless Team can refer patients requiring ongoing medical treatment to the MRC as a safe alternative to a prolonged hospital stay or complex outpatient follow up that is unlikely to succeed if the patient is discharged to the streets. The MRC's holistic care, encompassing medical, psychological and social supports can keep marginalised and disengaged rough sleepers under care for long enough to heal wounds and diseases and make progress on solving their homelessness. It can be an important circuit breaker in a life lived between the streets, hospital and prison."* **– Dr Amanda Stafford, Clinical Lead, RPH Homeless Team**

"One benefit of having several of our nurses work across both the MRC and the Homeless Team is that, when we see a patient in RPH and refer them to the MRC, we get to explain the service to them and reassure them that when they come across to the MRC, they are already familiar with Homeless Healthcare, and can appreciate seeing a familiar face." – **HHC Nurse**

Box 11 provides an example of how a combination of stays at the MRC resulted in an individual stabilising their situation and breaking a years-long spiral of homelessness, alcohol dependence and increasingly fragile health.

Box 11: Impact of Homeless Team Referral to MRC on Patient Outcomes

Background: *"Justin"* is a male in his mid-forties who has been homeless for over 10 years. His two-decade history of alcohol dependence had contributed to an increasing trajectory of hospital use. Whilst expressing motivation to change his alcohol use behaviour for years, he had been unable to do so while on the street, with relapses frequently triggered by relationship breakdowns and a lack of social support. While sleeping rough, he struggled to adhere to medication and treatment regimens for his diabetes, liver cirrhosis, Hep C and foot ulcers resulting in deterioration of his overall health.

Hospital Use: Over a four-year period since 2018, Justin had 24 ED presentations and 79 inpatient days, equivalent to an approximately cost to the health system of >$240,000.

Support Provided: Justin was first seen by the Homeless Team in mid-2018. However, over the next four years and seven episodes of support at RPH, the Team struggled to find suitable stabilising accommodation due to his active alcohol use; unfortunately an all-too-common scenario that prohibits individuals from getting off the streets.

The opening of the MRC provided an opportunity to break this cycle. In late 2021, Justin entered the MRC after a five-day hospital stay. During his month at the MRC, Justin received nursing and GP care to heal his chronic foot ulcers, stabilise his diabetes, and commence treatment for Hep C. He was also supported to attend 5 important outpatient appointments at RPH. He was also supported to address his alcohol use and recovery goals, and linked with community AOD services. Justin was discharged to supported transitional accommodation. This lasted for three months before he relapsed into heavy alcohol use, resulting in a 17-day hospital admission with severe intestinal bleeding due to his liver disease. Again, he was discharged to the MRC and stayed for 6 weeks to regain his health and await a place in a residential rehabilitation program. During the ensuing 8 months, he had no ED presentations or inpatient admissions and attended 14 outpatient appointments. Unfortunately, he did not complete the residential treatment and had a further alcohol use relapse in February 2023. This required a 16-day hospital admission to stabilise his chronic, deteriorating health. Once again, he was discharged to the MRC for a three-week period before being supported to return to residential rehabilitation.

Current Situation: Since the most recent period of residential rehabilitation, Justin has been housed and has maintained a long period of abstinence from alcohol use. This has meant that for the last 4 months, he has had no ED presentations but has had 3 elective procedures for routine care and to prevent further deterioration of his health. He has completed treatment for hepatitis B and C and his liver condition has stabilised. The downward spiral of homelessness, alcohol dependence and increasingly fragile health has been halted by the availability of the MRC, a stable environment in which truly holistic care can be delivered in a patient-centred and cost-effective way.

Notes: Estimated costs based on figures listed in Table 2.

The year one MRC evaluation showed that 55% of all referrals and 64% of all hospital referrals to the MRC in its first year of operation were from RPH,[80] and noted the benefits for RPH patients of the existing relationship between the Homeless Team and HHC, and the fact that some HHC staff work across the hospital and the MRC.

"Often homeless patients seen at RPH are already known to HHC and have previously seen HHC doctors or nurses at some of the drop-in centre clinics or on street health, or on HHC ward rounds at RPH. Being able to say that the MRC is run by HHC staff is helpful as it makes it less daunting for patients to go there..." – **Dr Amanda Stafford, Clinical Lead, RPH Homeless Team**

The way in which RPH and the Homeless Team facilitate referrals to the MRC has also been mentioned by patients:

> *"Yeah. I was at the hospital, RPH. They're the ones who got me moved to here. The social workers, yeah, and the hospital mob, the homeless team. If it wasn't for them, I would be probably back on the streets"* – **Patient Supported by the Homeless Team**

7.5.1.1 Impact of the MRC on the Homeless Team

When the MRC opened in October 2021, it was unclear to what extent this would impact on the role of the Homeless Team, and there was some speculation as to whether it would eventually reduce the number of people experiencing homelessness being seen at RPH. However, this has not been observed to be the case. In November 2022, for example, one year on from the opening of the MRC, the Homeless Team saw a total of 95 unique patients and provided 159 episodes of care, with only 12% of patients supported (13 people) being referred to the MRC. Further, the overall activity of the Homeless Team remained approximately the same between November 2021 (99 unique patients seen, 150 total consultations) and November 2022.

These figures demonstrate that most patients seen by the Homeless Team are not referred to the MRC. Reasons for this include patients' medical needs not being of high enough acuity to satisfy the MRC admission requirements and a lack of available beds at the MRC at a given point in time, among others. They reflect the fact that the MRC is a suitable discharge destination only for a small proportion of Homeless Team patients, as its designated purpose is post-hospital nursing and medical care and not purely accommodation for people experiencing homelessness. The bed availability of the MRC particularly is a challenge; currently, the 20 MRC beds have an expected length of stay of 14 days, and at the time of writing of this report the MRC had remained at near capacity for several months, meaning that it was not necessarily a potential discharge destination for patients seen by the Homeless Team, even if they met the admission requirements. By contrast, the Homeless Team's work involves assessing and referring patients who are potentially candidates for MRC admission but also its primary workload of providing alternative supports and attempting to source appropriate accommodation for most patients it sees, who do not meet the MRC admission criteria.

7.5.2 STAYWITCH'S NON-MEDICAL RESPITE

StayWitch's commenced in April 2021 at the former backpacker hostel that now is known as the MRC. StayWitch's was instigated at a time during the COVID-19 pandemic when the dearth of accommodation options for homeless patients awaiting hospital discharge was worsening, and the Homeless Team and HHC shared concerns about the vulnerability of people living on the street amidst an infectious disease pandemic. HHC secured philanthropic funding to lease the premise and provide 10 non-medical respite beds for stays of up to two weeks for patients experiencing homelessness being discharged from hospital.

Image 14: StayWitch's Welcome Sign

The core aims of StayWitch's were to:

- Provide non-medical respite care for people experiencing or at risk of homelessness to recover and recuperate after hospital admissions,
- Enable support workers to connect people to housing, accommodation and community support, and
- Provide therapeutic activities to support people to develop skills for independent living and to transition out of homelessness.

Funding for a peer support and wellbeing program at StayWitch's was obtained by HHC via a successful grant application to Lotterywest.[81]

After the MRC opened at the same North Perth location in October 2021, the model of care was streamlined with all referrals to StayWitch's coming via the MRC and StayWitch's providing step-down support for MRC patients who were medically cleared. Due to an increase in referrals to the MRC and the need to prioritise all beds for patients with medical needs, there has been a reduction in StayWitch's capacity over the first half of 2023, ultimately leading to StayWitch's being paused towards mid-2023.

7.5.3 HOMELESS DISCHARGE FACILITATION FUND

The Homeless Discharge Facilitation Fund Project (HDFFP) is a multi-phase pilot project funded by the WA Chief Allied Health Office, which seeks to support the safe and appropriate discharge of patients experiencing homelessness from WA hospital settings. The HDFFP commenced in the winter of 2018, with both Phase 1 and Phase 2 of the pilot being undertaken with the Homeless Team and with a broad aim of reducing demand on the RPH ED between May and September 2018. Successful trials at RPH in 2018 and 2019 led to the significant expansion of the HDFFP in 2020 to a year-round initiative across a total of five metropolitan hospitals and one hospital from the WA Country Health Services.

While specific objectives of the HDFFP evolved over the course of the pilot phases (particularly due to the COVID-19 pandemic), a key element throughout the project has been the provision of a pool of brokerage funds at each hospital site which could be accessed to support safe discharge of patients experiencing homelessness, and to reduce discharges into homelessness. Brokerage funds are utilised at the discretion of ED staff and hospital social workers to provide accommodation, transport, and other incidental items of short-term support to facilitate appropriate discharge of patients experiencing homelessness. The ability to discharge patients into accommodation can act as a critical circuit breaker to recurrent ED hospital attendance, and provides an important stepping stone between hospital discharge and connection to longer-term support services and accommodation.

Across the four phases of the project (2018-2021), the Homeless Team and ED staff provided 689 instances of support through the brokerage funding to patients experiencing homelessness (Table 25). In 2021, this included 541 nights worth of accommodation to 127 patients. As RPH sees most ED homeless presentations in Perth, this was reflected in the overwhelming utilisation of brokerage funds at RPH compared to other hospital sites throughout Perth and regional WA, with approximately 57% of all brokerage funds allocated to RPH (approximately $60,000). Following the conclusion of the fourth pilot phase, the WA Chief Allied Health Office agreed to maintain the HDFFP as an ongoing project, with further brokerage funding secured for RPH and other participating hospital sites.

Table 25: Instances & Types of Support of Patients by RPH through HDFFP Brokerage

Year	People	Instances	Accommodation		Travel		Other		Total
			$	%^	$	%^	$	%^	
2018	121	167	$33,885	94%	$1,353	4%	$763	2%	**$36,000**
2019	132	228	$31,489	86%	$5,231	14%	$69	0.2%	**$36,789**
2020	103	151	$40,521	96%	$1,388	3%	$320	1%	**$42,230**
2021	115	143	$37,335	90%	$3,723	9%	$576	1%	**$41,634**
Total	**471**	**689**	**$143,230**		**$11,695**		**$1,728**		**$156,652**

Note: ^ % of total yearly expenditure

An example of the effective use of the brokerage funds is provided in the case study in Box 12, which describes how funds were used to secure short-term hostel accommodation for an individual who had experienced considerable trauma in her life. This support allowed the Homeless Team time to advocate on her behalf, ultimately leading to an offer for public housing.

Box 12: Brokerage Support to Break the Cycle of Long-Term Homelessness

Background: *"Carly"* is an Aboriginal woman in her early fifties who cycled between couch surfing and rough sleeping for several years. She has experienced considerable trauma in her life, including domestic violence and the death of two sons. Health issues include anxiety, PTSD, cancer, osteoarthritis and chronic back pain, methamphetamine use and alcohol dependence. When the COVID- 19 restrictions emerged in April 2020, Carly grew extremely anxious about being on the street and becoming unwell.

Support Provided Following repeated presentation to the RPH ED for suicide ideation in October 2020, the Homeless Team utilised brokerage funds to secure Carly short-term hostel accommodation and worked alongside Daydawn Advocacy Centre to proactively support and advocate for Carly to secure safe and stable housing. The Homeless Team wrote letters in support of her urgent need for housing, and following substantial media coverage of Carly's situation, an offer for public housing was provided. As the accommodation was not immediately available, brokerage funds were again used to extend Carly's hostel stay for another week until she could be supported into her new home.

Current Situation: Carly has maintained her housing since the end of October 2020, and has ceased using meth, saying she *"no longer needs it"* now that she is safely housed. With the stability of being housed, Carly has been able to address her other chronic health issues, receiving regular GP and case worker home visits from HHC, and treatment for her back pain. Additionally, the Homeless Team arranged transport for her to go to hospital for an endoscopy – something that she had been unable to attend whilst rough sleeping, and Carly is committed to further reducing her alcohol use. Carly also now receives NDIS support, which has also allowed her to address many of her mental health issues, including counselling for her PTSD and trauma. Collaboration between the Homeless Team, HHC, and Daydawn Advocacy greatly enhanced the continuity of care and long-term support for Carly.

7.5.4 MENTAL HEALTH HOMELESS PATHWAYS

In early 2019, the Mental Health Homeless Pathway (MHHP) program was established after it was observed that 30% of mental health beds across the RPBG were occupied by people experiencing homelessness, and that longer lengths of stay were significantly associated with inpatients having nowhere safe to be discharged to.

The MHHP aimed to improve Royal Perth Bentley Hospital Group (RPBG) services for patients with mental health conditions experiencing homelessness by exiting long-term mental health inpatients into housing and connecting them with the required support services. The program was coordinated by a senior social worker with extensive experience across the homelessness sector. The recovery-orientated program:

- **supported patients directly,** including through active identification of patients who are homeless and their support needs, providing discharge planning advice, and connecting people to housing services and community support,
- **facilitated community follow up and advocacy,** including through advocating for people to be prioritised for public housing, advocating for community case workers and support services to assist people to maintain their housing, liaising with community mental health teams and other non-hospital-based health services to support people to address health and psychosocial issues once stably housed, and
- **provided capacity-building** and educational activities for staff across the RPBG service to improve awareness and the identification of patients experiencing homelessness.

The Clinical Lead of the Homeless Team was closely involved in the development of the MHHP and sat on its steering group. Additionally, the links with the Homeless team helped to facilitate the reach of the MHHP to support homeless patients admitted to inpatient wards at RPH, and in many instances, the Homeless Team had had prior contact with patients who ended up as longer stay inpatients at Bentley hospital. The MHHP was recently a finalist in the WA Mental Health Awards 2020 Innovation for Change and highly commended in the national Australian Council of Healthcare Standards Awards

for Non-Clinical Service Delivery 2020. In its approximately two years of operation, 40 people were housed into permanent homes. An independent evaluation found that for the 23 individuals that had been housed for over a year, when comparing their hospital use one-year prior to housing to one-year accommodated, there was a $35.8 million reduction in associated healthcare costs.[82] The MHHP program highlighted that long-term mental health inpatient service users can indeed live without 24/7 care when their basic needs of a safe place to live, appropriate community support, and mental health services are met.

Unfortunately, the MHHP was not continued beyond October 2022. However, its effectiveness was showcased in the recent report on the findings of the **WA Inquiry into the funding of homelessness services**,[75] with **Recommendation 46** of the report being that:

> *"The Western Australian government fund the continuation of the Mental Health Homeless Pathways Project or a similar program."[75]*

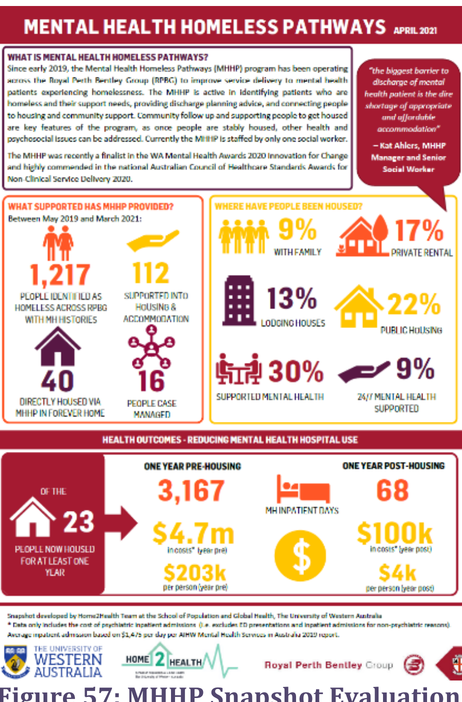


Figure 57: MHHP Snapshot Evaluation

7.5.5 HOMELESS OUTREACH DUAL DIAGNOSIS SERVICE

The Homeless Outreach Dual Diagnosis Service (HODDS) was an innovative dual diagnosis service that provided outreach psychiatric care to patients experiencing homelessness who had dual AOD and mental health issues. HODDS was a pilot project, funded by a Department of Health RTP grant awarded to HHC, and ran from February 2019 to March 2020. The HODDS team comprised a mental health- and AOD-trained doctor (dual diagnosis doctor) and nurse, who worked alongside HHC GPs and nurses. Prior to the HODDS pilot, there was a clear gap in specialist mental health care for homeless patients with a dual diagnosis of mental health and AOD issues; HHC estimated that only 15% of their patients with severe mental health illnesses were receiving any form of specialist mental health care, and that this rate is lower for patients with dual diagnosis. As noted previously there is considerable overlap between the Homeless Team and HHC patient cohorts and, in addition to specialist mental health care the HODDS team provided directly to patients during the pilot, having a psychiatrist working within HHC helped to facilitate improved access for Homeless Team and HHC patients to specialist mental health care.[83]

In total, 122 people were supported by the HODDS pilot. Support included trust and rapport building, clinical assessments, developing care/ treatment plans, advocacy to access housing, linkage with other community and health services and, for some patients where needed, facilitating access to mental health inpatient care or AOD detoxification or rehabilitation. An evaluation of the HODDS pilot by the Home2Health Team found that there was a 27% reduction in emergency department presentations and 7% reduction in inpatient admissions when hospital use was compared in the year before HODDS engagement compared to the year after HODDS support.[84]

