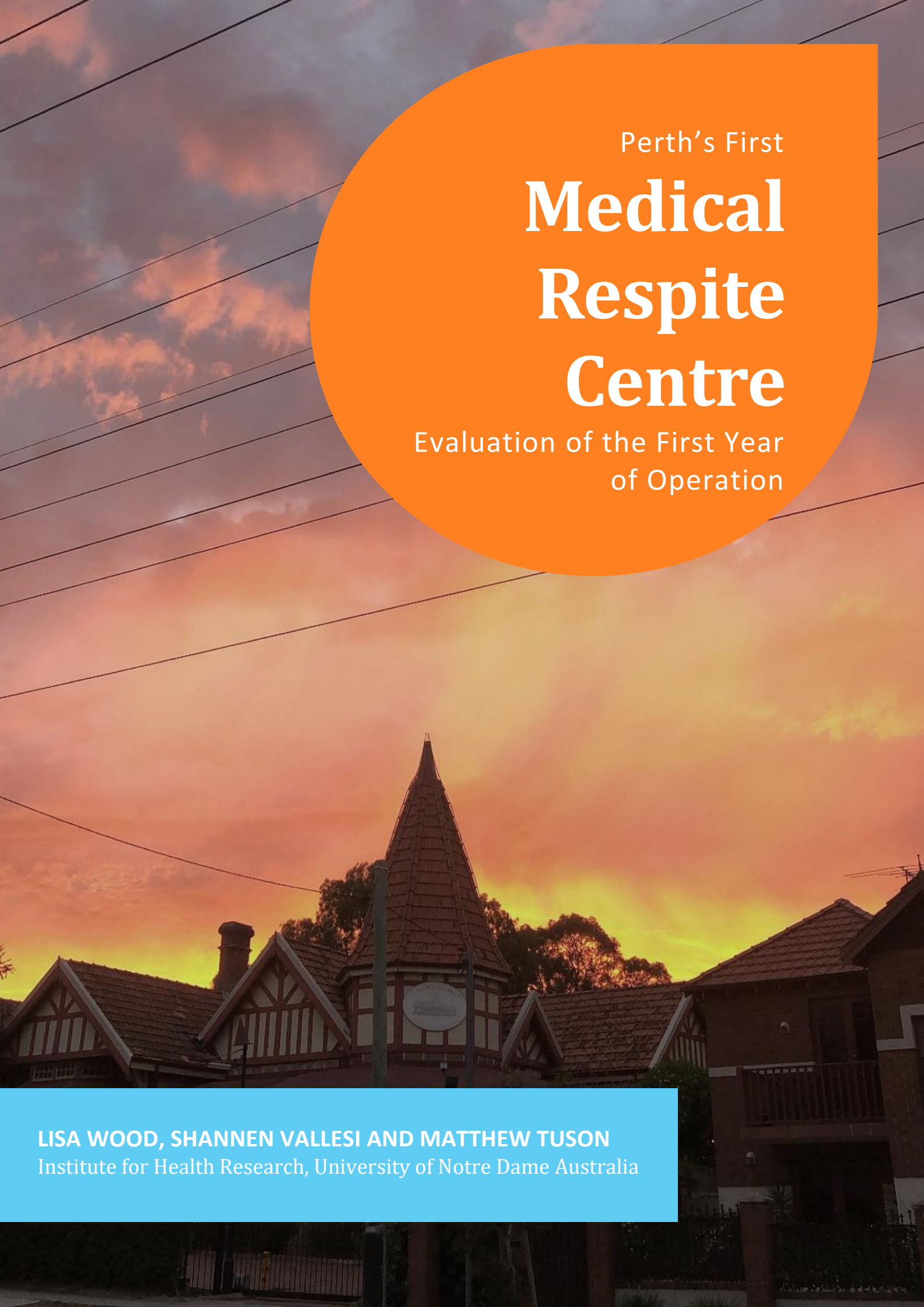

Perth's First

Medical Respite Centre

Evaluation of the First Year of Operation

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Acknowledgements

We acknowledge the Traditional Owners of the land on which we work and live, the Whadjuk people of the Noongar nation. We pay our respects to their culture and to their Elders.

We acknowledge with gratitude everyone involved in providing information, feedback, data, and support for this report. We especially thank the residents of the Centre who have taken the time to meet with us and share their experiences.

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Photos taken by Tony McDonough for Homeless Healthcare are used with permission in this report.

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Acronyms and Abbreviations

ACAT	Aged Care Assessment Team
AHSS	After Hours Support Service
AOD	Alcohol and other drugs
AIHW	Australian Institute of Health and Welfare
BMI	Body mass index
CEO	Chief Executive Officer
C-L/AOD	Consultation-Liaison/Alcohol and Other Drugs
CPOP	Community Program for Opioid Pharmacotherapy
DAMA	Discharged against medical advice
DDI	Data and Digital Innovation
ED	Emergency Department
EMHS	East Metropolitan Health Service
ETOH	Ethyl Alcohol
FDV	Family and domestic violence
GP	General Practitioner
HEART	Homeless Engagement, Assessment Response Team
HHC	Homeless Healthcare
HREC	Human Research Ethics Committee
ID	Identification document
IHACPA	Independent Health and Aged Care Pricing Authority (*previously IHPA)*
KPI	Key performance indicator
LOS	Length of stay
MCOT	Mobile Clinical Outreach Team
MH	Mental Health
MRC	Medical Respite Centre
NDIS	National Disability Insurance Scheme
NHCHC	National Health Care for the Homeless Council
NIMRC	National Institute for Medical Respite Care
NRT	Nicotine Replacement Therapy
OAG	Office of the Auditor General
ORM	Operational Reporting Measures
RITH	Rehab in the Home
RN	Registered Nurse
RPH	Royal Perth Hospital
RPBG	Royal Perth Bentley Group
SD	Standard Deviation
SHR	Sustainable Health Review
UMRN	Unique Medical Record Number
UK	United Kingdom
US	United States
UNDA	University of Notre Dame
UWA	University of Western Australia
WA	Western Australia

Year 1 MRC Evaluation: Executive Summary

Home2Health Research Team

The Medical Respite Centre (MRC)

The MRC is Australia's first medical respite care service for people experiencing homelessness who are being discharged from hospital. The MRC 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 on 25 October 2021 as an initial two-year pilot. The MRC is collaboration between Homeless Healthcare (HHC) and Uniting WA, based in inner-city Perth with close access to homelessness and health services.

20
RESPITE BEDS

24/7
ONSITE MEDICAL CARE

MRC Aims and Objectives

The overarching aim of the MRC is to ***improve physical health, mental health, and social outcomes by facilitating the transition out of homelessness***, underpinned by:

1. To provide coordinated medical and respite care following hospital admission or emergency department presentation for people without safe discharge options;
2. Identify and address physical and mental health issues contributing to hospital ED presentations and/or hospital admissions among people experiencing homelessness;
3. Link residents with a primary care provider to support identification, prevention, management and treatment of health conditions in the community;
4. Utilise MRC admissions as an opportunity to strengthen continuity of healthcare and care coordination;
5. Identify psychosocial and wellbeing needs of MRC residents and link them to community and support services (incl. case management), and;
6. Facilitate access to suitable housing and/or long-term accommodation and associated support.