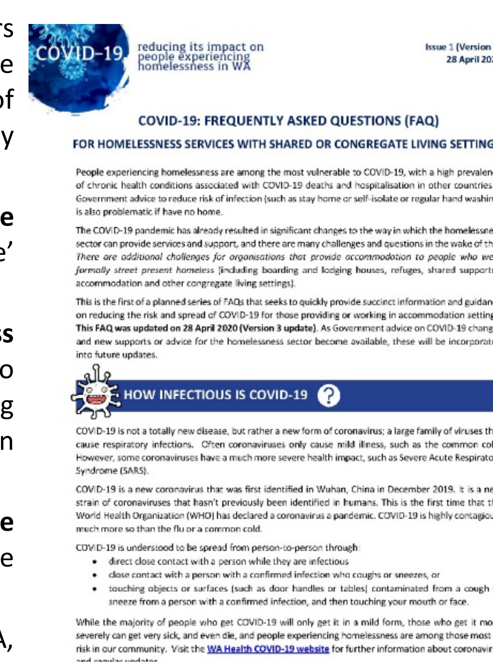
Unfortunately, the HODDS only had one year of funding, and HHC has not been able to secure funding to continue it, despite frequent requests from the homelessness sector for it to resume. As noted by Dr Amanda Stafford, Clinical Lead of the Homeless Team:

> *"The HODDS pilot filled a vital gap in services for homeless patients whose combined mental health and substance use problems see them rejected by mainstream specialist services as too complex or not within their narrow scope. For some patients, it is the first time they have received regular, dependable mental health care that is responsive to the complexity of dual diagnosis and the tangled web of social determinants of health that accompany homelessness."*
> **– Dr Amanda Stafford, Clinical Lead, RPH Homeless Team, November 2021**

7.5.6 COVID ADVOCACY AND SUPPORT

The vulnerability of people experiencing homelessness to COVID-19 is amplified because of the prevalence of co-morbidities, the absence of a home in which to 'stay home', and barriers to vaccination.[85] The Homeless Team and HHC thus quickly became highly involved in initiatives to support people experiencing homelessness during the peak of the COVID-19 pandemic, including:

- **Participation on advisory groups**, Rough Sleepers Outbreak Preparedness Group - State Welfare Incident Coordination Centre, Department of Communities Rough sleeper vaccination strategy group (formed Jan 2022),
- **Advocating for, sourcing, and coordinating discharge accommodation** for patients during the 'stay home' and lock down periods,
- **Encouraging vaccination uptake among homeless patients** seen by the team, and supporting others to address barriers to vaccination access - organising and encouraging maximum uptake of vaccination in homeless patients at RPH,
- **Providing input to COVID-19 resources for the homeless sector** developed by Home2Health (Figure 58), and
- **Responding to queries** from Shelter WA, Government and others regarding how to support people experiencing homelessness during the pandemic, e.g., asked to provide advice from a health perspective to the Department of Communities on appropriate accommodation options for people who are homeless to self-isolate to if required.



COVID-19 reducing its impact on people experiencing homelessness in WA

Issue 1 (Version 3)
28 April 2020

COVID-19: FREQUENTLY ASKED QUESTIONS (FAQ)

FOR HOMELESSNESS SERVICES WITH SHARED OR CONGREGATE LIVING SETTINGS

People experiencing homelessness are among the most vulnerable to COVID-19, with a high prevalence of chronic health conditions associated with COVID-19 deaths and hospitalisation in other countries 1. Government advice to reduce risk of infection (such as stay home or self-isolate or regular hand washing) is also problematic if have no home.

The COVID-19 pandemic has already resulted in significant changes to the way in which the homelessness sector can provide services and support, and there are many challenges and questions in the wake of this. *There are additional challenges for organisations that provide accommodation to people who were formally street present homeless* (including boarding and lodging houses, refuges, shared supported accommodation and other congregate living settings).

This is the first of a planned series of FAQs that seeks to quickly provide succinct information and guidance on reducing the risk and spread of COVID-19 for those providing or working in accommodation settings. **This FAQ was updated on 28 April 2020 (Version 3 update).** As Government advice on COVID-19 changes and new supports or advice for the homelessness sector become available, these will be incorporated into future updates.

HOW INFECTIOUS IS COVID-19 ?

COVID-19 is not a totally new disease, but rather a new form of coronavirus; a large family of viruses that cause respiratory infections. Often coronaviruses only cause mild illness, such as the common cold. However, some coronaviruses have a much more severe health impact, such as Severe Acute Respiratory Syndrome (SARS).

COVID-19 is a new coronavirus that was first identified in Wuhan, China in December 2019. It is a new strain of coronaviruses that hasn't previously been identified in humans. This is the first time that the World Health Organization (WHO) has declared a coronavirus a pandemic. COVID-19 is highly contagious, much more so than the flu or a common cold.

COVID-19 is understood to be spread from person-to-person through:

- direct close contact with a person while they are infectious
- close contact with a person with a confirmed infection who coughs or sneezes, or
- touching objects or surfaces (such as door handles or tables) contaminated from a cough or sneeze from a person with a confirmed infection, and then touching your mouth or face.

While the majority of people who get COVID-19 will only get it in a mild form, those who get it more severely can get very sick, and even die, and people experiencing homelessness are among those most at risk in our community. Visit the WA Health COVID-19 website for further information about coronavirus and regular updates.

HOME 2 HEALTH
HOMELESS HEALTHCARE
shelterwa

Figure 58: Example of COVID-19 FAQ Document Developed by Home2Health

The Homeless Team and HHC continue to advocate for and support low barrier COVID-19 vaccination access for people experiencing homelessness in Perth.

7.5.7 SYPHILIS TESTING

Since mid-2014, growing rates of infectious syphilis have been observed throughout WA, with related outbreak clusters moving through the Kimberly, Pilbara, and Goldfields regions.[86] By mid-2020, this outbreak reached the Perth metropolitan area, with an increasing number of infections observed amongst a diverse collection of vulnerable population groups.[86] Consequently, the WA Chief Health Officer declared a state-wide public health response was necessary to combat the concerning rise in infectious syphilis cases, particularly amongst people experiencing homelessness, Indigenous Australians, Culturally and Linguistically Diverse communities, women of childbearing age, injecting drug users, and men who have sex with men.[87]

In response to the outbreak, a syphilis screening program for people experiencing homelessness was instigated in the RPH ED. This initiative arose from two events in 2020:

- **The unexpected stillborn birth of a baby with congenital syphilis in the RPH ED.** The baby's mother was a homeless woman who had minimal antenatal care and became infected with syphilis during her pregnancy. The diagnosis was only made by coronial investigators when microscopy of the placenta showed infection with the characteristic spirochete bacteria. The birth of a syphilis infected baby is a sentinel health event in WA Health, indicating a failure of the health system and requiring a root cause analysis.

- WA Health's Metropolitan Communicable Disease Control (MCDC) division **declaring a public health emergency:** an outbreak of syphilis in Perth in the local rough sleeping population.

Between January 2019 and October 2020, there were 34 cases of infectious syphilis reported amongst people experiencing homelessness in the Perth metropolitan area, compared to just six in the previous four years.[86]

The target group of rough sleepers posed challenges for syphilis screening, treating and contact tracing due to social instability, day to day survival focus and common distrust of mainstream services. Therefore, the MCDC sought collaborations with medical services providing healthcare to Perth's rough sleeping population, including HHC and the local Aboriginal Medical Health Service, Derbarl Yerrigan. The RPH ED also became a focal point for screening and treatment due to the frequency of presentations by people experiencing homelessness. The Homeless Team's Clinical Lead was well placed to assist due to already working part-time in the RPH ED as an Emergency Specialist.

This led to initiation of the RPH ED Syphilis Screening Program for rough sleepers in June 2020. This was a program of syphilis screening and opportunistic treatment, targeting homeless individuals presenting to RPH ED with any type of health issue, not just those that were STI-related. The Clinical Lead of the Homeless Team initiated and managed the program. Key aspects of the program were:

- Education of senior ED medical staff (Registrars and Consultants) on the importance of syphilis screening and treatment, based around the case of the stillborn baby born at RPH ED. This included discussion around how to ask for consent to screen, using concerns around the effects of syphilis in pregnancy.
- Education around screening (serology) and treatment protocols for syphilis and ensuring that the treatment antibiotic, benzathine penicillin was stocked in the ED Pharmacy to allow easy, opportunistic treatment.
- Incentivising staff to add syphilis screening (with patient consent) and opportunistic treatment into their routine care of rough sleeping ED patients (see box). Staff were required to report testing/treatments undertaken to the Clinical Lead, who then conveyed these to the MCDC-led collaborative working group.
- Infected or high-risk individuals had RPH ED management plans at ED Triage to flag their outstanding needs, e.g., serology or treatment if they presented to RPH ED.
- Participation in a multi-agency Homeless Syphilis Collaboration including homelessness primary care services, WA Health Public Health and CDC divisions and the RPH Sexual Health Clinic.

Program of incentives for RPH staff to incorporate syphilis screening and treatment into routine care:

"This was done via a program of small culinary rewards, for five screen serology tests, any positive serology or any syphilis treatment carried out in ED." ***– Dr Amanda Stafford, Clinical Lead, RPH Homeless Team***

The program was most active for 18 months between mid-2020 and late-2021, during which time over 100 serology tests were performed. In the first three months it detected 13 cases of syphilis, over half of which were treated at RPH. The remaining cases were treated by other agencies.

It is pertinent to note that negative serology tests are also an important contribution to reducing syphilis in the rough sleeping population, as if a syphilis-infected individual has a negative syphilis serology within the previous two years a single intramuscular injection of benzathine penicillin suffices for cure. Without this, the duration of syphilis infection is not reliably known and a course of three doses of intramuscular benzathine penicillin given at weekly intervals is needed. The experience of the RPH ED Syphilis Screening Program was that administering a three-dose regime of spaced treatments was rarely achieved in the rough sleeping population.

In summary, the RPH ED was able to integrate a significant public health response into a busy ED to assist in treating an outbreak of syphilis in the rough sleeping population. This was achieved with education and incentivisation within the busy ED environment.

7.5.8 WOMEN'S SAFE NIGHT SPACE IN CBD

The extreme vulnerability of women who are rough sleeping has long been recognised by community homelessness services and the Homeless Team, and observed to be on the rise over the last 4-5 years. In the 2019 Homeless Team evaluation report,[4] women accounted for 30% of total rough sleepers, but this has increased to 40% in 2023. This increase is largely due to increased numbers of aboriginal women, who now make up 48% of female rough sleepers (BNL 16/8/2023), coupled with the lack of suitable accommodation and housing options.

Whilst permanent safe housing is the ultimate aim, this female cohort is extremely vulnerable to physical and sexual violence on the streets, the most dangerous time being at night. Most state-funded accommodation services for women are principally aimed at women with children who are escaping FDV. However, the Homeless Team has consistently observed that many of the female rough sleepers presenting to RPH are single women who either don't have children or whose children have been removed from them. The overwhelming demand in Perth for refuge places for women impacted by FDV unfortunately means there have been no viable options for other women rough sleeping. Mixed gender crisis or short stay accommodation options are limited in Perth generally but are also not applicable for women who have suffered gendered violence (child sexual abuse, sexual assault, FDV) and/or who only feel safe in female-only accommodation.

In 2019 the City of Perth council instigated a City Homeless Framework Committee, to work on Perth CBD homelessness issues, particularly aimed at reducing rough sleeping. The Homeless Team Clinical Lead, Dr Amanda Stafford was a founding member of this Committee. In response to concerns about the lack of options for women sleeping rough in inner city Perth, the City of Perth opened a 30 place Women's Safe Night Space (WSNS) in May 2021, in an underused community centre in East Perth, close to RPH. It opens every night, 7pm to 7am, with support worker staff from a local homelessness organisation. Intake requests opens at 7pm and entry into the WSNS is possible up to 11pm. The facility provides a place for women to rest and sleep, basic facilities such as showers and toilets and a place to seek support and connect to other services in a safe and secure environment overnight. There are 5 emergency places available each night for referral from police, ambulance and hospital services up to 11pm and 5 places for "walk-in" women. The facility allows 10-night stays with renewal possible after a 2 night break.

RPH refers women regularly to the WSNS, either by the RPH evening Social Worker or ED staff. Because WSNS intake opens at 7pm, it is rarely the Homeless Team that directly refers women to it, but the Team has helped raise awareness of this option within RPH. As awareness of the WSNS has grown in the homeless community, women sleeping rough have increasingly self-referred.

Data from the City of Perth indicates that, in its first 22 months of operation, the WSNS sheltered 709 individuals for a cumulative 7,966 instances of support.[88]

Unfortunately, however, the WSNS does not currently have a venue secured beyond November 2023, and will be imminently closing, leaving a concerning void in crisis accommodation options for these vulnerable women. This remains a deep concern to the Homeless Team as at the time of publishing of this evaluation report.

7.6 WIDER INTEREST IN THE HOMELESS TEAM MODEL

While there are a small but evolving number of other hospitals in Australia that have initiated some kind of targeted support or intervention for patients experiencing homelessness, the Homeless Team remains the only team of its kind that is hospital led but integrates specialist homelessness primary care in-reach and has embedded case workers with homelessness sector expertise. By contrast, in the UK there are now 14 public hospitals with variations of a Pathway homeless team.[89] The role of the Homeless Team in building evidence for the model has been recognised internationally:

> *"The RPH Homeless Team combines the best elements of Pathway Homeless Teams established in UK hospitals and ongoing research has supported the GP and primary care nurse in-reach and a consultant team clinical lead with homeless health experience embedded within the hospital itself. Having an internal hospital advocate for homeless patients who is also familiar with hospital policies, services and staff is necessary, and something that must be in place along with wider hospital buy in."* **– Dr Zana Khan, Specialist GP in Homeless and Inclusion Health**

From our team's work with many health and homeless services across Australia and from feedback through the Australian Health, Housing and Homelessness network and references to the Team in a number of key reports, it's clear that it's seen as a best practice exemplar.

Interest in the homeless team model, including potential adaption of the model in other settings or use of its learnings, has been demonstrated through:

A list of the specific visits to the RPH Team and feedback quotes can be found in Appendix E.

> *"It was a privilege to spend a day with the wonderful RPH Homeless Team and to see how it goes about identifying & supporting homeless patients in the hospital, and then connecting them to accommodation, GP care & other supports in the community. I would love to have a team like this in the NHS hospital I am based at in London. I also spent time with the Homeless Healthcare street health outreach team and visited the Hub and Medical Respite Centre – such dedicated people working in all these areas. I could also see firsthand the enormous benefits of having HHC staff working across all these settings - having a familiar face is so important* for trust building with people who have often felt let down by the health or social systems" – **Dr Agnies Zurakowska, A&E Doctor, NHS**

8 THE CUMULATIVE COMPLEXITY OF HOMELESSNESS, ILLNESS, & SUPPORT ACCESS

8.1 PREFACE

As the Homeless Team has now been operating for just over seven years, this chapter has been led by the Clinical Lead of the RPH Homeless Team, Dr Amanda Stafford. In this chapter, she reflects on the raft of complex factors that block many people experiencing homelessness from moving off the streets, resulting in many such people remaining homeless for many years, and a consequential deterioration in health and reduced life expectancy.

> *"This reflective chapter discusses the most common barriers to rough sleepers obtaining and retaining stable accommodation, based on the experience gained through the work of the Homeless Team over the last seven years and in my 20 years as an ED Consultant in RPH, Perth's only inner-city hospital"*- **Dr Amanda Stafford, Clinical Lead, RPH Homeless Team**

8.2 INTRODUCTION

The most important intervention to improve the health of people sleeping rough is housing coupled with support. However, some factors markedly reduce an individual's chances of obtaining this, resulting in entrenched homelessness that further perpetuates their poor health. Paradoxically, the medical and social systems, which should be assisting this most marginalised population, can instead create barriers to better outcomes. With a scarcity of public and supported housing, the limited housing and support resources available in a community should, logically, be prioritised and allocated to those with the highest need. However, these individuals are often the most complex and hence deemed by some as "too hard" to house. This is akin to the concept of the inverse care law discussed in Chapter 1.2.2, whereby the populations with greatest need have less access to the timely health care.[37, p405] This paradox can only be addressed by programs that specifically target the highest complexity rough sleepers, using a true Housing First approach (Figure 59).

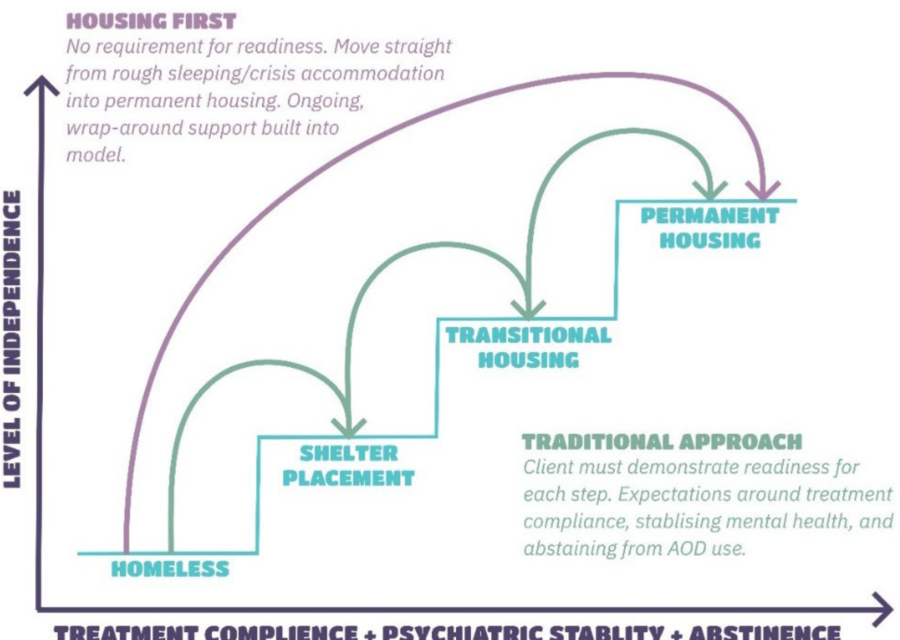


Figure 59: Housing First Vs. Traditional Stepped Housing Approach

Notes: **AOD=** alcohol and other drugs.

True Housing First in turn requires sufficient resourcing to provide rapid access to suitable long-term accommodation and comprehensive long-term supports.[90] Without this, rough sleepers in WA often can only exit homelessness by entering interim accommodation facilities such as crisis accommodation, transitional accommodation and budget hotels or hostels. Such accommodation typically has high-density occupancy and communal living facilities, and is hence often unsuitable for individuals with trauma and complex needs. Further, these accommodation services are rarely adequately funded or equipped to manage highly complex needs. This mismatch between client needs and service provider capacity often leads to high rates of evictions back to the street or to a series of placements in equally unsuitable short-term accommodation situations.

Among people with a prolonged experience of sleeping rough, there is rarely a single factor or barrier to accessing suitable housing or support. Rather, multiple health and psychosocial factors are typically at play, as depicted in Figure 60. These factors are multifaceted, and patients seen by the Homeless Team frequently fit into multiple categories of complexity, with each issue having a compounding negative affect on their ability to access suitable housing and support. Within the homeless population there are cohorts who have been further marginalised and systemically excluded (such as people exiting prison), and this is also depicted.

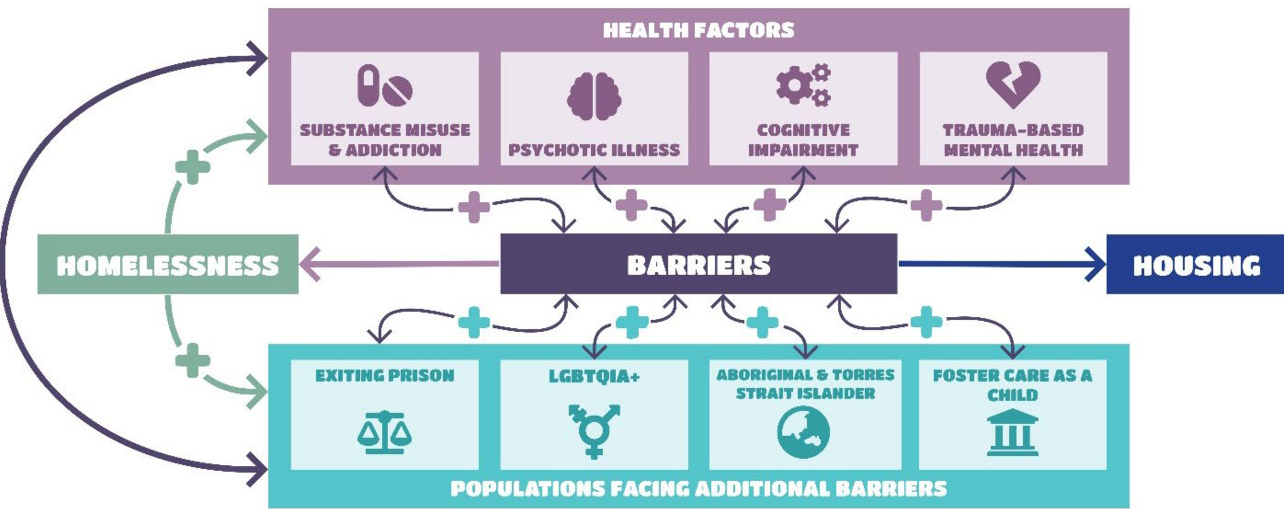


Figure 60: Health and Psychosocial Barriers to Exiting Homelessness

This cumulative disadvantage that entrenches prolonged homelessness is described extensively in the international literature on **multiple exclusion**.[91] When homelessness combines with factors such as substance use, experiences of trauma or institutional care (prisons, foster care, or mental health wards), the complex web of multiple and co-existing exclusionary factors is exposed. This serves to increase and entrench vulnerability and deep exclusion.[91] While each of these factors contributes, in some form, to the persistent barriers experienced by each patient, it is important to emphasise that many occur simultaneously in the most vulnerable cohort of patients who are sleeping rough. This chapter focuses primarily on the health factors.

The following subsections describe the four health-related factors I have primarily observed over the years to have the biggest impact on patients' ability to access and sustain housing:

- Active substance use,
- Trauma-based mental health conditions,
- Psychotic disorders, and
- Cognitive impairment.

8.3 ACTIVE SUBSTANCE USE

Homelessness combined with substance use problems signify deep social exclusion, and housing alone cannot tackle the reasons why some people are vulnerable to becoming and remaining homelessness.[92]

The active use of substances, primarily alcohol and methamphetamine, within WA's homeless population, is the **single biggest factor blocking or delaying access to accommodation.** This is because almost all accommodation facilities require residents to abstain from AOD use.

The major driver for AOD use in the homeless population is underlying mental health issues, usually based in traumatic experiences in childhood or adolescence. Substance use serves as self-medication for distressing symptoms in the absence of safety, social stability, support networks and mental health care. In the short term, the benefits of using substances can be substantial for people experiencing homelessness, rendering their current situation more bearable or enabling them to numb their traumatic experiences. Additionally, sedative drugs (e.g., alcohol) can assist with sleeping in uncomfortable or unsafe conditions, while stimulant medications (e.g., methamphetamine) allow people to stay awake during the unsafe, dark hours of the night when they are most vulnerable to assault and theft of possessions. However, this temporary relief comes with a heavy cost in that active substance use excludes rough sleepers from the vast majority of crisis and short- and medium-term accommodation because of strict *"no AOD"* rules.

There are good reasons that accommodation facilities mandate AOD rules, including protecting staff and other residents from unpredictable behaviour while individuals are intoxicated, injury from drug-related paraphernalia (e.g., needle-stick injury), fights over drugs and money, increased risk of theft, and the risk of turning the facility into an unsafe workplace that cannot attract or retain staff. Currently, the only homelessness facility in the Perth CBD with a *"managed drug use"* policy is Tom Fisher House, a 12-bed respite facility for rough sleepers with a seven day stay, open overnight from 6pm-8am. There, substance use is openly discussed and managed so that their rough sleeping clients can 'use' in a way that doesn't put others or themselves at risk during their stay. This contrasts to the UK, for example, where 'wet hostels' are common among the suite of accommodation options for people who are homeless.

Ideally, all rough sleepers in WA, with or without substance use issues, would be housed using a Housing First approach in which people are **rapidly housed in long-term housing with extensive supports provided, without preconditions** such as sobriety. However, with the current shortage of accommodation options in Perth, the most complex and vulnerable chronic rough sleepers tend to be excluded further. The longer people remain homeless, especially on the streets, the more entrenched their mental health and AOD issues become. This serves to further distance them from getting into stable housing unless a concentrated effort is made to house them under a Housing First approach in which safety and stability are provided first, to reduce stress levels and adverse social conditions. Once an individual is housed, their issues, such as AOD use and mental health, are worked on at a pace and in ways decided by the individuals themselves rather than in ways mandated by others. This may include ongoing AOD use, which is also something that is very common amongst people experiencing homelessness.

In response to this situation, a question often raised with me is, *"Why don't people simply enter AOD treatment and get sober so they can access accommodation.?"* This is the classic "Housing Ready" (vs Housing First) model that expects an individual to resolve their AOD or mental health issues while still experiencing homelessness. Not surprisingly, this approach has consistently shown low success rates for obtaining and retaining housing (e.g., 31% at 1 year[93]). Additionally, there are two major barriers to people sleeping rough accessing AOD treatment: the system itself, and dual diagnosis (the co-existence of AOD and mental health issues). These are described in Figure 61.

BARRIERS WITHIN THE AOD TREATMENT SYSTEM

Rehabilitation programs not operated on medical models

- Focus is often on creating therapeutic communities, counselling and recovery rather than medical evidence-based models of treatment.
- Tightly restricted medication use policies (including prescription medications), designed to "unmask" and explore the issues behind the substance use. This can conflict with the treatment of physical health conditions.
- In some residential services, limited staff with AOD or mental health qualifications equipped to manage severe distress and complex trauma.
- Little external oversight of these services regarding the quality, type, or success of their programs.

Demand of services leading to long wait times and exclusionary processes

- Demand outweighs capacity, with waitlists of 6-9 months common. This particularly disadvantages people sleeping rough, as they live unpredictable and chaotic lives and mostly fail to complete the long pre-entry process and they cannot afford to access privately operated services.
- 'success' KPIs can create a perverse incentive to select the least complex, most engaged clients.

The setting of AOD treatment services/facilities can be triggering

- Rehab facilities can remind people with complex trauma of time spent in institutions (e.g., state care, prison).
- Services with closed communal systems with multiple people simultaneously dealing various MH and AOD issues can impact on other clients, and communal bathrooms/shared bedrooms are particularly triggering for survivors of childhood sexual abuse.

Lack of medically supervised detox services

- Some substance withdrawal (e.g., alcohol and benzodiazepine) can be life threatening in severity, so medically supervised detoxification is strongly advised. Currently there are only two small, medicalised detox services available outside of hospitals (Next Step and the Medical Respite Centre)
- Thus, the majority of AOD detoxes in marginalised populations occur unplanned in prison or hospitals due to individuals being in these institutions and unable to use their substance of choice.

THE IMPACT OF CO-EXISTING AOD & MENTAL HEALTH ISSUES (DUAL DIAGNOSIS)

Siloed operation of AOD and MH services

- Many current services are focused primarily on AOD, despite the prevalence of dual diagnosis and most clients wanting integrated treatment and support.
- People with dual diagnosis are thus often required to engage with two separate services, with two separate eligibility requirements and processes to be followed before entry to either.

Dual diagnosis leads to a paradoxical exclusion from both systems

- MH services want people to be sober before evaluating their MH issues, believing that much of the MH problem will be resolved by abstinence from substances.
- AOD services want MH issues addressed prior to AOD treatment because they believe that the AOD problems would be more easily addressed if the MH issues were treated.
- People experiencing homelessness with intertwined AOD and MH problems are rejected from both AOD and MH services as requiring treatment by the other first and, ***as a result, receive care from neither.***

Figure 61: Key Barriers to People Sleeping Rough Accessing AOD Treatment

Examining a homeless patient's experiences in the WA healthcare system often shines a spotlight on something that is more broadly true: ***there is always something behind and driving a person's dependence on substances.*** The medical dogma is that a person's life will be better if they stop using drugs, but this fails to consider the vital relief from psychological distress the substance provides. This is particularly true in the rough sleeping population where there are elevated levels of severe childhood trauma and an appalling social situation to deal with, whilst also applicable well beyond people experiencing homeless. It is likely that the failure to understand and manage this aspect of addiction plays a large part in the abysmal outcomes from many AOD treatment programs.

The homeless population seeking AOD treatment need to be accommodated in a trauma-informed setting that also provides social stability, as outpatient treatment is not viable or feasible to succeed in if you remain on the streets. However, as noted in Figure 62, the typical NGO residential rehabilitation setting of a closed communal system is inappropriate for severely traumatised people such as rough sleepers. The combination of a stressful closed communal system, lack of access to stress-relieving substances or medications and lack of in-house expertise in managing severe mental health issues means that the complex trauma cohort seen by the Homeless Team either refuses to enter residential rehab or leaves rapidly, relapsing to substance use.

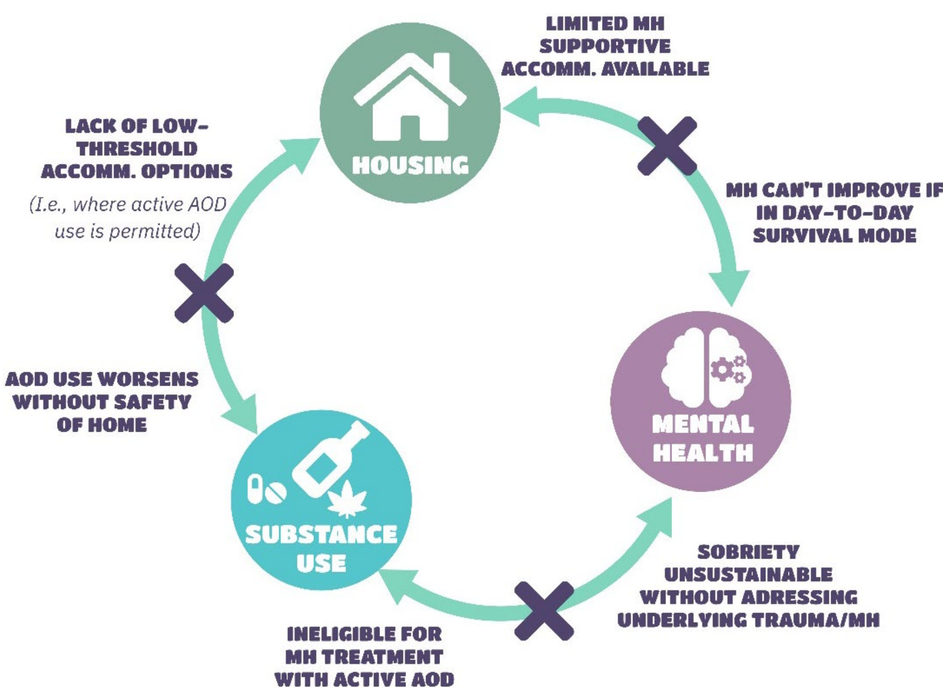


Figure 62: The Impenetrable Mental Health, AOD, and Housing System

Note: **AOD=** Alcohol and other drugs; **MH=** mental health.

A better model for this cohort would include flexible residential, intensive day, and outpatient programs underscored by trauma- and healing-informed design and practices in all aspects. Trauma-specific therapies delivered by skilled mental health and clinical staff should be readily available. Sobriety should not be a prerequisite, so programs will need managed substance use policies and/or medication substitution for substances to minimise distress.

Certain cohorts may require specific tailored programs, such as culturally appropriate and tailored for First Nations people, gender specific programs for men, women with and without children, families, and LGBTQIA+ identifying individuals. Programs for youth or elderly may also be needed to deliver age-appropriate care.

8.4 TRAUMA-BASED MENTAL HEALTH

The most severe psychiatric conditions due to psychological trauma are PTSD, complex PTSD (cPTSD) and Borderline/Emotionally Unstable Personality Disorder (EUPD). Classically, PTSD results from a single severely traumatic episode, usually in adulthood, for example sexual assault, natural disaster or a military service incident. The symptoms include flashbacks, nightmares, and severe anxiety. In contrast, cPTSD is usually based in repeated or prolonged childhood trauma, such that it impedes normal emotional development, and is often compounded by further traumatic exposures in later life. Additionally, PTSD can also develop in adulthood with exposure to severe, chronic trauma such as FDV, sex trafficking, slavery or living in a place where there is war or genocide. The additional

symptoms of complex PTSD are enduring issues of emotional dysregulation, a persistently negative sense of self and severe difficulties in forming and maintaining relationships. These are highly correlated with lifelong increases in AOD use, self-harm, and suicidal impulses and dysfunctional or abusive relationships.

Critically, and as well documented in the literature and frequently seen in the lives of patients supported by the Homeless Team, rough sleeping homelessness itself can be traumatising, as well as increasing the risk of exposure to attack, exploitation and other traumatic incidents.

The prevalence of trauma-based mental health conditions (TBMHC) is significantly underestimated in the homeless population and hidden in the rates of AOD issues. Amongst the 1,946 people seen by the Homeless Team in its first five years of operation, there are actually low rates of formal diagnosis of PTSD and EUPD (11% and 10%), compared with 81% having problematic AOD use. This observed under-diagnosis of PTSD and cPTSD is significant in homeless populations, and in my years of clinical practice, it is easy to see how this diagnostic gap occurs in people experiencing homelessness. Commonly, the hospital presentations of people with these mental health conditions undiagnosed or trauma unrecognised, are largely around the much more common AOD issues. These include intoxication, withdrawal, or medical complications. In this context, these patients will be referred to hospital and community based AOD services that focus on delivering AOD information. Mental health services are often reluctant to be involved in care, requesting that the AOD and social issues be resolved first. However, this is rarely possible without access to housing and supports, and because the AOD issue itself impedes access to transitional type accommodations (Figure 62). Thus, the focus remains on the AOD problem and the underlying mental health issues are neither explored nor formally diagnosed.