It's my home at the moment and that's how I feel when I come here. I've got my bed, my room, I can do my laundry, I can shower, come and go. Hospital wouldn't have felt that way; it just would have been clinical.
– MRC Resident

Core Elements of the MRC

- **INTEGRATED HEALTH & PSYCHOSOCIAL SUPPORTS**
- **PERSON-CENTRED HEALING & RECOVERY FOCUS**
- **TRAUMA-INFORMED, THERAPEUTIC ENVIRONMENT**
- **MULTI-DISCIPLINARY TEAM** *(incl. GPs, case workers, peer-support, and AOD specialists)*
- **RECOGNITION OF HOUSING AS FUNDAMENTAL TO RECOVERY**
- **LOW BARRIER ELIGIBILITY**
- **CULTURAL SECURITY & INCLUSION**
- **CONTINUITY OF CARE EMBEDDED INTO SERVICE DELIVERY & DISCHARGE PLANNING**

Referrals in Year 1

280
REFERRALS RECEIVED

86%
OF REFERRALS FROM HOSPITAL SITES

86%
ACCEPTED REFERRALS RESULTED IN ADMISSION

Most common reasons for referral:

- Post-hospital care to facilitate recovery
- Stabilisation of health issues
- Earlier discharge from hospital than otherwise possible (without the MRC)
- Provision of medical care not requiring acute hospital bed *(e.g., wound care, stabilisation of chronic health conditions)*
- Addressing underlying issues driving recurrent hospital use

Admissions in Year 1

152 PEOPLE ADMITTED

177 ADMISSIONS *(range: 1-4 p/person)*

20 DAYS AVERAGE LENGTH OF ADMISSION

79% OF ADMISSIONS >14 DAYS PREVENTED HOSPITAL USE (N= 64)

Who Had the MRC Supported?

Of the 152 residents supported in Year 1:

72% MALE

33% ABORIGINAL OR TORRES STRAIT ISLANDER

54% HOMELESS FOR >1 YEAR PRIOR TO MRC

46% DUAL DIAGNOSIS *(AOD and MH)*

39% >5 CHRONIC HEALTH CONDITIONS

Types of Support Provided

DIRECT MEDICAL CARE

post hospital follow up and monitoring/treatment of health issues, health assessments, preventive screening/investigation, primary care support and care plans, referrals to specialist, allied health and community health services, AOD specialist in-reach

100% OF MRC RESIDENTS HAD HEALTH ASSESSMENT

1 IN 6 MRC RESIDENTS HAD NEW GP CARE PLAN DEVELOPED

HEALTH EDUCATION AND HEALTH LITERACY

relating to existing and newly diagnosed health conditions, harm minimisation, lifestyle modifications, capacity building to self-manage chronic health conditions

IDENTIFICATION AND SUPPORT AROUND PSYCHOSOCIAL NEEDS

personal recovery goals, opportunities to engage with key workers and peer support staff, practical supports relating to housing, ID, financial and legal issues

3 IN 5 SUPPORTED ONTO PRIORITY HOUSING LIST *(of those eligible)*

ONE-THIRD SUPPORTED TO OBTAIN ID

> *Through events and circumstances, I ended up here realising that I need to go to rehab. I've gotten some brilliant support from the people here.* – **MRC Resident**

CONNECTIONS TO COMMUNITY-BASED HEALTH SERVICES AND PROGRAMS

such as AOD residential rehab or counselling, community mental health

TWO-THIRDS CONTINUED TO SEE HHC IN COMMUNITY POST-MRC

4 IN 5 CONNECTED TO AT LEAST 1 EXTERNAL SERVICE *(most common were AOD, MH, and housing)*

SUPPORTING PEOPLE TO ACCESS HOUSING AND ACCOMMODATION

administrative support, priority housing listing, rental bond assistance applications

2 IN 5 MRC RESIDENTS DISCHARGED DIRECTLY INTO HOUSING *(of those who completed admission, the majority of others stayed at StayWitch's or went into rehab)*

STRENGTHENING INDEPENDENT LIVING SKILLS

computer literacy, job seeking, financial management, cooking, attending appointments

HEALING AND MEANINGFUL USE OF TIME

provision of optional activities relating to cooking, arts and craft, music, gardening, physical activity, journalling

> *I'm nearly 65 this year... my provider's looking for a little place for me. I'm hoping to get a little dog... It's companionship and even though I can't walk far... It's motivation to get going. For now, that's my goals.* - **MRC Resident**

FUTURE GOALS

supporting residents to identify goals, investigate job or study options

Health Service Use Prior to the MRC

MRC residents had frequent and recurrent use of the health system prior to their MRC admission **in the three years prior to their first MRC admission:**

- ONE THIRD HAD >10 ED PRESENTATIONS
- ONE IN SIX HAD >10 AMBULANCE ARRIVALS TO ED
- ONE THIRD HAD >5 INPATIENT ADMISSIONS
- ONE THIRD SPENT >25 DAYS ADMITTED AS AN INPATIENT

Most common reasons for hospital use include intoxication, withdrawal and associated complications

$17mil
IN HOSPITAL COSTS IN THE 3 YEARS PRIOR TO MRC^
(APPROX. $38K PER PERSON PER YEAR)

Changes in Health Service Use Pre/Post MRC

Comparing one month pre- and post- MRC first admission date for all 152 residents:

EMERGENCY DEPARTMENT USE

- **45%** REDUCTION IN PEOPLE PRESENTING TO THE ED
- **46%** FEWER ED PRESENTATIONS
- **27%** FEWER ED REPRESENTATIONS WITHIN 7 DAYS

INPATIENT ADMISSIONS

- **64%** REDUCTION IN PEOPLE ADMITTED
- **44%** REDUCTION IN TOTAL DAYS ADMITTED

$2.3mil IN ASSOCIATED HOSPITAL COST REDUCTIONS ^ COMPARING 1MO-PRE MRC ADMISSION TO 1MO-POST MRC ADMISSION
(APPROX. $15K PER PERSON)

Perceived Impact of MRC on Hospital Use

REDUCE UNNECESSARY ADMISSIONS

I referred a 20yo patient to the MRC – he had an abscess drained under care of the surgical team. Typically, this procedure is discharge same day or maximum 1 night LOS. This patient had to stay in hospital until a suitable discharge plan could be ascertained due to needing daily wound dressings. Without a suitable address, he was not eligible for community supports. If the wound was not tended to appropriately, the risk of him representing with infection was astronomically high… In instances like this, the MRC is the absolute perfect solution to ensure people's healthcare needs can be met and avoidable hospitalisations are prevented. – **Stakeholder Survey**

FACILITATE HOSPITAL DISCHARGE

This service has been very beneficial in helping discharge patients from the hospital to ongoing health & accommodation support. – **Stakeholder Survey**

FREE UP ACUTE BEDS

Well [the MRC] frees up the beds, that's for sure. Yeah, like a lot of the people when you look at doing their case management you see that they're just continuously moving through the hospital system… like one person can just keep going through and through. So even just knocking the few on the head is beneficial. – **MRC Key Worker**

We liaised with Homeless Healthcare to discharge a patient to the Medical Respite Centre so that he could continue to receive medical support after leaving hospital. This in turn promotes better health outcomes for the patient plus access to community services and support. - **Social Worker, Tertiary Hospital**

REDUCE REPEAT ED PRESENTATIONS

Fantastic program that has been very useful for homeless patients presenting to ED and reducing unnecessary admission times for vulnerable patients. –**Stakeholder Survey**

^Based on average ED presentation costs to WA Public Hospitals of $922 per presentation and average cost of inpatient admission of $2,787 per day (IHACPA, 2022), on average cost of psychiatric inpatient admission of $1,675 per day (AIHW, 2022) and average cost of ambulance arrivals to ED of $929 (ROGS, 2023).

Year 1 MRC Impacts and Key Findings

This independent evaluation of year 1 MRC indicates that the combination of medical and psychosocial support provided in a trauma-informed MRC setting has to date achieved its two overarching aims:

1. **Improve physical and mental health outcomes for people experiencing homelessness; and**
2. **Improve social outcomes by facilitating the transition out of homelessness.**

This is the first medical respite service of its kind in Australia, with the only other examples much smaller in bed capacity and without onsite medical staff, limiting the acuity of patients who can be admitted.

The ways in which the MRC has benefitted different groups are summarised below:

PEOPLE EXPERIENCING HOMELESSNESS

The MRC has acted as a circuit breaker for the revolving door between hospital and street, provided opportunity to stay in safe trauma-informed environment where medical, wellbeing and social support is embedded. Supporting people to access housing/accommodation is integral.

For a subsample of 42 residents:

67% **REPORTED IMPROVED PHYSICAL HEALTH**

62% **REPORTED IMPROVED MENTAL HEALTH**

PERTH PUBLIC HOSPITALS

The MRC has provided safe discharge option to reduce discharge of homeless patients back into homelessness, reduced recurrent ED presentations and facilitated earlier discharge for some.