Even in the absence of an AOD problem, the public mental health system in Australia offers little treatment for trauma-based mental health conditions, although such treatment is readily available in the private health system (e.g., dialectical behaviour therapy or trauma-focused therapies). The psychological treatments needed are specialised and of variable duration, but, in the public mental health system, this capability has been whittled down to a miniscule proportion of the population's need. Since 2002, psychological therapies in Australia have been largely transferred to the Better Access Initiative of subsidised psychology sessions, accessed by GP referral. An evaluation of Better Access by the University of Melbourne[94] showed that it was failing low-SES individuals, with the average gap payment (payable by the patient) in 2022 of $90 per session putting the initiative well beyond the financial reach of most low-income patients. The evaluation also recognised that, for individuals with the most complex needs, the allocation of 10 sessions per year was insufficient for sustained improvement.

Given the major downstream impact of **untreated trauma-based mental health conditions** on government funded services, it seems sensible for government to fund evidence-based programs for comorbid mental health and AOD issues, in combination to housing and support access where required. This would target marginalised and low-income groups (such as people experiencing homelessness and disadvantaged First Nations people), with the aim of reducing morbidity and limiting intergenerational trauma.

An example of such a program is COPE,[95] which concurrently treats PTSD and AOD use using Prolonged Exposure Therapy, which has been developed and validated to address dual diagnosis in three steps:

1. Psychoeducation and psychological safety,
2. Accessing trauma-specific psychological intervention, and
3. Relapse prevention strategies for AOD use in a 12-session program.

There is merit in exploring the potential of such programs, as well as an urgent need more broadly to expand the suite of supports available for people who are dually experiencing homelessness and have untreated trauma-based mental health conditions.

8.5 PSYCHOSIS

People affected by psychosis have lost their connection to the reality of the world around them and are tormented by voices and delusional beliefs that are experienced as absolute reality. This means that psychotic patients typically do not believe they have a mental illness. This impacts on their relationships, and it can be easy for someone experiencing psychosis to end up homeless unless they have a solid support network and treatment with antipsychotic medication. Therefore, it is not surprising that 13% of the Homeless Team rough sleeper cohort has a diagnosed chronic psychotic illness. Mostly this is schizophrenia, a severe, long term mental illness with a world-wide prevalence of 1% but at least 10-20% in rough sleeping populations. These marginalised and severely mentally unwell individuals are extremely difficult to house unless treated with antipsychotic medication delivered as regular depot injections and sometimes under restrictive regimes such as community treatment orders. This is because, unlike most patients, they fervently believe that they are not ill and therefore won't accept any treatment.

Over the last 40 years, Australia and countries such as the UK and the US have witnessed a rising number of homeless people with schizophrenia, perpetrated by health system closures of many inpatient mental health beds and facilities, with the intention of moving as a society to a model of more community based mental health services. While the closures of dedicated mental health facilities happened on a large scale, there was no equivalent investment in outpatient treatment programs, supported housing and social support services. The tragic result has been the abandonment of many patients with schizophrenia who have ended up in precarious social situations or homelessness.

The management of patients with schizophrenia in Perth (and elsewhere in Australia) has also been complicated by the ***widespread availability of high purity methamphetamine***, since around 2015. This drug has a powerful pro-psychotic effect: methamphetamine use can push people into florid psychosis, especially those with an established psychotic illness or with significant risk factors for developing one, e.g., a family history of schizophrenia.

This splits the psychotic population into three groups, those with:

- **Pure drug induced psychosis:** psychosis will generally cease within two weeks of drug abstinence without antipsychotic medication,
- **Schizophrenia with no AOD use:** most will endure chronic psychosis if not treated with antipsychotic medication, and
- **Schizophrenia with concurrent methamphetamine use:** treatment requires both abstinence from AOD use and antipsychotic medication.

Prior to the widespread availability of high purity methamphetamine in WA, the appearance of psychotic symptoms was assumed to be due to schizophrenia and a multi-week inpatient admission ensued, followed by long-term outpatient clinic follow up. However, in the last decade, there have been increasing numbers of psychosis presentations, often involving methamphetamine use. This has caused a steeply increasing demand for inpatient mental health beds and consequent pressures to shorten these admissions to meet demand. Under this pressure, a change in mental health practice has occurred. Patients in psychosis who are suspected or known to use methamphetamine are now often assumed to have methamphetamine induced psychosis, and this is frequently the case for people rough sleeping if they present to ED. They are often refused mental health admission or promptly discharged as they are viewed as having a purely AOD problem, ignoring that the patient does or may have a chronic mental health condition such as schizophrenia.

This results in patients "slipping between the cracks", receiving neither mental health nor AOD care. This is particularly problematic when applied to people with established schizophrenia or bipolar disorder who are using or suspected of using methamphetamine. This is often the case in the rough

sleeping population, where without family or someone to advocate for them or challenge the diagnosis/decision to discharge, their psychosis is often misdiagnosed as purely drug induced.

The common categorisation of psychotic patients into distinct categories of either drug induced psychosis or chronic psychotic conditions has been dismantled by longitudinal studies from two Scandinavian countries, Finland[96] and Denmark.[97] These studies examined whole of country data to find first episode drug-induced psychosis in the absence of any known psychiatric diagnoses and tracked these patients for subsequent mental health diagnoses over the following eight years. Both studies found substantial rates of later diagnosis of schizophrenia and bipolar disorder, highest for cannabis (46%, 47%) and around 35% for all other substances, including polysubstance abuse. They concluded that an episode of drug induced psychosis was a significant risk factor for development of chronic psychosis, especially schizophrenia, and that drug-induced psychosis identified an important target population for early and intense intervention. However, the current Australian practices around drug-induced psychosis, described above, are the antithesis of these recommendations and portend a steady increase in the number of patients developing schizophrenia in our community given the widespread use of high purity methamphetamine. This will inevitably increase the future workload of our overwhelmed mental health services.

Even when patients experiencing homelessness have a schizophrenia diagnosis, they are often discharged from WA mental health services back into homelessness with oral medications they are consistently non-complaint with. Not surprisingly, there are many challenges associated with medication compliance, compounded by being mentally unwell. Alternatively, some patients have a discharge plan to receive ongoing antipsychotic medication via assertive community mental health care, often including the use of Community Treatment Orders and depot antipsychotic medication to enforce compliance. However, the itinerancy of homelessness means extra work finding people and thus they are relegated to "crisis care only".

8.6 COGNITIVE IMPAIRMENT

Cognitive impairment is widespread and highly under-diagnosed in the chronically homeless population.[98] The underlying cause may be a specific event such as a traumatic brain injury (TBI), but in individuals with a lifetime of social disadvantage there can be many potential causes of brain injury. These include Foetal Alcohol Spectrum Disorders (FASD), birth injury, childhood abuse, and neglect and childhood illnesses such as meningitis. Causes in later life include AOD use, drug overdoses, and TBIs from falls, assaults, and repeated concussions. Damage to the frontal lobes of the brain is particularly problematic, leading to a loss of functions of self-control, reflexion, social behaviour, and judgement. The typical picture is of aggressive behaviour and poor impulse control with little ability to problem-solve, plan, or consider the outcome of actions. Substance use is common in this cohort because of the rapid desirable effects but the use of stimulant or disinhibiting drugs exacerbates their impulsive and aggressive tendencies. The brain injury also means that reduction or abstinence from substances is extremely hard to attain and maintain especially in an environment where the substance is readily available or when facing life stresses. These individuals often repeatedly commit offences without considering the consequences and are over-represented in the prison population.[99] Prison is an environment that can contain their aggressive behaviours but has no deterrent or rehabilitative effect and many such individuals spend a considerable proportion of their life incarcerated.

However, people with a TBI or other forms of cognitive impairment who are experiencing homelessness often face additional barriers to getting the support they need. In the current Australian disability funding situation, the NDIS is now the only long-term, flexible source funding stream for accommodation and support, but detailed cognitive and functional assessments are typically needed as part of the application process. This is very difficult for people experiencing homelessness in the context of often chaotic day-to-day lives, unpredictable behaviour, substance use and underlying trauma. These factors have a compounding effect and conspire as barriers to gathering the type of

objective cognitive function data and neuropsychological testing that would make the strong case needed for a comprehensive NDIS support package (as depicted in Figure 63).

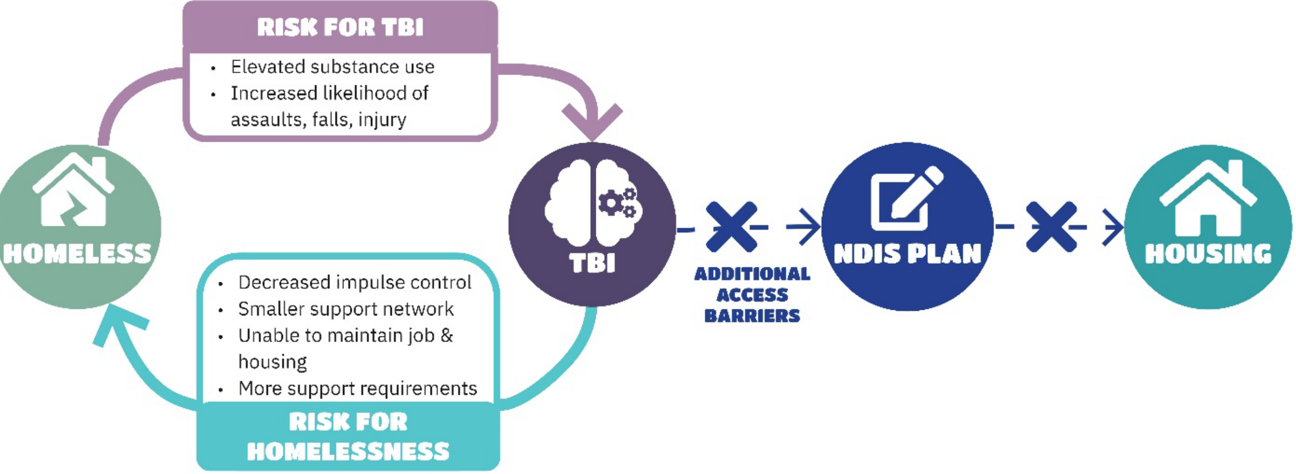


Figure 63: Relationship Between Brain Injury & Homelessness

Notes: **TBI=** Traumatic Brain Injury; **NDIS=** National Disability Insurance Scheme

One alternative to NDIS lies in the fact that individuals experiencing homelessness can apply for Aged Care funding for home supports or residential aged care a decade earlier than the general population (i.e. age 55), in recognition of the premature aging caused by homelessness. However, a successful application for aged care support also requires assessment of cognitive function which is often problematic as per above. In addition, behaviours such as substance abuse and aggression are not compatible with most Aged Care Facilities. In WA, there is currently only one specific aged care residential service for people who have experienced homelessness (St Bart's), whereas Melbourne, for example, has more options.

In the UK by contrast, there is growing attention to the need to increase access to cognitive assessments and support for people experiencing homelessness, and this is further discussed in our recommendations (see Section 9.2.4.1).

"In the UK there is increasing recognition of the need to act on neuro and brain injury issues affecting people experiencing homelessness. This complex interplay between brain injury (traumatic or acquired), physical health, mental health, neuro-psychological and cognitive impairment issues led to the development of innovative multidisciplinary homeless neuro pathway services. The first service piloted in the London Borough of Lambeth since 2020, includes GP and Clinical Psychologist co-leads, outreaching to homeless hostels in the borough to provide specialist assessment and support services The service has since been extended to Westminster Borough in London."

– Dr Zana Khan, Specialist GP in Homeless and Inclusion Health

9 CONCLUSIONS & RECOMMENDATIONS

Upstream systemic barriers and burdens contribute to downstream medical causes of high morbidity and mortality of homeless people. In turn, downstream causes magnify negative effects of upstream causes. Thus, care for homeless people must address intersecting health and social burdens by combining health-related and social interventions.

- Liu and Hwang (2021)[100]

9.1 SUMMARY OF FINDINGS

Homelessness is an enormous health, equity, and social challenge around the world and in WA. Pervasive trauma and entrenched social determinants of health underlie barriers to healthcare access, co-occurring health issues, high levels of hospital use and enormously shortened life expectancy. The fact that the average age of death of people experiencing homelessness in Perth (49 years)[101] is more than three decades younger than that of housed Australians (81 years)[54] is a confronting indictment on our society.

Homelessness in Australia is shaped by a complex range of factors, including poverty, trauma and inter-generational trauma, family and domestic violence and the continuing shortage of affordable and public housing. Although these factors lie beyond the control of the WA health system, they have a significant impact not only on the individual health of people experiencing homelessness, but also on disproportionate rates of recurrent hospital use. ***References in this report to the 'revolving hospital door' are thus not just metaphorical; the data literally show the escalating frequency of hospital use the longer people remain homeless, and that even the best medical care has limited impact unless housing and critical support needs are addressed.*** Given the strains on the WA health system and the substantial health, social and economic burden associated with homelessness, there is a clear need to reduce experiences of homelessness and its associated consequences. Herein lies the ethos and drive for the RPH Homeless Team.

Homelessness in Perth and WA is not confined to the geographical catchment in which RPH operates. However, RPH is the public hospital that sees by far the greatest proportion of homeless patients in Perth, due to its inner-city location and its proximity to many homelessness services and where many people experiencing homelessness congregate or sleep. The Homeless Team commenced in June 2016 as a response to the large number of people experiencing homelessness who recurrently presented at RPH. The Homeless Team's approach, and that of HHC more broadly, is based on the recognition that homelessness is fundamentally an entrenched social problem with complex health consequences.

Independent evaluation of the Homeless Team commenced in 2017, and this is the third and most comprehensive evaluation report to date. Since the Homeless Team began, its model of care has continued to expand and adapt to help meet the enormous health needs of the increasing number of people experiencing homelessness in Perth. Underpinning the model is a trauma-informed, holistic approach, which is an essential component of care for people experiencing homelessness. The capacity of the Homeless Team staff to relate to and build trust and rapport with patients has been a key strength since its inception.

Since the Homeless Team commenced, a total of approximately 2,900 unique patients have been seen up to the time of writing of this report (over almost seven and a half years of operation). The

quantitative findings presented in this report focussed specifically on the cohort of patients seen in the first five years of the Team's operation, during which it provided 5,874 consultations during 4,454 episodes of care to 1,946 unique patients. Corresponding with the increase in homelessness since the onset of the COVID-19, an increasing number of patients seen by the Homeless Team have not previously been known to the Team and are not well connected to community-based homelessness services. As noted in previous evaluations, **multi-morbidity is common amongst patients seen by the Homeless Team, often exacerbated by patients' experiences of homelessness**. The tri-morbidity of co-existing physical health, mental health and alcohol and other drug use issues was recorded for a third of Homeless Team patients. Most primary diagnoses associated with hospital visits were medical-related, debunking a myth that patients experiencing homelessness present to EDs primarily to obtain a 'bed for the night' or due to intoxication, rather than for 'legitimate' health concerns.

Soberingly, the proportion of patients seen by the Homeless Team who identify as Aboriginal has increased over the five-year period covered by this report, from 30% in the first year of operation (2016/17) to 41% (two out of five patients) in the Homeless Team's fifth year of seeing patients at RPH (2020/21). This mirrors the increase seen in the proportion of WA's homeless population who identified as Aboriginal and/or Torres Strait Islander people between the 2016 census (29%) and the 2021 census (35%).[1]

Whilst people experiencing all forms of homelessness are seen by the Homeless Team, the proportion who are literally rough sleeping at first contact with the team is staggering, accounting for almost three quarters (72%) of all patients seen by the Homeless Team to date. The Homeless Team goes to enormous lengths to avoid discharging patients back into homelessness, with just under one third (32%) of patients discharged back into rough sleeping, often only in the absence of suitable accommodation options. This 40% difference reflects the tireless work of the Homeless Team to help support patients into some form of accommodation through early, collaborative discharge planning and enhanced care coordination, despite the worsening housing crisis. Further, the proportion of patients discharged to rough sleeping decreased from 37% in 2016/17 to 27% in 2020/21 (a 27% reduction).

"There appears to be an apparent increasing gap between the between the demand and provision of support services, as evidenced by the increasing number of homeless individuals presenting to our hospitals and living on the nearby streets"
-**EMHS submission to Parliamentary Inquiry**[74]

Not only is homelessness associated with high hospital use, this and previous Homeless Team evaluation reports have **shown that hospital use escalates the longer people are homeless, both in terms of ED use and unplanned admissions**.[102] As shown in this report, over the three-year period leading up to first contact with the Homeless Team, hospital use escalated and equated to $155 million for 1,946 patients alone. Enduring homelessness therefore literally contributes to a hospital use carousel of people cycling in and out of the hospital system as their health continues to deteriorate.

However, as demonstrated in this third evaluation report, **the Homeless Team has contributed to reductions in the revolving door between homelessness, poor health and high hospital utilisation at the individual patient, hospital and system levels**. Whilst it was beyond the scope of this evaluation and the available data to undertake a full return on investment or cost benefit analysis, and while reductions in hospital use are acknowledged to not be literal bankable cost savings per se, the observed reductions in costs associated with the hospital use of the cohort substantially offset the operational costs of the Homeless Team, with the current annual cost of staffing the Homeless Team ($780.5k, or ~$1,109 per patient over six months based on the number of unique patients seen: n=352) being >3 times lower than the reductions in costs associated with the hospital use of the cohort over an equivalent period ($7.2 million, or ~$3.7k per person).