HEALTH SYSTEM

The MRC has demonstrated effectiveness of providing alternative discharge pathway for a population with higher hospital use than general population, freeing up of ED, inpatient, and mental health beds via earlier discharge and reduced re-presentations, cost saving associated with reduced hospital use

7x **CHEAPER PER BED DAY COMPARED TO INPATIENT BED DAY**

$1.9mil **MINIMUM OF EQUIV. HOSPITAL USE PREVENTED BY THE MRC** (for a sample of 42 residents)

SUSTAINABLE HEALTH REVIEW IMPLEMENTATION

The MRC has demonstrated shift in healthcare use from acute hospital use to greater engagement with primary care, outpatient clinics, public community health services (e.g., AOD, mental health), and secondary prevention services (e.g., residential rehabilitation)

HOMELESSNESS SECTOR IN PERTH

The MRC has demonstrated the effectiveness of integrating health and homelessness expertise within the MRC model of care; chousing and support needs are able to be identified and addressed in tandem with healthcare, and connecting people to housing/accommodation and follow up supports are a critical aspect of MRC discharge planning.

Key Considerations

The WA MRC has in its first year, demonstrated substantial reductions in hospital use among the cohort of people supported of a magnitude that is impressive in the context of findings from published evaluations of more established respite services internationally. As a pilot, there are nonetheless learnings and considerations for the future of the MRC from this evaluation. These are just some of the considerations as outlined in the full report:

CONSIDERATIONS FOR YEAR 2 OF THE MRC PILOT:

- **Revise KPI for average MRC Admission to be up to 3 weeks:** 14 days is much shorter than the average length of stay in comparable respite care internationally and the complexity of health needs and lack of available housing upon discharge make it challenging to meet this current KPI.
- **Establish prioritised pathways for public housing and supported accommodation** for MRC residents to facilitate timely discharge and free up beds to meet growing waitlist demand for the MRC.

CONSIDERATIONS FOR MRC MODEL AND FUNDING BEYOND YEAR 2:

- **Investigate a more 'fit for purpose' premise** that would enhance capacity to take more referrals for AOD detox, women who have experienced trauma/violence (where shared spaces are challenging), people with mobility needs.

1 Background

1.1 What is A Medical Respite Service?

It is well established that people experiencing homelessness experience higher rates of hospitalisation, prolonged lengths of stay and increased likelihood of hospital readmission relative to housed people, and that they face distinct challenges for complete medical recovery after an acute medical hospitalisation.[1] The concept of providing post-hospital respite care for people experiencing homelessness began in Boston in the early 1990s, and has now expanded to over 141 programs across 39 States in the US,[2] with a growing number of iterations in other countries, including the UK, Denmark, and Australia.[3-7] Medical respite for people experiencing homelessness has been defined by the US National Health Care for the Homeless Council (NHCHC) as:

> *acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in the hospital. Medical respite is short-term residential care that allows individuals experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services. -* **US NHCHC**[8]

There is a mounting body of international evidence supporting the benefits of medical respite care, both to individuals in terms of improved health and social care and to hospitals and health sectors in terms of reducing discharges to homelessness and hospital use.[9-11] The US NHCHC has developed valuable best practice guidelines and standards for medical respite services,[6] and Homeless Healthcare (HHC), which runs the Medical Respite Centre (MRC) in Perth that is the subject of this evaluation, is a member of both the NHCHC and the affiliated Respite Care Providers Network.[12]

While respite services for people experiencing homelessness vary according to local needs and health system context and funding, one of their core elements is the co-location of clinical and support services in a short-term residential setting, with the provision of beds, meals, and coordinated, trauma-informed care. Some examples of other international and Australian respite facilities are provided in Table 36 (Appendix 1).

As alluded to above, evidence from robust evaluations of international[11, 13, 14] and Australian[3, 15, 16] medical respite centres have demonstrated a range of benefits at the individual, hospital and health system levels. Most commonly, these include the role that respite care can play in:

- Providing hospitals with discharge pathways that avert the futility of returning patients experiencing homelessness back to the environment that contributes to their poor health;
- Acting as a 'circuit breaker' for recurrent emergency department (ED) presentations and lengthy, expensive inpatient admissions;
- Facilitating earlier discharges from hospital;
- Supporting post-hospital recuperation and treatment, which is severely hampered if people are discharged to the street;
- Providing a non-clinical, non-institutional environment for trauma-informed post-hospital recovery;
- Facilitating preparation for planned hospital procedures that would not be possible for people living on the street; and
- Supporting the integration of post-discharge medical and social care with primary care, case management, and connections to longer-term accommodation and support.

1.2 Context for Establishing a Medical Respite Centre in WA

The Western Australian (WA) Sustainable Health Review (SHR)[17] highlighted the complexity of issues facing one of the most vulnerable groups in our society – people experiencing homelessness – setting out specific strategies and recommendations for WA over a 10-year period, with Strategy 4, Recommendation 13 specifically recommending WA Health to *'Implement models of care in the community for groups of people with complex conditions who are frequent presenters to hospital'* with a priority for implementation being the *'Introduction and evaluation of a medical respite centre model for homeless people in Perth':*[17]

> *…there are significant challenges in improving the health and wellbeing outcomes for people experiencing homelessness. Homeless people experience a disproportionately high rate of chronic health conditions, which can often be left undiagnosed and untreated for long periods of time. This often results in a reliance on acute health services, supporting the need for increased focus on partnership with other government agencies and community organisations.* **– SHR**[17 pg. 82.]

Accordingly, the MRC model has been designed to contribute to the delivery of three outcomes associated with Strategy 4 of the SHR, including:

i. People are cared for in the most appropriate setting;
ii. Patient experience and quality of life is improved through integrated care; and
iii. Hospital readmissions are reduced.

The MRC model also supports recommendations and findings from the SHR, emphasising the imperative for integration and coordination of health care, particularly as people transition from acute to community settings.

1.3 Structure of This Report

Following on from this chapter:

- ***Chapter 2*** discusses the evaluation methodology;
- ***Chapter 3*** describes the overall MRC model, the key elements of the model and the referral and admission process, and provides an overview of the StayWitch's model (non-medical beds at the MRC);
- ***Chapter 4*** documents the overall numbers of referrals received and admissions to the MRC;
- ***Chapter 5*** describes the demographics and health and social needs of the Year 1 MRC cohort;
- ***Chapter 6*** describes the support provided to MRC residents to meet their needs;
- ***Chapter 7*** provides a comprehensive overview of health service usage of MRC residents both prior to and following their MRC admisisons; and
- Finally, ***Chapter 8*** draws together key findings and learnings from the first year of operation of the MRC and presents recommendations going forward.

2 Methodology

This evaluation used a mixed-methods approach, triangulating numerous data sources to address the aims of both the MRC and its evaluation. Prior to the commencement of the evaluation and the opening of the MRC, an evaluation framework was developed to guide the evaluation process, taking into account the intention of the WA MRC pilot, the MRC aims and its contractual key performance indicators (KPIs), and the MRC model set forth by the tendered consortium of HHC and two key WA homelessness and social sector organisations: Uniting WA and Ruah. Broadly, the evaluation framework was informed by a review of:

- Published international and Australian studies and evidence relating to medical respite care for people experiencing homelessness;[11]
- Outcome measures and data collection recommendations for MRCs developed by the US NHCHC;[18] and
- Evaluation methods, findings and learnings from other homelessness respite models in Melbourne,[3, 19] Sydney,[16] and Adelaide.[15]

This chapter provides an overview of the specific evaluation aims and the data used to measure them. Where possible, comparisons are made with the above-mentioned learnings and findings from other medical respite evaluations.

Most data presented in this report related to the MRC's **first year of operation: 25 October 2021 to 24 October 2022, inclusive.** However, where applicable, some data relating to the first three months of the MRC's second year ('Year 2') have been included to demonstrate continuing or changing trends since late-October 2022.

2.1 Evaluation Aims

To examine the extent to which the MRC has achieved its objectives and intended impacts, and to capture learnings from the pilot that might inform refinements to the MRC and model future sustainability, this evaluation has seven key aims.

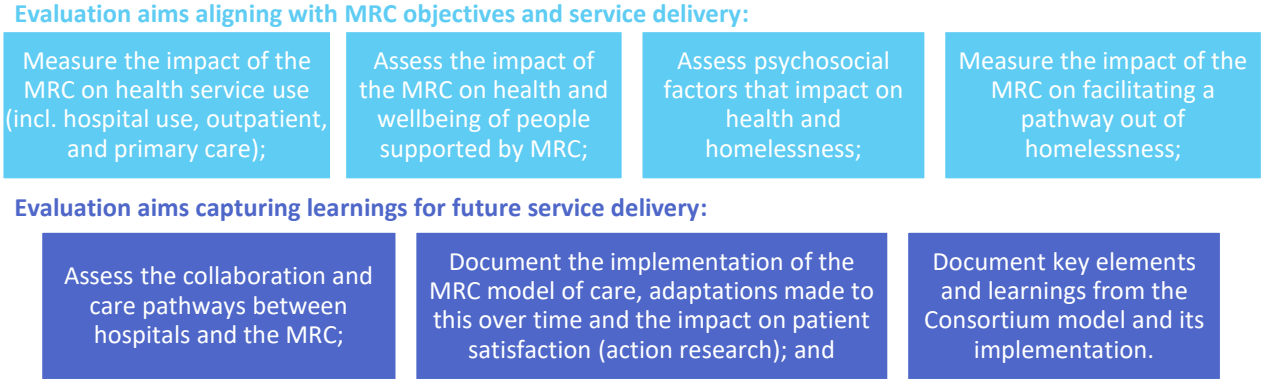

Figure 1: Evaluation Aims

2.2 Key Data Sources

Figure 2 provides an overview of the different types of qualitative, quantitative, and external data sources accessed for this evaluation.

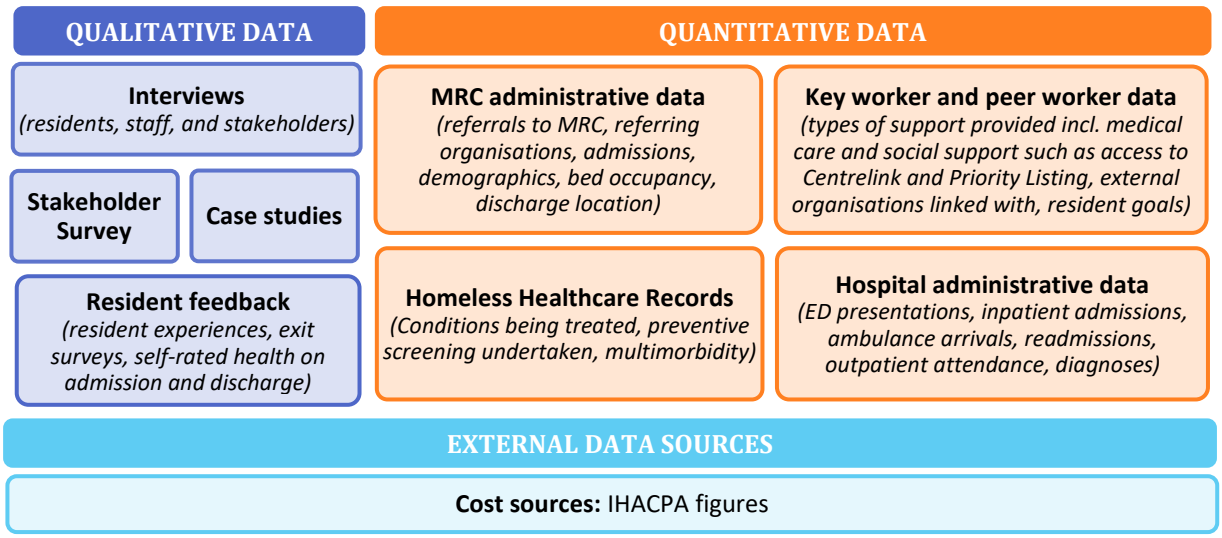

Figure 2: Evaluation Data Sources

Notes: **ED-** emergency department; **IHACPA-** Independent Health and Aged Care Pricing Authority

2.2.1 Quantitative Data

2.2.1.1 Administrative Data

The MRC collects data related to the operation of the service and key information regarding residents, independently from the evaluation. These data sources were used to enhance the richness of the evaluation measures. Table 37 (Appendix 2) provides a summary of key variables collected by the MRC on admission (referral data, intake form, care plan) and discharge (discharge plan and feedback form).

Additionally, the MRC reports on its KPIs to the East Metropolitan Health Service (EMHS). Table 38 (Appendix 2) outlines these KPIs, what the related MRC targets were, and where in this report data relating to each measure are located.

2.2.1.2 Hospital Data

The list of people referred to the MRC in Year 1 was sent to the Data and Digital Innovation (DDI) Unit of the EMHS for linkage to administrative hospital records. This list comprised individuals: who were admitted to the MRC (n=152); whose referrals were either premature / incomplete or rejected; who were ineligible to stay at the MRC; and whose referrals were accepted but who either did not show or who subsequently declined acceptance. Thus, hospital data for 231 individuals in total were requested. A password-protected list of these individuals was provided to the DDI with four identifying fields – unique medical record number (UMRN), name, date of birth and gender – to enable accurate linkage.

As UMRNs were available for all individuals for whom hospital data were requested, those data were provided to the research team with UMRNs intact to enable reverse linkage. The UMRNs were copied throughout the hospital datasets, and were further linked by the research team to the other (MRC and HHC) evaluation datasets. Similar methods of linkage and receipt of hospital data from the EMHS DDI have been used by the research team for previous evaluations of both the Royal Perth Hospital (RPH) Homeless Team and HHC.[20, 21]

The period of time for which hospital data were extracted was 1 Jan 2016 to 31 Dec 2022 inclusive, to facilitate examination of up to five years of hospital use pre-, and as much as possible post-, MRC admission. Data from 11 WA public hospitals (Table 39, Appendix 2) were extracted from the following health datasets:

- **Emergency:** hospital code, mode of arrival, triage date and time, triage category, time in ED, diagnosis, ward (if admitted) and disposition (e.g., did not wait, discharged, etc.);

- **Hospital Admissions:** hospital code, admission type, admission date and time, discharge date and time, length of stay (LOS), number of psychiatric and non-psychiatric bed days, diagnosis codes and descriptions, procedures undertaken, admission status (elective, emergency etc.) and disposal code (e.g., discharged, discharged against medical advice (DAMA));
- **Outpatient:** hospital code, clinic category, date of appointment and outcome (e.g., attended, did not attend, etc.); and
- **Mortality:** date of death, where applicable.

2.2.1.3 Primary Care Data

HHC primary care and summary medical statistics data were extracted in January 2023 from the two systems used by that organisation between 2016 and 2022: Best Practice[a] (up to Nov 2022) and MasterCare[b] (from Nov 2022), to facilitate examination of the reasons for General Practitioner (GP) visit, past medical history conditions, number of primary care plans developed and/or implemented, and other relevant outcomes amongst the Year 1 admitted MRC cohort.

2.2.1.4 Key Worker and Peer Worker Data

Data relating to the types of support provided, referrals made, and any accommodation sourced (including date housed, date exited house and reasons) were extracted from the Apricot software[c] that was being used by the MRC key workers and peer workers in Year 1. Subsequently, two members of the evaluation team worked with three key workers and one peer worker to capture missing and additional data relating to types of engagement and types of support for residents.

2.2.1.5 C-L/AOD In-Reach Service Data

Data were requested from the Consultation-Liaision/Alcohol and Other Drugs (C-L/AOD) In-Reach Service and provided on their behalf by the Business and Activity unit within the Mental Health Division of the Royal Perth Bentley Group (RPBG).

Unfortunately, data were not available for several of the KPIs specified in the Standard Operational Procedure of the C-L/AOD. The information provided included the number of e-referrals from the MRC to the C-L/AOD service, the number of MRC residents that engaged with the in-reach service, and summary patient notes.