Compellingly, by far, **the greatest associated cost reductions were seen among patients supported by the Team who were able to be discharged to accommodation**, with the reduction in ED

presentations, ambulance arrivals and inpatient days for these 1,196 patients being over $8 million in a 6-month period alone. The same decrease was not evident among patients who were unavoidably discharged to the streets due to a lack of available accommodation, with these patients also being more likely to return to hospital within a 28-day period.

In the UK there is a government directive to NHS hospitals to not discharge patients to homelessness, but sadly this has been less overtly articulated in Australia, with the exception of the 2020 Australian Productivity Commission Mental Health Inquiry Report[73] that recommended that:

> *The cycling of people in and out of hospital at great personal cost and cost to taxpayers, should be addressed. Emergency Departments – or alternatives – should be adapted to work for those experiencing mental illness, **and hospital discharges into homelessness should be avoided**.*[73(p.2)]

Over the course of this evaluation and Home2Health's wider work in homelessness and health, there is a clear disquiet among health professionals about discharging a patient back to the street and the very circumstances that have contributed to their vulnerability and health deterioration. It is also clear that **one of the reasons the Homeless Team is greatly valued by wider RPH staff is because the Team can practically step in on daily basis to try and find ways to avert discharges of homeless patients to the street**. Even when a successful discharge to accommodation is not possible due to the sheer lack of suitable options, it is clear that RPH staff hugely value having a team that has the contacts, time and perseverance to try and find accommodation options for RPH homeless patients. Further, the differential reduction in hospital use for patients discharged to accommodation (even where there is a small cost underwritten by the Team's access to brokerage funds), convincingly speaks to the cost effectiveness as well as morality of doing so.

Since the WA Sustainable Health Review[40] and our last Homeless Team evaluation report,[4] there has been a sharper focus in the WA health system on the flow on effects of escalating ED use, ambulance ramping, bed blocks, timely patient discharge and longer stay patients. All of these are hospital and health system challenges in which people experiencing homeless are over-represented; hence, the importance of having a dedicated Homeless Team within the public hospital that sees the majority of Perth's homeless patients has never been more salient. Whilst ambulance ramping tends to get the most media attention, it is the cost per day and bed flow implications of hospital bed occupancy that is one of the most significant economic pain points for the WA health system. This was reflected in the 2022 WA Auditor General's report on the management of long stay patients in public hospitals,[70] which highlighted the bed flow and cost implications to the WA health system of lengthier hospital admissions. As reflected in the WA Sustainable Health Review,[40] there are also a significant number of ED presentations each year for needs that could have been more appropriately and cost effectively met through primary care or community based services; thus, efforts to encourage people to access lower cost healthcare options outside of the ED frees up available resources (staff and beds) to meet the needs of other patients. The submission by EMHS[74] to the recent WA Parliamentary Inquiry into homelessness services[75] also emphasises the need for wider systemic solutions.

> *"Having appropriately resourced external health, social and housing providers is critical to ensure that those experiencing homelessness do not unnecessarily stay in an acute hospital bed, which is an inappropriate use of expensive resources and negatively impacts hospital and patient flow"* - **EMHS submission to Parliamentary Inquiry**[74, p2]

This evaluation report has triangulated the various findings, outcomes and feedback about the Homeless team (from both patients and hospital staff) and highlighted the beneficial outcomes for patients, the hospital, and the wider health care system. Increasingly, the beneficiaries lie beyond the patients directly supported, with the Team's advocacy on homeless health issues, innovations and forging of collaborations across the homeless

> *"Addressing the structural drivers of homelessness requires advocacy from healthcare services for health equity through better social policy".*[103]

sector having a much wider ripple effect. Figure 64 summarises the key domains of beneficiaries from the work of the RPH Homeless Team.

Domain	Description
IMPROVED HEALTH OUTCOMES FOR HOMELESS PATIENTS	Improved outcomes for patients are evident through the detection and addressing of underlying health issues, greater access to primary care and reduced hospital use.
IMPROVED CARE COORDINATION	Via advocacy, facilitating links to other health and homeless services, and improved discharge planning (including discharging to accommodation).
ENHANCING RPH CAPACITY TO SUPPORT HOMELESS PATIENTS	Increased RPH staff confidence to identify and respond to the needs of patients experiencing homelessness. Brings homelessness expertise into the hospital.
IMPROVED CAPACITY FOR OTHER HOSPITALS & HEALTH SERVICES	Increased understanding and capacity across services regarding impact of homelessness and health, and via the support and advocacy provided to other services' clients.
REDUCE WA HEALTH SYSTEM BURDEN	Reductions in hospital use including representations, reduced length of stay when discharged to accommodation. Freeing up bed blockages for others.
THE WA HOMELESS SECTOR	Via involvement in multiple homelessness sector initiatives, resulting in more holistic support and improved outcomes for people who may otherwise have slipped through service gaps. Increased presence of health "at the table".
NATIONAL & INTERNATIONAL BEST PRACTICE	The Homeless Team model and evidence of impact is considered an exemplar of best practice and has been used by other organisations and policy makers to inform health-led initiatives to address homelessness.
WIDER CONTRIBUTIONS TO ADDRESSING HOMELESSNESS	Impact on wider contribution to addressing homelessness in WA, including through participation in high-level advisory groups and committees, advocating on policy and service gaps, and involvement in collaborative, cross-sector initiatives.

Figure 64: Who Has Benefitted from the Homeless Team

9.2 RECOMMENDATIONS

To continue and sustain the impact of the Homeless Team, including its wider contributions to the WA health system and reducing homelessness in this state, we make five key recommendations as depicted below. However, there are also many other suggestions made within the body of this report.

- INCREASING HOMELESS TEAM CAPACITY TO SUPPORT OTHER HOSPITALS
- SUSTAINABLE ONGOING FUNDING FOR HOMELESS TEAM
- ONGOING ACCESS TO BROKERAGE FUNDING
- NEW INITIATIVES TO ADDRESS GAPS
- FUTURE EVALUATIONS AND RESEARCH

9.2.1 INCREASING HOMELESS TEAM CAPACITY TO SUPPORT OTHER HOSPITALS

As awareness of the Homeless Team has grown, the Team is increasingly contacted by staff from other public hospitals seeking advice on how to best meet the needs of patients experiencing homelessness. Such requests most often come from social workers or clinicians, usually in the context of a current patient and their medical or psychosocial needs, particularly if the patient is thought to be already known to RPH. However, the Team also gets asked for advice on homelessness more broadly, such as

in relation to accommodation or homelessness service options. Requests to provide staff professional development on homeless health care at other public hospitals have also increased.

While the Homeless Team Clinical Lead, case workers and peer/administrative officer are very willing to provide advice and share their expertise with other hospitals, the time spent responding to these has expanded over time. **It is thus recommended that the role that the Homeless Team does and can play beyond its RPH footprint is both more formally recognised and expanded**. This has direct benefit to RPH also, as by its very nature homelessness is geographically transitory, and our data shows that more than three quarters of patients seen by the Homeless Team had attended at least one other hospital since the Homeless Team commenced. Moreover, we have seen in case study data, examples of patients discharged to the street from other hospitals only to re-present to RPH, or frequently presenting to other EDs without having been identified as homeless. Also, there are examples of patients discharging against medical advice from inpatient admissions elsewhere due to feeling stigmatised because of their homelessness. All these scenarios speak to the benefits of supporting other Perth public hospitals to respond to homelessness more consistently.

From our team's concurrent evaluations of the Department of Health discharge facilitation fund[55] and the MRC,[80] it is clear that other hospitals would benefit from more staff capacity building around supporting patients experiencing homeless. It is not realistic to expect busy clinical and allied health staff in public hospitals to have specialist homelessness knowledge or housing and accommodation referral and community contacts, and the proportion of homeless patients attending hospitals other than RPH means that it is not practical or cost effective to establish separate homeless teams at the other WA hospitals. The recent UK NICE guidelines on integrated health and social care for people experiencing homelessness also recommend that:

> *"in areas assessed as not needing a full-time homelessness multi-disciplinary team because of lower numbers of people experiencing homelessness, establish links with multi-disciplinary teams in nearby areas."*[69 ,p18]

We recommend that **the Homeless Team capacity is increased to employ an additional two case workers and two primary care registered nurses, who could be 'mobile' or 'roaming' and provide regular in-reach support and advice to non-RPH hospitals.** These inter-hospital Homeless Team members could work alongside staff at other hospitals to directly support homeless patients, as well as helping to build staff capacity to respond to patients experiencing homelessness and link them with support services and accommodation providers. Of benefit to RPH and these other hospitals, the inter-hospital team could also help to facilitate continuity of care where patients are presenting across multiple hospitals or community health catchments. There ideally would be an additional case worker to service the wider EMHS catchment (Midland, Armadale, Bentley), whilst the two additional 'mobile' case workers and primary care nurses could have a primary responsibility for either the north or south metropolitan health service areas, enabling them to develop relationships with hospital staff and networks with local community health and homelessness services, whilst also reducing travel burden.

An example of a Homeless Team having staff working across multiple hospitals has evolved in South London, where the King's Health Partners (KHP) Homeless Teams work across three NHS Foundation trusts, providing care across multiple hospital sites within their catchment. These multidisciplinary teams include GPs, nurses, social work, OT, housing workers and a peer advocate.[89] The first KHP team commenced in 2014[104] and has expanded their service provision over time, now supporting and undertaking in-reach at eight hospitals.

9.2.2 SUSTAINABLE & ONGOING HOMELESS TEAM FUNDING

Notwithstanding the impacts of the Homeless Team demonstrated in this report, the reality is the prevalence of homelessness remains high in Perth, with recent By Name List data indicating that in October 2023 there are 1,122 people experiencing homelessness in Perth, 594 of whom were people sleeping rough.[105] Moreover, as shown in the 2021 Census, the WA homeless population had the

greatest percentage of people sleeping rough in the country (24% compared with 6% Australia-wide)[1] and people sleeping rough comprised a staggering 72% of all patients seen by the Homeless Team over its first five years of operation. Recent figures from the WA Department of Communities have also shown increasing demand for public housing, with wait times growing by 41% since the start of COVID-19 pandemic. In fact, there has been very little shift in the supply or wait-times for public housing since the Homeless Team began, and unmet demand for crisis and short-term transitional accommodation for people experiencing homelessness in the inner-city area and Perth more broadly has increased in the last few years.

Thus, the need for a dedicated Homeless Team at RPH is not going to end anytime soon. To date, the Homeless Team has had a succession of fixed-period funding arrangements, and we strongly recommend that there be a formal commitment by EMHS to sustained ongoing funding of the Team, including its core staffing and the GP and primary care in-reach by HHC. Assurance of ongoing funding is not only important for retaining high calibre staff on the Homeless Team, but also signals to RPH and its homeless patients that there is an ongoing commitment to their healthcare.

At a minimum, it is recommended that the current staffing level and multidisciplinary mix of the RPH Homeless should be continued (and CPI indexed), including the recent addition of weekend shifts covered by case workers. Prior to this, there was a void on weekends in terms of supporting homeless patients, as the Homeless Team case workers had been present on weekdays only, and on weekends there is less social work cover across the hospital overall. The recommended core staffing composition of the Homeless Team is outlined in Table 26.

Table 26: Current and Recommended Staffing of Homeless Team

Current staffing	Recommended
Clinical Lead (RPH medical clinician), 0.5 FTE	As per current
Administrative support, 5 days per week, 1FTE	Increase to 7 days/week at 1.5 FTE
Case workers (Ruah/HHC in-reach), 1-2 case workers, 7 days per week	As per current, ensure weekend caseworker presence maintained
Registered Nurse, primary care in-reach from HHC, 7 days per week, 6 hours per day	Increase to 7.5 hours per day
GP in-reach and consult liaison from HHC, 1 hour per day*	Increase to 0.5 FTE (across 7 days)
Other proposed staffing to expand inter-hospital role	
2 additional case workers to provide roving in-reach support to other hospitals (see section above)	
2 additional RNs, to work alongside additional caseworkers to in-reach to other hospitals	
A Mental health OT as exists in some of the UK Pathway teams	

Note: * was originally 3.25/hours/day (0.5 FTE) but has had to decrease due to budget constraints.

In the UK, a number of the Pathway hospital teams have expanded their multidisciplinary team over time to include other areas of expertise, such as a mental health OT, an outreach psychologist, a housing officer or embedded access to neuropsychological assessments and care planning. This has not been done to replicate similar services within these London hospitals, but rather recognises the value added to a Homeless Team model of care when such areas of specialisation can be integrated and tailored to the needs of people experiencing homelessness and their care coordination. **It is recommended that the Homeless Team and its funders consider, going forward, whether there are other areas of staff expertise that would further enhance its impact.**

9.2.3 ONGOING ACCESS TO BROKERAGE FUNDING

From its inception, the Homeless Team has recognised the difference that can be made to a patient's discharge planning and outcomes through even small amounts of brokerage funding that can be used

in a timely, discretionary way. Common examples of brokerage expenditure that are far cheaper than the cost of a hospital bed include securing a few nights' accommodation in a hostel or budget motel to avert a patient discharge to the street, or to transport people to accommodation or medical appointments. In the very early days of the Homeless Team, this was only able to be done on a very small and ad hoc basis, but in 2018 the Team received its first annual and more substantial allocation of brokerage funds as part of a Department of Health pilot project to improve safe discharge planning for homeless patients seen at RPH (and since 2020 expanded to provide proportional brokerage funding also to four other metropolitan and one regional hospital). This annual allocation has continued. Both quantitative hospital data and qualitative feedback from patients, RPH hospital staff and members of the Homeless Team consistently points to the way in which such discretionary brokerage funding has contributed to better patient outcomes and reduced hospital re-presentations. **This is a hugely cost-effective strategy, with the money expended on short-term accommodation, transport, and small incidentals far outweighing the cost of lengthier inpatient stays, frequent ED presentations or missed attendances at outpatient and community health services.**

Since mid-2018, about two thirds of the brokerage funding used by the Homeless Team has been covered by an annual funding allocation from the Department of Health's Homelessness Discharge Facilitation project, with remaining costs covered by the hospital itself when this runs out. However, significant increases in the cost of living, and particularly cost of short-term accommodation options, over the past couple of years has started to put significant strain on the level and quantity of support the Homeless Team can provide across a full 12-month period with current brokerage funding levels. In our team's most recent evaluation of the Discharge Facilitation Fund project (2021-2022 financial year),[55] approximately $6-7k per month was being spent by RPH, most often on securing short term accommodation so that patients were not discharged back to the street. This is a conservative figure, however, as it does not account for some other brokerage expenses funded directly by the Homeless Team. Thus, in consultation with Homeless Team staff, it is believed that approximately $100,000 a year is sufficient to cover all necessary brokerage related expenses being incurred at current levels.

Given the compelling findings of this report in relation to substantial differences in returns to hospital among patients not discharged back to the street, the brokerage funding required by the Homeless Team is a drop in the ocean when compared to the cost of hospital bed-days and ED presentations in the WA public health system.

9.2.4 NEW INITIATIVES TO ADDRESS GAPS

As part of our evaluation of the Homeless Team and our wider work in homelessness in WA, any identification of support or service gaps is followed by investigation of potential solutions or leanings from other jurisdictions and countries. Often, these ideas are shared directly with the RPH Homeless Team Clinical Lead and HHC, but we have focused on three for inclusion in this report.

9.2.4.1 Neuropsychology Assessments and Support

Given the higher rates of mental health issues, brain injury and cognitive impairment in homeless populations (see also Section 8.6), coupled with the barriers to NDIS access for this cohort, there are two noteworthy examples elsewhere of initiatives to provide access to tailored neuropsychology services that we recommend could be adapted to the WA context. Broadly speaking, neuropsychology is concerned with the links between behaviour and cognition and the brain and nervous system. At first contact with the Homeless Team, one in ten patients had a condition affecting the brain (including brain injuries and epilepsy). This is likely to be an underestimate, with both the Homeless Team Clinical Lead and HHC Medical Director indicating that cognitive impairment and brain conditions are often poorly identified in this population, particularly where behaviour has been simplistically attributed to substance use. Childhood adversity also means that conditions that get diagnosed in childhood in the mainstream population (such as ADHD or dyslexia) may have been missed. The underdiagnosis and documentation of cognitive impairment or deficits in neuropsychological functioning in turn is a barrier to NDIS access for many patients seen by the Homeless Team.

"There is an urgent need for access to neuropsychological assessments for many people experiencing homelessness as the main source of additional support funding for people with a disability is now the NDIS, with the vast majority of state-based disability services having disappeared. Obtaining NDIS funding is predicated on having information from objective assessments from health professionals, for example cognitive, neuropsychology testing…). In order to carry out such testing, people need to be in a more stable social situation, medically optimised and had completed detox from any substance use, and this rarely occurs in the short time frame of most hospital admissions. Consequently, rough sleepers miss out the very testing that NDIS requires to obtain a suitable support package for their complex needs." – **Dr Amanda Stafford, Clinical Lead RPH Homeless Team**

In NSW, grant-funded programs have provided free access to neuropsychiatric assessments for people experiencing homelessness,[106] helping to understand the neuropsychiatric profile and support needs of patients and overcoming the financial and access barriers that normally limit access to these services for patients experiencing homelessness.