2.2.2 Qualitative Data

2.2.2.1 Interviews

Semi-structured interviews were undertaken with a sample of seven residents and seven MRC staff. Additionally, members of the evaluation team spent considerable time at the MRC facility during Year 1 and had countless incidental interactions with staff and residents that have contributed to case studies and key findings for the evaluation.

Residents were asked about their experiences of the MRC (including overall environment and inclusivity); the types of support they received; what their goals were while at the MRC and how they were being supported to achieve these; what external services they engaged with during their stay; if they noticed any changes in their health and mental health since being at the MRC; and, finally, for

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[a] **Best Practice Premier Software** (https://bpsoftware.net/) was the medical software used by HHC to capture medical notes during Year 1 of MRC operation (and up to November 2022)

[b] **MasterCare Software** (https://www.master-care.com.au/) was the medical software used by HHC to capture medical notes from November 2022

[c] **Apricot Social Solutions** is a cloud-based case management system that was used by key workers to capture case notes and support provided to residents

feedback relating to overall benefits and challenges relating to the MRC model, including if they had any suggestions for improving the service.

MRC staff were asked what benefits they had observed for the residents, referring hospitals and the homelessness sector overall; if they had any suggestions around what other services or activities needed to be included in the MRC model of care; what they thought the key learnings to date were; to provide some examples around the types of support they provided; and to suggest examples of residents to be used as case studies, both where residents had positive stays or where the referral may have been inappropriate.

2.2.2.2 Stakeholder Survey

An online survey was designed in collaboration with the MRC manager to elicit key stakeholder feedback on engagement with the MRC, the referral process, perceived benefits and challenges, and case study examples. As all formal referrals to the MRC are sent via email, the survey was sent to all email addresses associated with one or more referrals in Year 1. This included predominantly staff from referring hospitals, but also some contacts from community organisation referrals (which commenced in May 2022). Additionally, the survey was sent to contacts in the social work departments of the five metropolitan public hospitals that were involved in the 2022 Homelessness Discharge Facilitation Fund Project[22] overseen by the Chief Allied Health Office, WA Department of Health. The survey was disseminated at two time points; in August 2022, for all MRC referrals prior to this point, and in January 2023, for any additional referrals made in the last two months of Year 1.

A total of 168 stakeholders were identified and emailed an invitation to complete the online survey. A total of 65 responses were received. The calculation of a response rate removed survey recipients where a reply email indicated that they had ceased working in that organisation or were on extended leave beyond the survey period (n=8). The response rate was thus 39%.

2.2.2.3 Resident Feedback

A patient reported experience feedback form was created by the evaluation team in collaboration with MRC staff and with input from two people with a lived experience of homelessness and the health system. Prior to discharge the feedback form is provided to residents by MRC staff. In Year 1, 21% of MRC residents completed a feedback form. This is a reasonable response rate given that some residents unexpectedly self-discharged or had to return to hospital due to deteriorating health. MRC staff also noted that residents sometimes felt overwhelmed or anxious prior to MRC discharge, and declined completing the feedback form.

The evaluation team also collated examples of unsolicited feedback provided by residents to the MRC, often occurring close to their time of discharge, or sometimes sent to the MRC after they had left. These ranged from letters of thanks, poems expressing gratitude and cards.

2.2.2.4 Case Studies

Numerous case studies were developed by triangulating both the qualitative and quantitative data to document person-centred trajectories of health care and outcomes. These case studies provide rich contextual insights, as the aggregated health service utilisation data capture neither the complexity of interrelated health and psychosocial needs experienced by many of the Year 1 MRC residents, nor the nature and breadth of individually tailored support provided while in respite care.[3]

The case studies (blue break out boxes) and short stakeholder/staff vignettes (orange break out boxes) are scattered throughout the report to capture contextual examples of both the impacts on individuals supported and the workings of the MRC in practice.

All case studies have had identifying details changed and use a pseudonym to protect the anonymity of the residents.

2.3 Data Analysis

2.3.1 Quantitative Data Analysis

Descriptive statistics were computed for age, sex, and ethnicity, with the latter being classified as either "Aboriginal and/or Torres Strait Islander" or "non-Aboriginal", where non-Aboriginal represents residents of all other ethnicities. The age of each resident was calculated as at their date of first admission to the MRC.

Longitudinal analyses of the linked administrative hospital data were undertaken to investigate changes in health care utilisation (ED, inpatient and outpatient) for people who completed one or more MRC stays. Specifically, descriptive statistics were computed to indicate the number of ED presentations, ambulance arrivals to ED, inpatient admissions, inpatient bed days (split by psychiatric/non-psychiatric) and outpatient appointments in the periods three years prior to and 1-month, 3-months and 6-months pre/post each individuals' first MRC admission. The former were computed to characterise the cohort's hospital use over an extended period leading up to MRC admission, and the latter were computed to identify changes in hospital use pre/post MRC admission, i.e., to evaluate the impact of the intervention. The number of individuals with at least one of each type of hospital event, the total number of such events and the proportion of the cohort who experienced decreases, increases or no change in their hospital use pre/post MRC admission are reported.

In terms of the specific calculations undertaken, the following were compared for the Year 1 admitted cohort both pre-to-post MRC admission:

- The number and frequency of ED presentations;
- 7- and 28-day ED re-presentation and re-admission rates;
- The number and duration (length of stay) of hospital admissions; and
- Scheduling and attendance at outpatient clinic appointments.

With regards to the above pre/post comparisons, two approaches were undertaken: first, the hospital use of the cohort was examined pre/post the ***MRC admission period,*** in order to quantify the impact of the intervention as a whole, i.e., as a self-contained period. And second, hospital use was examined pre/post the ***date of MRC admission itself,*** to quantify the direct/immediate cost-effectiveness of the MRC. Further, preliminary analyses were undertaken to characterise differences in this cost effectiveness based on discharge status from the MRC (i.e., whether self-discharged, exited by the MRC team, discharged normally, etc.). And finally, preliminary analyses were also undertaken to investigate the feasibility of a comparison cohort comprising individuals whose referrals to the MRC were accepted but who either did not show or who declined that acceptance to, for example, instead return to family/friends. As noted, these analyses were preliminary in nature only, largely due to the lack of adequate follow up for the Year 1 admitted cohort. However, they will be investigated more fully in the Year 2 evaluation report.

All statistical analyses were undertaken using R[23] and Microsoft Excel.

2.3.2 Qualitative Data Analysis

Interviews with staff and residents were recorded and uploaded for transcription by a professional transcription service that has strict confidentiality processes in place. Interviews were transcribed verbatim by the service and sent back to the evaluation team after completion.

Interview transcripts were coded using the NViVO software[24] and analysed thematically, with the key themes identified including some that were specifically aligned to measures outlined in the evaluation framework.

2.3.3 *Economic Analysis*

As articulated in the SHR,[17] there is a pressing imperative to move away from acute and costly hospital care and better manage health conditions through increased access to community-based primary care and prevention. This evaluation describes the healthcare use of MRC residents and the costs associated with their utilisation of hospital services.

Specifically, **the economic analysis component of this evaluation** examines the costs associated with both the pre- and post-MRC admission hospital use of the Year 1 admitted cohort, utilising cost estimates based on the Independent Health and Aged Care Price Authority (IHACPA), the *National Hospital Cost Data Collection,*[25] the Australian Institute of Health and Welfare (AIHW)[26] and the 2023 Productivity Commission *Report on Government Services.*[27] The average costs used were:

- $922 per ED presentation for WA public hospitals;[25]
- $2,787 per non-psychiatric inpatient bed day for WA public hospitals;[25]
- $1,675 per for WA public hospital psychiatric inpatient bed day;[26] and
- $929 per WA ambulance arrival to ED.[27]

These costs were used to estimate the hospital use costs of the Year 1 admitted MRC cohort in the three years prior to first MRC admission, and to compare the cost of the use of the cohort pre/post both the MRC admission period and the date of MRC admission itself (see previous reasoning). Importantly, consideration was made of potential short-term ***increases*** in hospital use and associated costs, which have previously[16] been shown to arise where untreated or poorly managed conditions (e.g., undiagnosed mental health issues or untreated diabetes) are discovered and addressed, but which have also been shown to diminish over time as patterns of health service use shift towards less expensive primary health services. Potential changes in resident's health service use into the second year of the MRC will be examined in the Year 2 evaluation report.

Finally, cost reductions/savings identified for the cohort in the post-MRC periods were related to the operational costs associated with running the MRC, to estimate its cost-effectiveness. These comparisons help to characterise the potential benefits of avoiding potentially long hospital stays through shifting to lower-cost healthcare modalities.[28]

2.4 Ethics Approval

Human Research Ethics Committee (HREC) approval for the overall MRC 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 MRC Evaluation was initially obtained from the RPH HREC (as an amendment to include the hospital data for the MRC cohort in the longitudinal homeless healthcare research study with reference number RGS0000000075). The RPH HREC provided site ethics approval for each hospital site included in this evaluation, and governance approval was obtained directly from each site. All participants provided informed consent to the use of their data in this report. All data collected and collated during the MRC Evaluation has been stored according to the HREC approval and Western Australian University Sector Disposal Authority Guidelines.

3 What is the MRC and its Model of Care?

3.1 Introduction

Documenting the implementation of the MRC model of care and subsequent learnings is one of the key objectives specified in the MRC evaluation framework. Accordingly, this chapter examines and describes the MRC model of care as implemented for Year 1, and, as is important for any pilot program, notes adaptions and refinements.

Further, this chapter summarises the overarching aims and core tenets of the MRC, and distils key elements of the MRC model and the service it provides according to the following themes:

- Development and underpinnings of the MRC model;
- How the MRC model was developed, and the organisations and sectors involved;
- Role of the physical residential environment and location;
- Staffing model; and
- Flexibility and adaptability of the operational model.

3.2 MRC Aims

The overarching aim of the MRC is to **improve physical health, mental health, and social outcomes by facilitating the transition out of homelessness**.

The primary focus of the MRC is to support people experiencing homelessness to receive post-acute care during their recovery from illness or injury in a safe, community-based environment, while providing the transitional 'window of opportunity' to link the person with housing, community, and social supports as a component of the broader system aimed towards assisting people out of homelessness.

3.3 Development and Underpinnings of the MRC Model

The Perth MRC is a collaborative, integrated service model, developed and delivered by HHC in collaboration with Uniting WA. The service delivery model for the MRC was developed in response to the request for tender issued by the WA Department of Health in early 2022, and has been informed by:

- Models of care and learnings from international examples of MRCs for people experiencing homelessness, including guidelines, standards and examples auspiced by the US National Institute for Medical Respite Care;[6]
- Published evidence from robust evaluations of international MRCs[13,14] and from smaller Australian respite centres affiliated with St Vincent's Hospital Melbourne (The Cottage),[3] St Vincent's Hospital Sydney (Tierney House)[16] and the 2020 pilot of a Homelessness Respite Facility in Adelaide;[15]
- Co-design and involvement of people with a lived experience of homelessness and hospital discharge to homelessness; and
- Contextual considerations specific to the Perth homeless population and the WA homelessness sector and WA health system.

A program logic was developed for the MRC prior to its commencement, with input from the UNDA evaluation team, HHC, Uniting WA and the EMHS MRC Commissioning Group. This original program logic is included as Appendix 3 in this report, and is referred to in later sections.

As the Perth MRC is the first fully medical respite service of its kind in Australia (the only one with onsite 24/7 medical care), there have been some minor operational adjustments to the MRC model over Year 1. However, the core model and ethos has remained constant. Any modifications to the model of care (e.g., the internalisation of the AOD service in Year 2) have been made in consultation with the EMHS MRC Steering Group.

The Perth MRC model has a strong focus on person-centred care, service integration and continuity of care, in alignment with the emphasis in the final SHR report on service integration, whereby people *"have access to services that are provided in a way that is coordinated around their needs, respects their preferences, and is safe, effective, timely, affordable and of acceptable quality"*.[17 p.36]

The core tenets underpinning the Perth MRC model of care are shown in Figure 3.

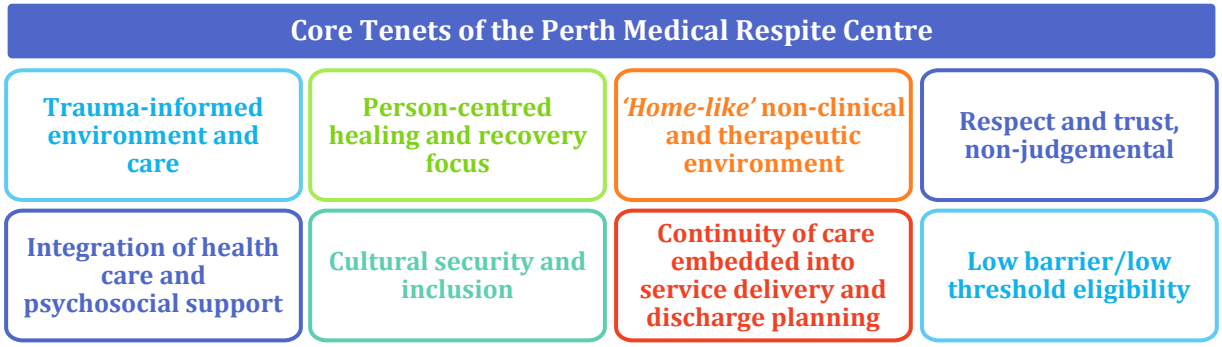

Figure 3: Core Tenents of the Perth MRC

Although the MRC is a location-based service, it is important to note that its underpinning model goes beyond the immediate MRC environment, with continuity of care enhanced through its collaboration with a wide range of hospitals, healthcare services, and homelessness and social sector organisations.

3.4 The MRC Model of Care

3.4.1 Organisations and Sectors Involved

As noted earlier, the MRC was established as part of a tendered consortium collaboration between HHC and two key WA homelessness and social sector organisations, Uniting WA and Ruah. All three organisations were involved in the development of the MRC model of care put forward in the tender. Uniting WA and HHC are the service delivery partners for the MRC pilot: the MRC service contract is with HHC, with Uniting WA sub-contracted to provide key worker staff to the MRC. Ruah is the service partner, providing key worker support staff to the RPH Homeless Team.

In Year 1, the MRC model of care included an in-reach service to support residents with alcohol and other drug (AOD) issues, provided by the C-L/AOD In-Reach Service from the RPBG. Since the commencement of Year 2 of the MRC, an alternative AOD service led by HHC has been implemented that is more integrated into the day-to-day service delivery model of the MRC (see Section 3.4.4.4).

It is pertinent to note that many international MRCs are predominantly medically focused, whereas the Perth MRC model is premised on the critical need to simultaneously address health, psychosocial, and housing needs if the cycle of deteriorating health and hospital use is to be broken. It is on this basis that the strong links with the homelessness sector were established, to enable psychosocial and housing needs to be concurrently addressed alongside medical needs. These links are also embedded physically in the MRC itself via the formalised partnership with Uniting WA, as an organisation with extensive homelessness and social service experience, and with the embedding of key workers from Uniting WA into the MRC model of care.