Internationally, the Lambeth Hostels Brain Injury and Neuropsychology Service[107] supports the work of the SLAM Pathway Hospital Team in the UK, providing a flexible and responsive psychology service to adults with complex needs in the Lambeth homeless hostel network. The service provides specialist assessment from a health and neuropsychological perspective to patients with challenges related to traumatic brain injury, alcohol or substance related brain injury, neurodegenerative conditions or neurodevelopmental conditions. These assessments are often completed jointly by the specialist Inclusion Health GP and Clinical Psychologist and can help to link patients with suitable accommodation and support. The Statutory Team Enabling Pathways (STEP) Service, a multidisciplinary team supporting patients with complex health problems, including trauma, brain injury, substance use, neurodiverse conditions and learning difficulties in Westminster, UK, is another international example of a service that provides neuropsychiatric assessment for patients experiencing homelessness.[108]

Access to free neuropsychiatric screening would enable the Homeless Team to refer patients and more comprehensively understand their needs.

9.2.4.2 Trauma Therapy for People with a Dual Diagnosis

Trauma is pervasive among Perth's homeless population, and often underlies dual AOD and mental health issues. As discussed in Section 8.4, substance use disorders among the majority of rough sleepers are related to underlying psychological trauma, and this complexity is ill suited to the siloed AOD and mental health services. Dual diagnosis programs such as the COPE program[109] operating in Victoria are evidence-based programs treating combined substance use and trauma, by using trauma-specific psychology and therapy programs. Similar programs could address this gap that exists in WA and for the homeless population seen at RPH and elsewhere. The former HODDS program piloted by HHC that provided dual diagnosis outreach to people sleeping rough in Perth also merits a revival, as evaluation of the pilot demonstrated that it addressed a critical sector gap and was associated with reduced hospital use and improved health outcomes among people supported.[110]

It is recommended that EMHS support the introduction and evaluation of evidence-based dual diagnosis services with embedded trauma therapy for people experiencing homelessness, as this would address enormous unmet need.

9.2.4.3 Expansion of Step-Down Accommodation Pathways within EMHS

Homelessness is in effect a 'bed-blocker', with lengthier, costly hospital stays arising because there is no appropriate accommodation for people to be discharged to. This has been particularly noted in the context of mental health inpatient admissions, nationally in a Productivity Commission report on Mental Health and in the Victorian Royal Commission into Mental Health System.[73,111] In WA, the most

recently available Mental Health Commission's Mental Health Survey Snapshot, from April 2021, reported that one in four patients occupying mental health beds in a public hospital could have could have been discharged if appropriate accommodation and/or treatment and support services were available.[112] The recent Office of the Auditor General Report has also highlighted the bed flow and costs associated with long stay patients whose health needs could be more suitably and cost effectively met outside of the acute hospital system.[70]

While the advent of the MRC has provided a valuable discharge option for some patients experiencing homelessness Perth, it is not a mental health facility and aims for a 2-3 week average length of stay. **Given the prevalence of mental health conditions and trauma in the homeless population, we recommend, for EMHS and MHC consideration, that this gap in medium-longer term step-down mental health accommodation be addressed**. As well as the therapeutic and recovery benefits of such a non-hospital-based facility, as shown in this evaluation report, mental health and inter-related AOD issues continue to be a major driver of ED presentations and unplanned hospital admissions for homeless patients seen at RPH. Thus, step-down accommodation options with integrated mental health support are a cost effective alternative, given the average cost of a mental health inpatient day in a WA public hospital is $1,596. The cumulative cost of this is astronomical, with patients seen in the first five years of the Homeless Team having a total of over 25,000 psychiatric inpatient bed days, equivalent to over $40 million in estimated costs to the health system.

While the EMHS *Bidi Wungen Kaat Centre* transitional accommodation that opened in 2022 is a promising example of a recovery-oriented mental health residential service, it is not necessarily suitable for people who are still enduring chronic homelessness and who have high levels of trauma, dual diagnosis and complex psychosocial and other challenges. Therefore, **we recommend a bespoke, co-designed option tailored for people experiencing homelessness that is trauma and healing informed, with integrated pathways to long-term housing or supported accommodation.**

9.2.5 DATA, FUTURE EVALUATION & RESEARCH

Prior to the establishment of the Homeless Team in 2016, early advice to RPH and HHC from UK homeless health colleagues who had been involved in setting up the initial Pathway hospital-primary care teams in a handful of London hospitals, stressed the importance of building in robust data collection from the outset. This sage advice incorporated the importance of both data that captures the activity and outcomes associated with the work of a Homeless Team and ensured that data systems would enable measurement of any changes in hospital use.

The importance of quality data capture and impact evaluation has thus been a signature hallmark of the Homeless Team since its inception, and, through the involvement of the independent Home2Health team since 2017, there has been a strong commitment to strengthen routine data collection, as well as a commitment to periodic independent evaluation.

As this report marks the culmination of the most major and long-term evaluation report since the Homeless Team commenced, we take this opportunity to make a number of recommendations around future evaluation and research.

9.2.5.1 Future Evaluation

Due to COVID-19 and some other intervening factors, there has been an acknowledged gap between the second Homeless Team evaluation report (late 2019) and this third major evaluation report. Going forward, **we recommend that a major evaluation of the Homeless Team be undertaken (including new data collection, analysis and report) approximately every 2-2.5 years**, as homelessness and its impact on the health system is not static. With increasing attention across the health system and WA government to preventing the escalation of preventable acute hospital use, it makes enormous sense to continue this unique longitudinal evaluation of a real-world intervention, with data for patients supported by the Homeless Team now covering a 10-year period (2013 to 2023).

This makes this independent evaluation of the RPH Homeless Team one of the largest long-term evaluations of a real world, health-led homelessness intervention in the world to our knowledge. Even the UK Pathway homeless teams, on whose model of care the RPH Homeless Team was originally based, have often only had an initial one-year evaluation published. This then begs the question of how those teams have evolved over time, and how has their impact on health outcomes and hospital use tracked over time. As demonstrated in this report, monitoring and evaluation of data over time yields rich insights into where the system and service gaps and barriers to healthcare access lie.

Additionally, whilst periodic major published evaluation reports are important for accountability and can have considerable traction, we suggest that, in between these, that there be an openness to 'snapshot'-style short infographic evaluation reports on particular issues salient to the work of the Homeless Team. This is the approach we have taken with HHC, producing in a very timely way short infographic snapshots pertaining to particular target groups (e.g., young people) or areas of intervention (e.g., Street Health).

9.2.5.2 Peer Review Publications

Notwithstanding the value of the periodic and published evaluation reports on the work of the RPH Homeless Team, it is acknowledged that there have been a few peer review publications, and none that harness the rich longitudinal findings of now up to a decade of data (pre- and post-Homeless Team support) for patients supported in the early days of the Team. The substantial longitudinal cohort size; the access to hospital, outpatient, and mortality data; and the rich qualitative insights from hospital staff and people experiencing homelessness, are all aspects that render the RPH Homeless Team unique. As an example, the cohort size for the ongoing longitudinal follow up of patients seen by the RPH Homeless Team is impressive in the context of the many challenges involved in tracking outcomes among people experiencing homelessness over time.

Although there has been growing national and international interest in the model of care and impact of the Homeless Team, we recognise the importance of a more concerted effort to disseminate findings and learnings via the international peer review literature. We are committed to working with the Homeless Team on this and propose that **2-3 journal papers be submitted for peer review publication over the next 18 months.** To begin with, an initial and salient 'low hanging fruit' paper could focus on the stark differences observed in post-Homeless Team contact hospital use between individuals discharged to accommodation versus rough sleeping.

9.2.5.3 Consolidated, Refined, & Expanded Data Collection and Statistical Analysis

Key to our evaluations of the RPH Homeless Team to date has been the availability of clean, comprehensive data. Particularly, beyond access to linked administrative hospital data, we remain indebted to the comprehensive database of patient contacts, needs, and support provided that is maintained by the Homeless Team Administrative Assistant and Clinical Lead. This database has been of very high quality and completeness, and has not been vexed by the missing or inaccurate data issues that can plague many 'real world' service evaluations.

Nevertheless, given the Homeless Team's commitment to quality improvement and service refinement, we do make the following recommendations around data and statistical analysis going forward:

- That an episode-level flag be introduced to identify episodes where patients seen by the Homeless Team refused or were ineligible for support, to address minor skewing of the pre/post hospital analyses.
- That, if possible and appropriate, future evaluations consider a comparison group, potentially comprising people experiencing homelessness who attended hospital but who did not receive Homeless Team support. Such a group might be identified via patients having NFA in hospital

data, but care would need to be taken to exclude patients with NFA due to being transient (e.g., backpackers).

- That, if appropriate, future evaluations consider the hospital use of the cohort pre- and post-all Homeless Team contacts, rather than just the first contact. It is recognised that the first contact represents the start of a process of engagement with HHC, but qualitative and/or quantitative analyses might usefully explore the gradual impact of the Team through multiple episodes of Homeless Team contact.

All of the evaluation and research undertaken for the Homeless Team continues to be covered by RPH Human Research Ethics Committee approval, and the suggestions above are covered by the existing approvals and research protocol.

9.3 CONCLUSION

The WA Sustainable Health Review[40] acknowledged the disproportionately poor health of people experiencing homelessness, and the barriers and challenges of ensuring timely and appropriate healthcare for this population group. The RPH Homeless Team is proactively addressing this and has consistently demonstrated over more than seven years of operation how prioritising the medical and social needs of people experiencing homelessness can improve their health and wellbeing, and break the cycle of recurrent hospital presentations by connecting them to housing, support services and long-term primary care. However, the greatest testament to its impact is ultimately the voice of lived experience:

> *"I was homeless for two years. I lost all my family before the age of 12, my mum, my dad, one brother by suicide, the other by car crash. I was at Royal Perth Hospital; I didn't even know this place [the Medical Respite Centre] existed. Someone from the Homeless Team at the hospital suggested it to me and here I am. I never before had enough courage to go somewhere and go, but they didn't push me, when I woke up from my coma they told me about some options. If the people at the hospital hadn't told be about this, I would still be living on the streets, and I'd still be on the drugs, 100%. I never got offered things like this before."* – **Patient Supported by the Homeless Team**

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APPENDICES

APPENDIX A: RPH HOMELESS TEAM FEEDBACK SURVEY QUESTIONS

1. **Which area of the hospital do you work in / are most associated with? (Select all that apply)**
   - ☐ ED Main
   - ☐ Medical IP ward
   - ☐ Surgical IP ward
   - ☐ ED OBS ward
   - ☐ Psych ward
   - ☐ Other (if so specify):_____

2. **Which of the following best describes your current position at RPH?**
   - ☐ Clinical Nurse
   - ☐ Aboriginal Liaison Officer
   - ☐ Senior Doctor
   - ☐ Nurse Manager
   - ☐ Allied Health
   - ☐ Other, please specify:
   - ☐ Social Worker
   - ☐ Junior Doctor

3. **The RPH Homeless Team has been operating for over 5 years, and other hospitals have shown interest in setting up similar service. Below is a list of potential benefits of having - which (if any) of these benefits have you observed? (Choose all that apply)**
   - ☐ Improving identification of patients experiencing homelessness within the hospital
   - ☐ Identification of underlying psychosocial and other factors that contribute to hospital use among patients experiencing homelessness
   - ☐ Linking homeless patients to a GP and primary care
   - ☐ Linking homeless patients to allied health and community services
   - ☐ Supporting improved discharge planning, including knowledge/access to options in community for follow up support
   - ☐ Connecting patients to accommodation options to reduce discharges back to homelessness
   - ☐ Reducing likelihood of patient re-presentation in the future
   - ☐ Provides access to brokerage funding that can be used to provide accommodation cost effectively
   - ☐ reduce likelihood of re-presentation
   - ☐ Other (please state): ____

4. **We are also interested in how the RPH Homeless Team might support or complement the work of other staff/teams/departments within the hospital. Some examples are indicated below, but you may have others to add. Please indicate the extent which you agree or disagree with the following:**

The Homeless Team…	Agree	Somewhat agree	Somewhat disagree	Disagree	N/A
...can provide background context and information to help us understand a patient's circumstances.	☐	☐	☐	☐	☐
...can help reassure patients experiencing homelessness, as it provides someone to come talk with them.	☐	☐	☐	☐	☐
...can help address non-health issues that might be impacting on hospital presentations (eg. access to Centrelink, ID, accommodation, etc.).	☐	☐	☐	☐	☐
...provide advocacy for patients (eg. in relation to access to community services or housing).	☐	☐	☐	☐	☐
...can help to coordinate care for patient across different areas of hospital.	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐

5. **Can you provide a brief example of how a patient may have benefitted from having the RPH Homeless Team embedded within the hospital?** ____

6. **Do you have any additional comments or feedback about the Homeless Team, including suggestions for service improvement?** ____

Thank you for taking the time to complete this survey. All responses will be kept confidential and de-identified in publishing unless express permission is granted.

APPENDIX B: RPH HOMELESS TEAM PATIENT SUPPORT DOCUMENTS

EXAMPLE OF FUNDED ACCOMMODATION CONDUCT & AGREEMENT CHECKLIST

RPBG HHC expects the following conduct from clients receiving funded accommodation.

☐ **NO aggressive / abusive behaviour or language**
All staff & guests at accommodation to be treated with respect

☐ **NO smoking inside accommodation**
Smoking allowed only in areas designated by the accommodation

☐ **Accommodation to be left clean and tidy**
Mess & deliberate damage to the accommodation is not acceptable

☐ **No guests in accommodation**
Only the clients named on the accommodation request are allowed into accommodation

☐ **No drug / alcohol use inside accommodation**
Alcohol and drugs are not to be consumed in the accommodation

☐ **Telephone & Extras use not included**
RPBG HHC will not pay for any telephone or minibar use – you must pay this yourself if you choose to make use of them.

☐ **Accommodation Rules**
The rules of the accommodation must be followed at all times

Guest Name: ______________________________ **Accommodation Dates:** ____________________

Guest confirmation: I confirm the expected conduct whilst in funded accommodation have been explained to me, and I agree to them. I understand that failure to abide by this agreement may result in this booking and any future bookings being cancelled.

Signed: ______________________________

HHC Team Member confirmation - I confirm that I have explained the above expectations to the client

First name & Initials: ______________________________

Royal Perth Bentley Group Homeless Team
Level 3, D Block, Wellington Street, PERTH, WA, 6000
T: (08) 9224 1137 F: 9224 1628
W: **WWW.RPH.HEALTH.WA.GOV.AU**

EXAMPLE OF A DAMAGES WAIVER LETTER

Dear SERVICE PROVIDER NAME,

Thank you for accommodating our client, CLIENT NAME.

Accommodation is for the period of Click here to enter a date. to Click here to enter a date.

For the total agreed cost of TOTAL AMOUNT TO PAY.

Royal Perth Bentley Group agrees to the responsibility for losses/damages caused by the above-named client, up to the amount of your facility's usual bond charge of BOND AMOUNT.
Please disable paid services such as pay TV and charging to the room account.

Please send all invoices to rph.socialworkadmin@health.wa.gov.au

Notes/ Special requests: Click here to enter text.

Thank you again for your assistance,
Sincerely
HHC REPRESENTATIVE NAME.

EXAMPLE OF ID DOCUMENT FOR PATIENT

To whom it may concern,

This document has been issued by a representative of RPBG Social Work Department as identification support for the individual named below.

Please contact the RPH Social Work Department on 9224 2711 with any questions.