The organisations involved in the MRC model of care (Year 1) are shown in Figure 4:

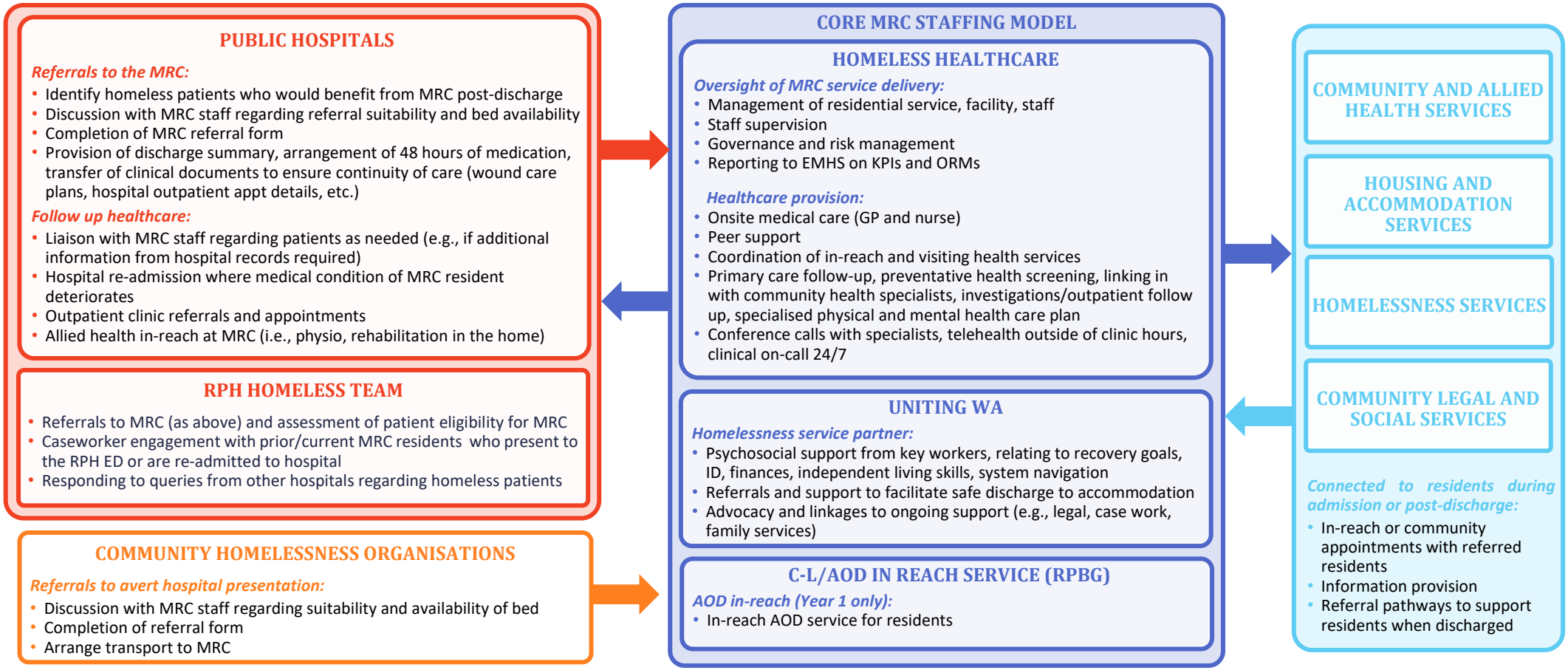

Figure 4: Organisations and Sectors Involved in the Year 1 MRC Model of Care

Notes: **AOD**: alcohol and other drugs; **C-L/AOD:** Consultation Liaison/Alcohol and other drugs; **EMHS**: East Metropolitan Health Service; **ED**: emergency department; **GP**: general practitioner; **ID:** identification document; **KPI:** key performance indicator; **ORM:** operational reporting measure; **RPBG:** Royal Perth Bentley Group; **RPH:** Royal Perth Hospital.

3.4.2 The MRC Property

Photo 1: The Medical Respite Centre Building

The facility for the MRC pilot is a former backpacker hostel located at 148 Palmerston Street in North Perth, in close proximity to inner-city Perth. It is a heritage-listed building with 13 bedrooms that can be shared and 5 bathrooms. Prior to the awarding of the MRC tender, HHC had already secured a lease for this property and had opened 10 beds as a trial non-medical respite service under the banner of **StayWitch's**. StayWitch's provided short-term accommodation for homeless patients who were medically well enough to be discharged from hospital but who had no home or accommodation to be discharged to. Unlike the MRC, StayWitch's was only able to provide non-medical respite; hence, its residents were of much lower medical acuity. Since the commencement off the MRC, StayWitch's has continued to operate within the same building but with a limited number of beds, enabling some MRC residents who no longer require medical care to be 'stepped down' to StayWitch's while awaiting suitable accommodation or for post-discharge support to become available (see Section 3.4.5 for further discussion).

3.4.2.1 Proximity to Royal Perth Hospital, Health, and Homelessness Services

In many cities, homelessness is concentrated in inner city areas and in close proximity to homelessness services, crisis accommodation and inner-city public hospitals with EDs. This is also the situation in Perth, with RPH accounting for 53% of all metropolitan ED presentations by 'no fixed address' patients in 2019; almost 5 times higher than occurred at either Sir Charles Gairdner Hospital or Fiona Stanley Hospital in that year.[29] The MRC is within 2 km of RPH and in close proximity to many homelessness and other health-related services accessed by people experiencing homelessness (Figure 5).

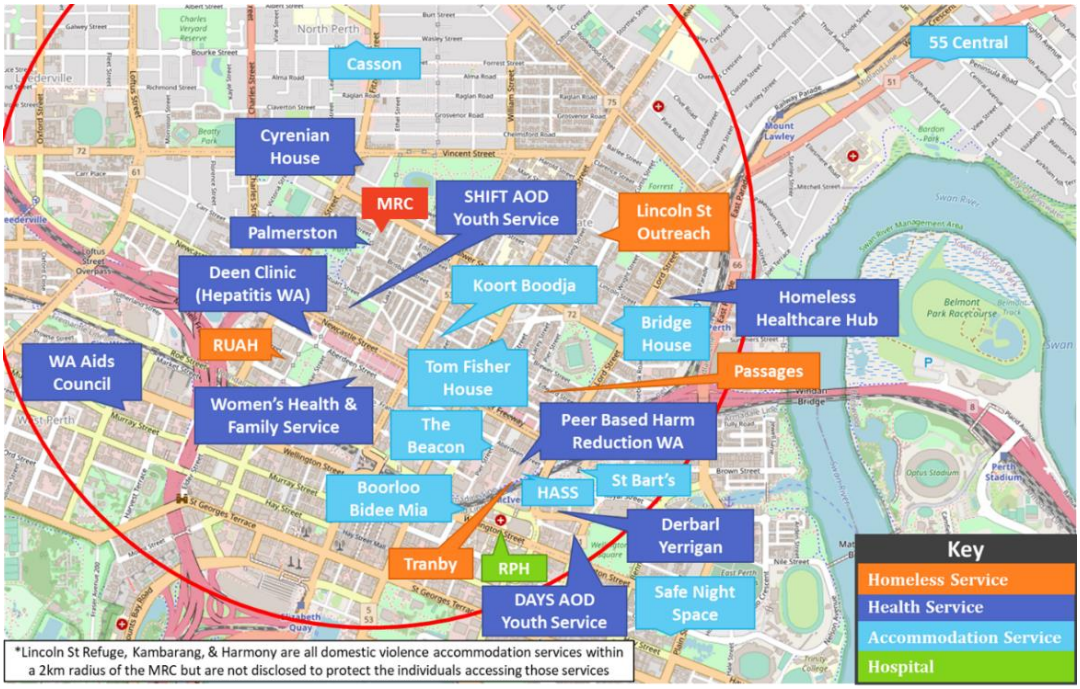

Figure 5: MRC Location and Proximity to Services Frequented by People Experiencing Homelessness

Note: Red circle depicts 2 km radius from the MRC

The property is intentionally located centrally in Perth and nearby other services frequented by people experiencing homelessness, including RPH. It is also within 1.7 km of HHC's Hub, the base for the coordination of all other HHC services, where GP clinics are run every weekday.

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 RPH 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.

> *One benefit of having several of our nurses work across both the MRC and the RPH 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**

> *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**

Proximity to a range of services that support people experiencing homelessness has also been important, and the strategic location of the MRC allows most residents to walk to a number of nearby services. For example, Uniting WA's drop-in centre is a short walk away, with residents also able to walk to appointments at services such as Palmerston AOD service or Hepatitis WA, and walk to a nearby pharmacy for methadone or suboxone dispensing.

Close proximity to green space and public transport is another benefit of the current MRC location. There is a shaded park directly across the road and Hyde Park is less than 500 m away, providing opportunities for exercise and the restorative benefits of nature. Residents needing to catch public transport are close to a free CAT bus[d] service as well as a Transperth[e] bus stop on Fitzgerald Street.