Nala Wood **Date of birth: 16/06/1998**	

I confirm that the above is a true photograph of **Nala Wood**
Signed
HHC REPRESENTATIVE NAME.
Click here to add date

APPENDIX C: ADDITIONAL DATA

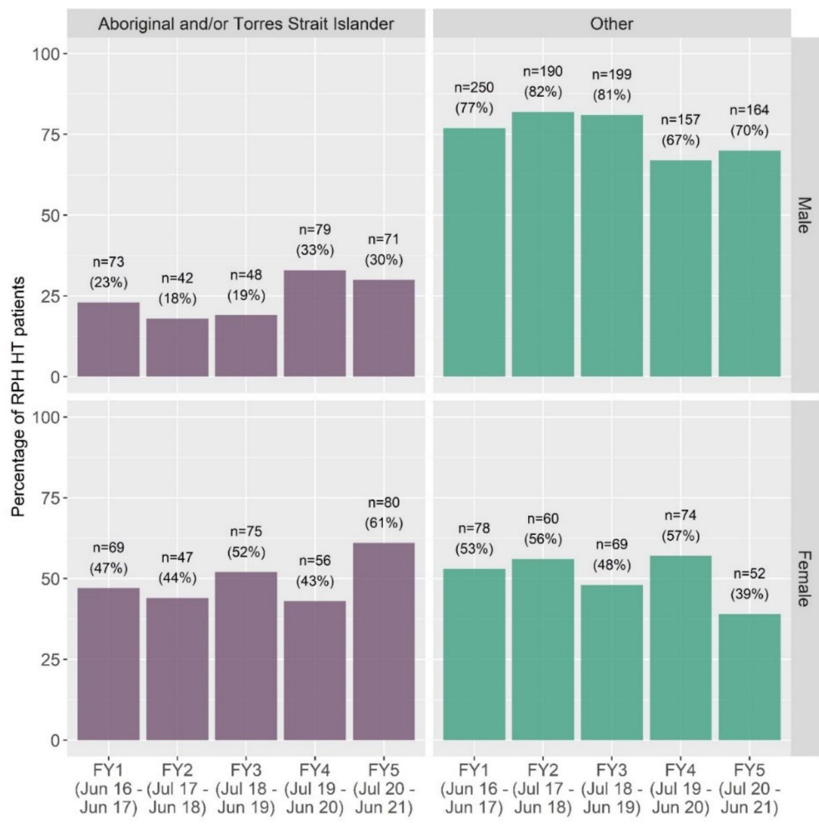

Figure 65: Proportion who Identified as Aboriginal Over Time, by Gender

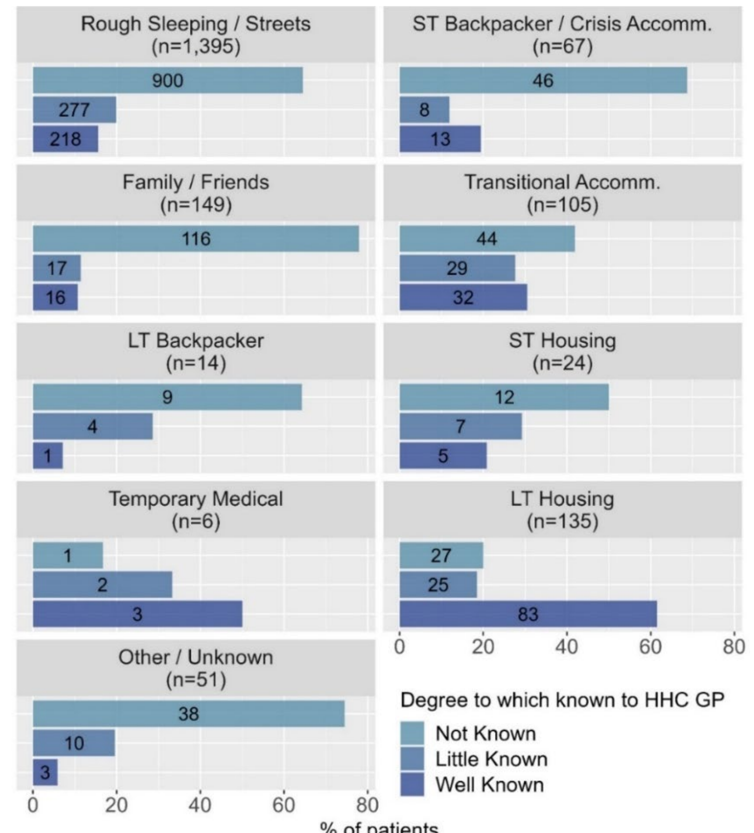

Figure 66: Living Situation at First Contact and Degree to which Known to HHC

Note: **Temporary Medical** includes Detox / Rehab, Hospice / Palliative Care, Involuntary Psychiatric Facility, StayWitch's, Other Hospital / Medicare, and Voluntary Psychiatric Facility. **ST** = Short-term; **LT** = Long-term.

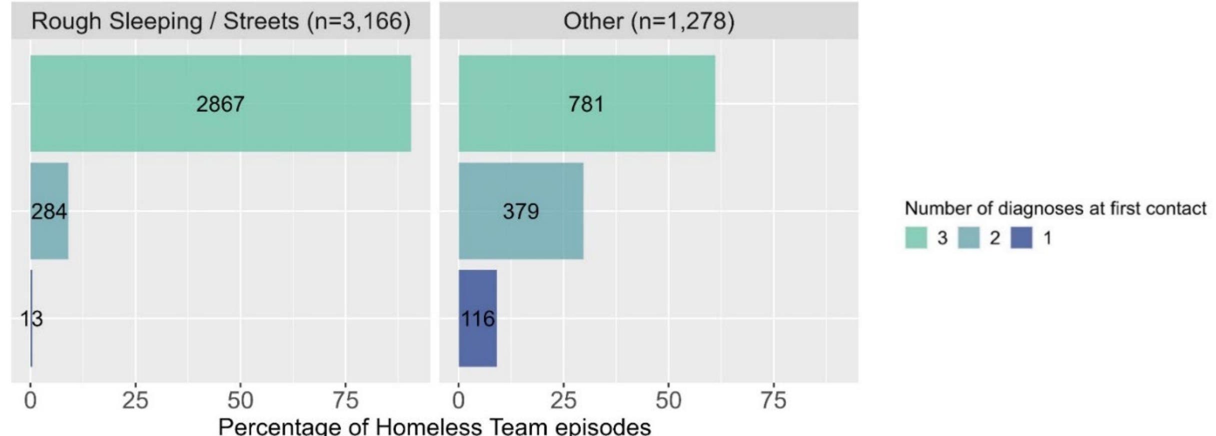

Figure 67: Proportion of Episodes with 1, 2, or 3 Diagnoses, by Living Situation at Admission

Note: Other includes all living situations other than Rough Sleeping / Streets.

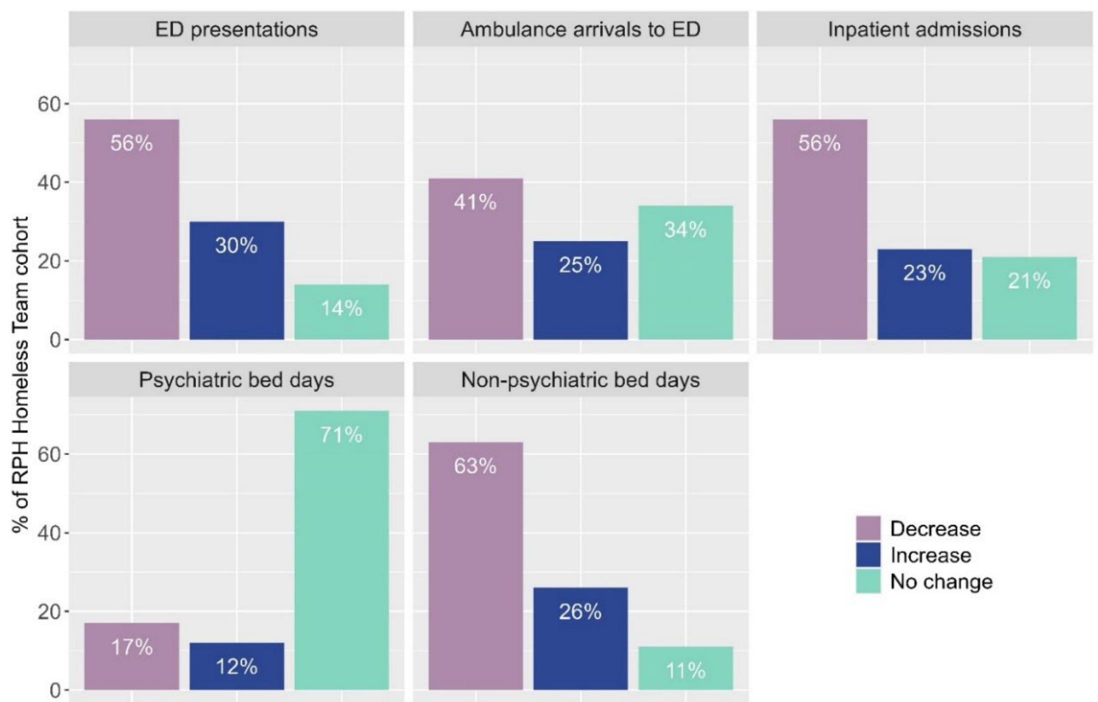

Figure 68: Proportion with Changes in Hospital Use 6 Months Pre/Post First Contact

Notes: Excludes patients who died during follow up.

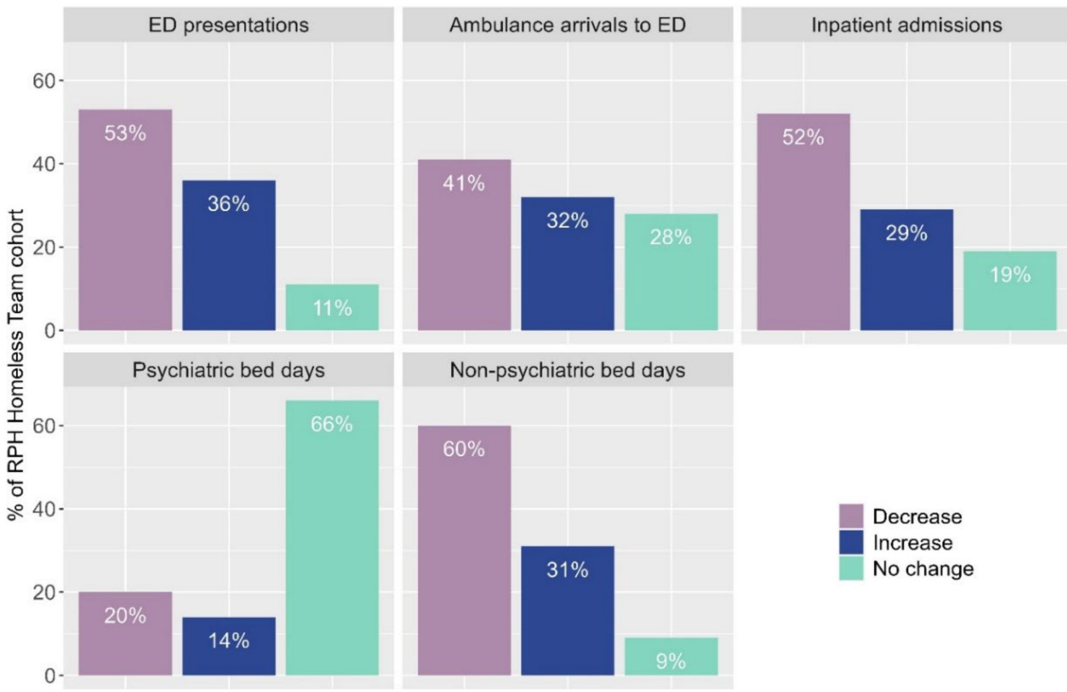

Figure 69: Proportion with Changes in Hospital Use 1 Year Pre/Post First Contact

<u>Notes:</u> Excludes patients who died during follow up.

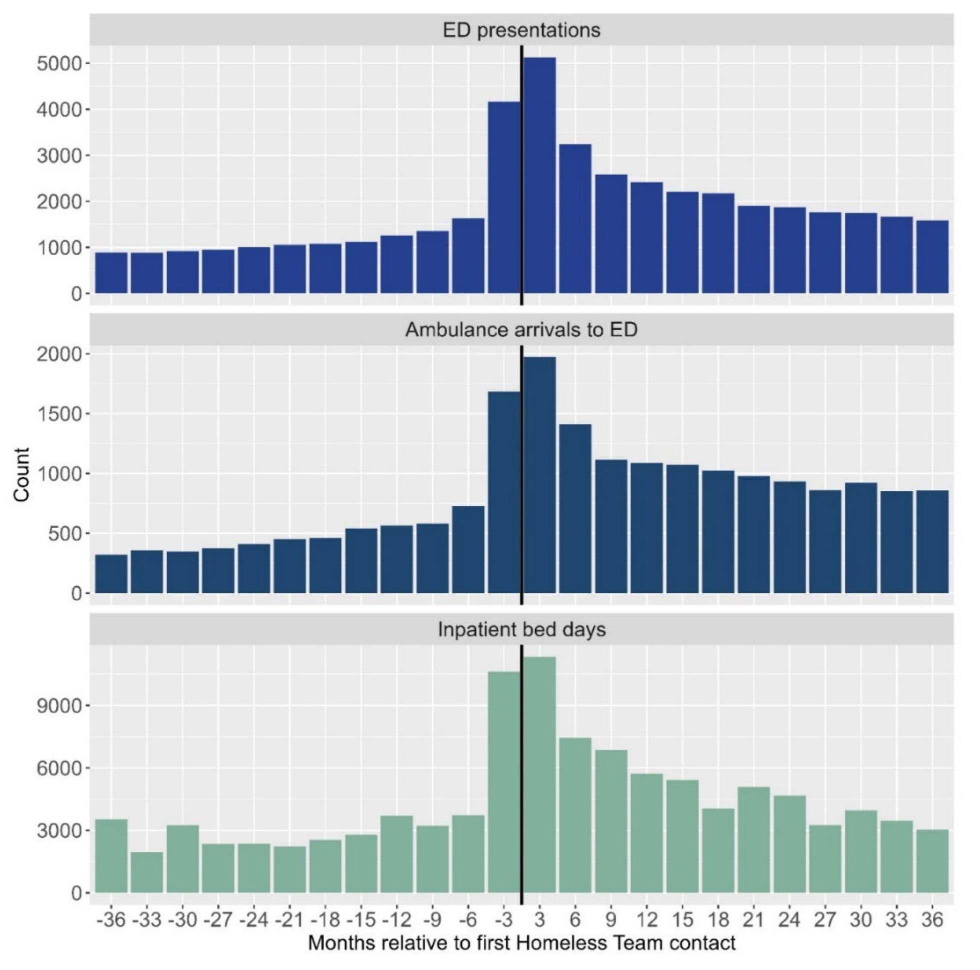

Figure 70: Changes in Hospital Use Pre/Post First Contact, Adjusted for Death

<u>Notes</u>: Counts in the 'pre' period are identical to those in Figure 42. Counts in the 'post' period are inflated through accounting for the reduced length of follow up of some individuals due to death.

Table 27: Pre/Post Changes in Hospital Use, by Discharge Destination – 1-Year Cohort

	Rough Sleeping (n=625; 32%)			Accommodation (n=1,196; 61%)		
	Pre	Post	change	Pre	Post	change
ED Presentations						
N (%) people with 1+ Presentation	623 (100)	544 (87)	-13	1,188 (99)	968 (81)	-19
Total ED presentations	4,207	4,714	12	6,658	7,017	5
Mean^ (SD)	6.7 (7.3)	7.5 (12.3)		5.6 (6.1)	5.9 (9.2)	
Range	0 - 70	0 - 156		0 - 51	0 - 104	
N (%) presentations with leave events^^	423 (10)	508 (11)		552 (8)	746 (11)	
Ambulance Arrivals to ED						
N (%) people with 1+ arrival	463 (74)	397 (64)	-14	844 (71)	691 (58)	-18
Total ambulance arrivals	1,901	2,124	12	2,759	3,011	9
Mean ^ (SD)	3 (4.9)	3.4 (7.3)		2.3 (3.7)	2.5 (5.4)	
Range	0 - 39	0 - 75		0 - 44	0 - 83	
Inpatient Admissions						
Admissions						
N (%) People with 1+ Admission	575 (92)	440 (70)	-23	1,115 (93)	795 (66)	-29
Total Admissions	1,681	1,756	4	3,085	2,732	-11
Mean ^ (SD)	2.7 (3)	2.8 (4.5)		2.6 (2.5)	2.3 (3.3)	
Range	0 - 36	0 - 44		0 - 19	0 - 25	
N (%) Admissions Ending in DAMA ^^^	354 (21)	306 (17)		255 (8)	285 (10)	
Total Days Admitted						
Psychiatric days	2,614	5,663	113	8,670	6,618	-24
Non-Psychiatric days	5,026	6,185	23	10,773	9,464	-12
Mean (SD) LOS (Days)	4.6 (6.6)	8.5 (24.8)		7.4 (17.9)	6.8 (12.2)	
Range in Days Per Admission ^^^^	1 - 132	1 - 725		1 - 338	1 - 221	

Notes: "Accommodation" excludes individuals whose discharge destination was died, Returned to Country, Prison, Other or Unknown (n=125, 6%). ^of the relevant Homeless Team sub-cohort (n=1,946). ^^of the total number of ED presentations. ^^^of the total number of inpatient admissions. ^^^^of LOS per admission beginning during the relevant period rather than days that fell within that period; thus, the maximum can be longer than the period reported

Table 28: ED Re-Presentation Rates for the Cohort 1-Year Pre/Post First Contact

	Rough Sleeping (n=625; 32%)			Other Accom. (n=1,196; 61%)		
	Pre	Post	change	Pre	Post	change
N(%) individuals re-presenting within 7 days^	339 (54)	366 (59)	9	597 (50)	563 (47)	-6
Total number of 7-day ED re-presentations	1,593	2,334		2,167	3,035	
N(%) 7-day re-presentations resulting in admission	532 (33)	743 (32)	-3	769 (36)	898 (30)	-17
N(%) individuals re-presenting within 28 days^	430 (69)	461 (74)	7	761 (64)	728 (61)	-5
Total number of 28-day ED re-presentations	2,600	3,633		3,740	5,065	
N(%) 28-day re-presentations resulting in admission	906 (35)	1,230 (34)	-3	1,420 (38)	1,645 (33)	-13
N(%) individuals re-presenting within 90 days^	489 (78)	505 (81)	4	865 (72)	854 (71)	-1
Total number of 90-day ED re-presentations	3,332	4,339		4,975	6,305	
N(%) 90-day re-presentations resulting in admission	1,212 (36)	1,495 (35)	-3	1,967 (40)	2,152 (34)	-15

Notes: ^calculated as % of the relevant Homeless Team sub-cohort. Results for "Accommodation" exclude data for individuals whose discharge destination following first contact was Died, Left Perth / Returned to Country, Prison / Police Custody, Other or Unknown (n=125, 6%).

Table 29: Pre/Post Changes in Hospital Use, by Discharge Destination, 6 months cohort

	Rough Sleeping (n=625; 32%)			Accommodation (n=1,196; 61%)		
	Pre	Post	change	Pre	Post	change
ED Presentations						
N (%) people with 1+ Presentation	622 (100%)	510 (82%)	-18%	1,184 (99%)	872 (73%)	-27%
Total ED presentations	2,843	2,917	3%	4,687	4,390	-6%
Mean^ (SD)	4.5 (4.5)	4.7 (7.5)		3.9 (4.2)	3.7 (6.1)	
Range	0 - 49	0 - 93		0 - 38	0 - 75	
N(%) presentations with leave events^^	273 (10%)	310 (11%)		372 (8%)	458 (10%)	
Ambulance Arrivals to ED						
N (%) people with 1+ arrival	432 (69%)	342 (55%)	-21%	772 (65%)	572 (48%)	-26%
Total ambulance arrivals	1,244	1,250	0%	1,945	1,826	-6%
Mean ^ (SD)	2 (2.8)	2 (4.4)		1.6 (2.6)	1.5 (3.8)	
Range	0 - 23	0 - 45		0 - 33	0 - 70	
Inpatient Admissions						
Admissions	**1,195**	**1,090**	**-9%**	**2,279**	**1,679**	**-26%**
N (%) people with 1+ admission	558 (89%)	375 (60%)	-33%	1,089 (91%)	672 (56%)	-40%
Mean ^ (SD)	1.9 (1.9)	1.7 (2.7)		1.9 (1.7)	1.4 (2.1)	
Range	0 - 24	0 - 23		0 - 14	0 - 20	
N (%) admissions with DAMA^^^	271 (23%)	194 (18%)		176 (8%)	183 (11%)	
Total Days Admitted	**4,965**	**6,746**	**36%**	**13,087**	**10,257**	**-22%**
Psychiatric days	1,320	3,061	132%	4,931	4,533	-8%
Non-Psychiatric days	3,645	3,685	1%	8,156	5,724	-30%
Mean (SD) LOS (Days)	4.3 (5.9)	8.2 (23.9)		6.6 (11.6)	7.1 (13.8)	
Range in Days Per Admission ^^^^	1 - 81	1 - 725		1 - 159	1 - 221	

Notes: "Accommodation" excludes individuals whose discharge destination was Died, Returned to Country, Prison, Other or Unknown (n=125, 6%). ^of the relevant Homeless Team sub-cohort (n=1,946). ^^of the total number of ED presentations. ^^^of the total number of inpatient admissions. ^^^^of LOS per admission beginning during the relevant period rather than days that fell within that period; thus, the maximum can be longer than the period reported

Table 30: Costs Associated with Pre/Post Changes in Hospital Use by Disch. Destination (1-Yr Cohort)

Discharge destination	Estimated cost change^	Based on	cost change pre/post
Rough Sleeping / Streets	**$8,886,805**	507 additional ED presentations 223 additional ambulance arrivals 75 additional psychiatric bed days 1,159 additional non-psychiatric bed days	**36.5%**
Accommodation	**-$6,462,089**	359 additional ED presentations 252 additional ambulance arrivals 2,052 fewer psychiatric bed days 1,309 fewer non-psychiatric bed days	**-12.0%**

Notes: ^ Estimated costs based on figures listed in Table 2. Results for Other exclude data for individuals whose discharge destination following first contact was Died, Left Perth / Returned to Country, Prison / Police Custody, Other or Unknown (n=125, 6%)

APPENDIX D: MEDIA, PUBLICATIONS & PRESENTATIONS REFERENCING THE HOMELESS TEAM

Table 31: Academic Publications Referencing the Homeless Team

Article	Mention/ Description of Article
Optimising Access to Healthcare for Patients Experiencing Homelessness in Hospital EDs (2023)	Explores the challenges faced by EDs in providing appropriate care to patients experiencing homelessness, and drawing on insights from the RPH Homeless Team details four recommendations for optimising healthcare access for this population. Emphasising the importance of patient-centered approaches that recognise and addresse the unique needs and challenges faced by homeless patients, and the need for further collaboration between hospitals and community service organisations.
Reducing Hospital Discharges Back into Homelessness (2021)	An invited paper in a Parity special issue on **Ending Homelessness in Western Australia**. Details strategies employed by the RPH Homeless Team to prevent discharging patients back into homelessness and rough sleeping following hospital admission. Examining hospital use for 88 Homeless Team patients supported, it found significant reductions in ED presentations and inpatient admissions in the two months following support. While the article notes that these strategies are largely 'band-aid solutions' amongst broader issues of housing supply and affordability, these temporary solutions can act as 'stepping-stones' to further support and long-term housing.
Socially Marginalised Populations and Their Health: Busting Myths and Shifting the Paradigm (2021)	An invited paper in a Parity special issue on **Preventing Homelessness Deaths**. From the perspective of clinical lead of the RPH Homeless Team, Dr Amanda Stafford, the article explores four common myths and proposals forward around persons experiencing homelessness healthcare service use and best delivery. This includes: • Health is largely determined by the healthcare system, • Improving the health of socially and economically marginalised populations is best achieved by improving access to healthcare services, • Homelessness, the most severe form of social marginalisation, is just too complex to ever fix, and • It's too expensive to fix social marginalisation and homelessness.
Homelessness: the imperative for a public health response (2020)	2020 Douglas Gordon Oration by Lisa Wood invited by the Public Health Association of Australia (PHAA) for its third Prevention Convention. Mentions a case study about 'Craig who through the work of the RPH Homeless Team was housed in an aged care hostel in late 2017 and ceased to present to hospital.
Hospital Collaboration with a Housing First Program to Improve Health Outcomes for People Experiencing Homelessness (2018)	Explores the collaborative partnership between the RPH Homeless Team and the 50 Lives 50 Homes Housing First initiative, and the ways in which coordinated supported between healthcare and housing providers can improved overall support for patients experiencing homlessness. Drawing on hospital, and community service data for a cohort of 44 Homeless Team patients, it concludes that this model of collaboration not only improved discharge outcomes and re-admission in the shorter term, but also contributes to more supportive and stable housing.
Homeless health care: meeting the challenges of Providing primary care. (2018)	This narrative review paper was led by Dr Andrew Davies, the HHC Medical Director who co-founded the RPH Homeless Team. The paper discusses the complexities of people experiencing homelessness and are unaffiliated with any formal primary care, the barriers preventing them from accessing primary care and the key solutions such as prioritising stable housing, continuity of healthcare, specialised homeless healthcare and hospital in-reach with planned discharges and coordinate care.
Tackling Health Disparities for People who are Homeless? Start with Social Determinants (2017)	This paper draws on the case histories and hospital use of three RPH Homeless Team patients to highlight the interplay between social determinants of health and homelessness. The article explores how poverty, lack of affordable housing, and food insecurity contribute to health disparities and high hospital utilisation seen among people experiencing homelessness. It concludes that there is a need to treat homelessness as a combined health and social issue to improve health outcomes and reduce high economic costs associated with chronic hospital utilisation.

Table 32: Conferences and Invited Presentations Referencing the Homeless Team

Title	Person	Conference Name, Location (date)
International Conference Presentations		
The Power of integration: What happens when General Practice and a hospital & community services really do work together?	Dr Andrew Davies, Dr Amanda Stafford & Prof Lisa Wood	Pathways from Homelessness 2020: A Decade for Inclusion Health. London, UK. (Mar 2020)
What can a real time "By Name List" of Perth's rough sleeping population do?	Ms Shannen Vallesi, Dr Amanda Stafford	
Housing First to a pathway to improved health – learnings from Australia	Ms Shannen Vallesi & Prof Lisa Wood	Pathyways from Homelessness: Rethinking Housing and Health. London, UK. (Mar 2019)
Housing First & health service evaluations; Wicked problems, messy data & knowledge mobilisation	Ms Shannen Vallesi & Prof Lisa Wood	
Finding Funding for Homelessness Programs: Target the Head, Not the Heart	Dr Amanda Stafford & Prof Lisa Wood	
Housing First as a pathway to improved health; learnings from Australia	Ms Shannen Vallesi & Prof Lisa Wood	
A week in 15 minutes: The Perth Homelessness Collaboration	Dr Amanda Stafford	
National Conference and Invited Presentations		
Homelessness and Diagniostic Challenges	Dr Amanda Stafford	ANZA-SIDM 2022 Conference, Virtual. (2022)
Homelessness & the ED: Untying the Knot that Binds Us	Dr Amanda Stafford	ACEM Winter Symposium: Shattering Illusions, Embracing the Impact. Cairns. (Jul 2021)
Seven ways to support homelessness week	Dr Amanda Stafford	
The RPH Homelessness Team	Dr Amanda Stafford	Department of Communities WA South Metropolitan Identity Workshop. (Aug 2019)
Health & Homelessness from a Creative Perspective- Walk a Mile in My Boots & more	Dr Amanda Stafford	Homelessness Conference, Adelaide. (Aug 2019)
How GPs can reduce high hospitalisation rates of vulnerable population groups	Dr Andrew Davies	General Practice Reducing Hospitalisation for Homeless People, Gold Coast. (Oct 2018)
Accelerating Evidence into Policy & Practice – lessons from homelessness and health	Ms Shannen Vallesi	Australian Public Health Conference, Cairns. (Sept 2018)
Wicked Problems & Messy Data: Learnings from knowledge mobilisation around homelessness	Prof Lisa Wood	Sax Institute Knowledge Mobilisation Conference, Sydney. (Jul 2018)
What does the latest RPH data tell us?	Dr Amanda Stafford	Health & Homelessness Forum. Cairns, QLD. (Apr 2018)
Healthcare and Homelessness.	Dr Amanda Stafford	Mental Health, Housing and Homelessness Event. Shelter WA. Perth. (Aug 2017)
Homelessness - No fixed address – Can we still deliver care?	Dr Amanda Stafford	2016 Clinical Senate debates. Department of Health. Perth. (Nov 2016)
Invited Presentations		
Mental health & homelessness – structuring a team & collaborating to Support	Dr Amanda Stafford	Mental Health Access & Quality in EDs, Melbourne. (Jun 2023)
Understanding Homelessness in WA	Dr Amanda Stafford	City Rotary Breakfast, Perth. (Feb 2022)
Wicked Problems & Messy Data: Learnings From Housing First & Homelessness	Ms Shannen Vallesi	Homelessweek 2021, Perth. (Aug 2021)
Homelessness	Dr Amanda Stafford	RCD Meeting, Perth. (Nov, 2020)
Homelessness and Creativity	Dr Amanda Stafford	Creative Revolutionaries- Podcast.(Aug 2019)
Finding Funding for Homelessness Programs: target the head, not the heart	Dr Amanda Stafford	Narrowcast Media Group, London. (Mar 2019)
Homelessness and health – integration, collaboration & continuity of care	Prof Lisa Wood	Forum on Homelessness & Health (hosted by SESLHD Populations Priority Unit), Sydney. (Nov 2018) Kirketon Road Centre, Sydney (Nov 2018)
Meeting Wider Needs in a Mental Health Crisis	Dr Amanda Stafford	ACEM: Mental Health in the ED, Melbourne. (Oct 2018)
Health and Homelessness Forum panel	Dr Amanda Stafford	Health and Homelessness Forum, Cairns (Apr 2018)
Mental Health, Housing & Homelessness Forum	Dr Amanda Stafford	Shelter WA, Perth. (Aug 2017)

Table 33:Media Referring or Related to the Work of the Homeless Team Since 2019

Article Title	Journalist, Media Forum	Date
Boorloo Bidee Mia marks 35,000 nights of support and counting	WA Government (story also published in Mirage)	9 Aug 2023
Perth homelessness crisis: Meet Natalie, the city's only 'street nurse'	Justin Benson-Cooper, The West Australian	11 May 2023
My Health Record in Emergency Departments	Dr Amanda Stafford, Australian Digital Health Agency Podcast	2 Nov 2022
Hospital crisis: WA's stretched hospitals having to assist people who have been released from jail	Annabel Hennessy, The West Australian	16 Oct 2021
Homeless deaths in Australia's richest state	Giovanni Torre, The Saturday Paper	18 Sept 2021
Homelessness Week 2021: Change of approach to homeless issue amid mental health, domestic violence	Amanda Hunt, The West Australian	2 Aug 2021
Health care and the homeless	Jan Hallam, Medical Forum	2 Feb 2021
Homelessness and Health	Lawrence Drown, RTR FM92.1	13 Aug 2020
Amanda Stafford Episode	Dr Amanda Stafford, The Frontline Response to Health and Homelessness Podcast	Mar 2020
Helping homeless people get healthy – Interview with Dr Wood and Dr Davies	Life Matters – Radio National	8 Feb 2019

Notes: See the second evaluation report of the Homeless Team[4] for media references made prior to 2019.

APPENDIX E: VISITORS TO THE RPH HOMELESS TEAM

Table 34: Visits by Key Personnel to the RPH Homeless Team

Who	Organisation	Year	Key Comment/Quote
Dr Agnies Zurakowska	NHS	2022	*"It was a privilege to spend a day with the wonderful RPH Homeless Team and to see how it goes about identifying & supporting homeless patients in the hospital, and then connecting them to accommodation, GP care & other supports in the community. I would love to have a team like this in the NHS hospital I am based at in London. I also spent time with the Homeless Healthcare street health outreach team and visited the Hub and Medical Respite Centre – such dedicated people working in all these areas. I could also see firsthand the enormous benefits of having HHC staff working across all these settings - having a familiar face is so important for trust building with people who have often felt let down by the health or social systems"*
Dr Aamena Bharmal	GP Specialist Trainee, Imperial College London	2022	*"Thank you so much for hosting me for my Churchill fellowship. It has been an amazing start of my fellowship - you have set the bar very high for my future observations of services across Australia and New Zealand! Please pass on my thanks to the wider team who have been so welcoming, kind and patient in explaining how their service works - it has been invaluable gaining their insights."*
Dr Stafan Kuiper	Dept. Emergency Medicine, Cairns Hospital (QLD)	2019	*"The Homeless Team at RPH provides an outstanding service, which serves as an example to the rest of Australia of what can be achieved… The Homeless Team addresses the root cause of these patient's problems."*
Ms Helen White	ED Nurse Manager, Sydney Hospital (NSW)	2019	*"SSEH ED commenced last year our own project HOPE (Homelessness Opportunities for Presentations to Emergency) and we are currently building a rich data profile of Homeless presentations. We look toward the learnings and experience of the leading work of the Homeless Team in WA which has shown how homeless health services can make a difference. Collaboration between hospitals with homeless populations enables the sharing of ideas and experiences and ways of capturing data to measure impact."*
Mr Graham Brown	CEO, Bapitistcare (SA)	2019	After his visit, the first RPH Homeless Team evaluation report and the HHC evaluation report were taken by BaptistCare to a meeting with the SA Health Minister.
Mr Jack Snelling	SA Minister for Health (SA)	2019	*"Homeless Healthcare uses a best-practice multi-disciplinary approach to provide primary healthcare to Perth's most marginalised. Similar models will be critical to breaking the revolving-door of hospital presentations overwhelming EDs around Australia."*
Dr Simon Quilty	Katherine Hospital (NT)	2018	*"It was exciting for our team working on developing a program for homeless people within our hospital setting to discover the work done by the RPH Homelessness Team, and to recognise that what we considered essential - community, collaboration and covering a broad range of disciplines and service providers - was very similar to the approach that we have developed organically from within the Katherine community."*
Mr Mark Jentz	Program Manager, Mission Australia (QLD)	2018	*"In 2018 we were able to witness the Homeless Team in action which was very beneficial and provided us with the guidance and support we needed to engage our hospital regarding establishing a similar model in. Mission Australia's plan is to support the Cairns Base Hospital to establish their own Homeless Team, similar to RPH, so we can provide the aftercare and ongoing support that homeless patients require and are entitled to."*
Ms Leslie Dunbar	Drug and Alcohol CN, Mission Australia (QLD)	2018	*"One of our key strategies is to better integrate with the tertiary hospital in Cairns in an attempt to provide long term improvements to health outcomes, to reduce the number of client presentations to the emergency department, to improve client health literacy and encourage independence in personal health decisions. Being able to visit the RPH Homeless Team and Homeless Healthcare enabled us to see this type of integrated care in action."*

Dr Adrian Gillin	Royal Prince Alfred Hospital (NSW)	2018	*"One of the best advantages that we witnessed in Perth was the comprehensive establishment of Homelessness Healthcare. This service has evolved since 2007 and continues to expand to meet the service needs of Perth's homeless population… I wish there was an ability to replicate the RPH service for the homeless in SLHD. It is going to takes years to catch up. The Perth model is an exemplar for homeless health services in Australia and overseas…"*
Ms Stefanie Macfarlane	South Eastern Sydney Local Health District (NSW)	2018	*"What we know from our NSW experience is that often our patients experiencing homelessness present to the ED or are admitted- however upon discharge they are given a discharge summary and instructions to follow up at their GP (where often there is none) or are referred to one of our homelessness health specialised clinics and services- however mostly there is little or no integration among these care providers so follow up runs the risk of being patchy and is often very separate to the care provided in the hospital. The RPH team effectively cuts out the middleman so that the care and support can be streamlined and holistic."*

Notes: * The COVID-19 pandemic precluded any external visits to the RPH Homeless Team between March 2020 and mid-2022