> *I spend all day walking. I'll go down to the river and walk back, go to [rehabilitation centre] or go to the local cafe... I've got like a little morning routine. Get up, make my bed, and have breakfast, porridge, shower, shave and go* – **MRC Resident**

3.4.2.2 Trauma-Informed Therapeutic Environment

The building for the MRC was specifically chosen for its scope to provide a therapeutic, trauma-informed, home-like environment. Some of the international MRC premises are in more clinical-like settings, and advice to HHC from the founder of Barbara McInnis House in Boston (the inaugural MRC in the US) was to locate it in a more home-like setting if possible. This was reiterated by staff from the small non-medical respite centres affiliated with St Vincent's Hospitals in Melbourne and Sydney respectively, both of which are cottage or home-like environments. As reflected by the Manager of Tierney House (Sydney), creating a homely and supportive environment that doesn't feel clinical is critical to helping residents relax and achieve the best possible outcomes for their health:

> *…creating a calm, relaxed environment where the residents can improve their physical health, access good nutrition, plentiful H_2O, hopefully improved sleep hygiene, formulate a care plan driven by them and be linked with health and psychosocial services of their choice, leads to the best possible outcomes for them.* - **Cameron French, Manager, Tierney House**

The US National Institute for Medical Respite Care recently released a checklist for creating a trauma-informed environment in medical respite settings for people who have experienced homelessness, and

[d] Perth's Central Area Transit (CAT) system offers free bus services along several inner-city routes.
[e] Transperth is the name of Perth's major public transport system operator (includes buses, trains, and ferries)

this highlights the **importance of a healing physical and psychological environment that enables people to feel safe, to have choice, and to be in a space that promotes health and wellbeing.**[30] The benefits of a comfortable home-like environment that does not feel medical or institutional have also been observed by people with a lived experience of homelessness in relation to respite care.[3, 31]

The heritage-listed building used for the MRC was initially a substantial home built in 1898 that has been added to over the years and used for a variety of different purposes, most recently, as noted earlier, a backpacker hostel that closed during the COVID-19 pandemic. When HHC first leased the property for StayWitch's, some minor renovations and adaptions were made to create a more therapeutic environment, including painting, cleaning, installation of a universal access bathroom, and living and dining area refurbishment. With its high ceilings and large bay windows, there is considerable natural light, and there is a large, paved courtyard area. The décor and furnishing of common areas have intentionally avoided conveying an institutional atmosphere, as many people who have been homeless in WA have experienced institution-related trauma.

As reflected by one past resident, the MRC felt like their home:

> *It's my home at the moment and that's how I feel when I come here. I've got my bed, my room, I can do my laundry, I can shower, come and go. Hospital wouldn't have felt that way; it just would have been clinical.* **– MRC Resident**

Photo 2: MRC Layout and Features

3.4.2.3 An Environment that Fosters Independent Living Skills

When people are living on the street or in and out of crisis or short-term accommodation, even basic independent living skills are often not possible or are hindered. This includes daily and sleep routines, meal preparation, laundry, personal hygiene, budgeting and finances, and self-care. As the MRC has a strength-based model of care that seeks to empower individuals towards being able to live independently, it has intentionally incorporated a range of opportunities for people to regain or build skills relating to independent living. The recent US guidance on trauma-informed respite care notes the importance of providing people who have experienced homelessness with choice and agency,[30] and this is reflected in the examples provided in Figure 6 of ways that the MRC fosters independent living skill development, responsibility and agency.

Household/Domestic Skills	Safety and Security	Computer/IT Literacy	Self-Empowerment
• Purchase own food items and store these in the resident's fridge • access to kitchen to make hot beverages/snacks • contribute to daily meal prep • self-service laundry room for laundering of own clothes • gardening space, beds & tools to encourage therapeutic activities • encouraged to assist with day-to-day MRC tasks (e.g., wash dishes, preparing bed linen for rotation)	• access to lockers so residents in shared rooms feel comfortable leaving possessions when off site • providing a temporary residential address so that people can store & receive mail, be eligible for services that require a residential address (e.g., public housing appointments or specific medical appointments)	• computer terminals in common room to enable access to Centrelink, MyGov, banking, other online services • support to search online for jobs, create resumes, write job applications, • access to phones and computers to make appointments	• opportunity to choose their own toiletries, basic clothing from MRC supplies • hair dressing sessions to restore resident's dignity & boost self-confidence

Figure 6: Support for Independent Living Skills

Many of these elements are 'small things' that can be significant in the eyes of residents, and help to highlight the non-institutional and non-clinical nature of the MRC setting.

> *people often want to help out with cooking. We don't expect them to, but having a sense of purpose and feeling useful matters to many residents who stay here. The residents can suggest a recipe or come up with an idea about something to cook, and it is a great way for staff to just informally spend time with residents and get to know them better* - **MRC Peer Worker**

> *One of the residents was often anxious but enjoyed helping out around the property, offering to water the kitchen garden or help out with handyman tasks*. - **MRC Peer Worker**

> *…we often have residents who don't know how to use a washing machine, here they get to learn how to do without feeling ashamed, and sometimes other residents help out to show new residents how to use it* - **MRC Key Worker**

> *I know the staff are busy with patients... That's why if I see the yard needs a bit of a sweep, I'll get up and sweep. It gives me something to do… keeps my mind off things. And because I think they've tried to make it feel more like a house, so I don't mind pitching in...* – **MRC Resident**

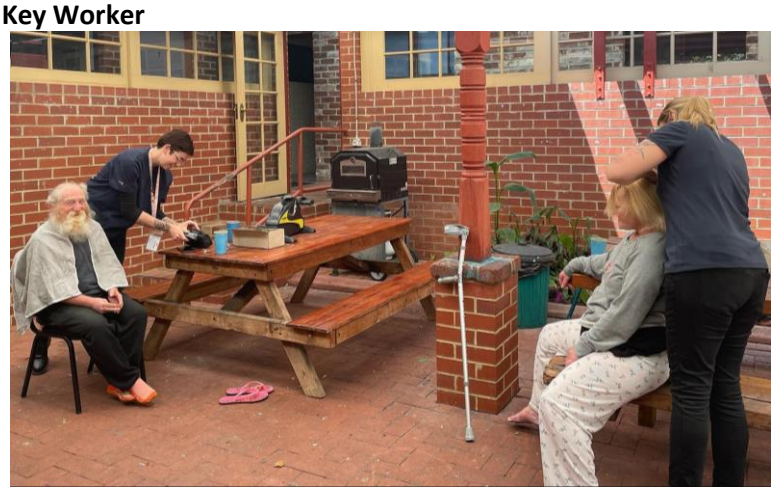

Photo 3: Staff Cutting Residents Hair

3.4.2.4 Adaptations to Support Inclusion and Diversity

While modifications to the property being used for the MRC pilot are significantly constrained by its heritage listing and lease conditions, and budget limitations, there has been a commitment from the outset for the MRC to be inclusive and 'low threshold' in terms of the types of referrals it can accept. To facilitate this, modifications made to the property in the first year included:

- A wheelchair accessible bathroom;
- A bedroom with a private bathroom for residents requiring single-gender bathrooms;
- Furniture configuration that facilitates mobility of residents with walking aids or wheelchairs;
- Security measures and services to prevent uninvited external access to the MRC, as many residents have anxiety relating to safety and past experiences of family violence; and
- Enabling residents to bring their pets on site (a common barrier to engaging in services).

Photo 4: Some of MRC's Furry Visitors

3.4.3 The MRC Staffing Model

Because of the collaborative nature of the MRC model of care, the MRC staff are a multidisciplinary team consisting of clinical support, case support and peer support. Figure 7 provides an overview of the core roles of staff present at the MRC. The Perth MRC has medical nursing staff on site 24/7, as well as daily GP in-reach and an on-call GP. This renders it a fully 'medical' respite service, in contrast to, for example, The Cottage (run by St Vincent's Hospital Melbourne) and Tierney House (run by St Vincent's Hospital, Sydney) which do not have 24/7 medical staffing.

Figure 7: Core MRC Staff Roles

Note: this figure only includes core MRC model staff and does not describe additional administrative support provided by HHC.

3.4.3.1 Staffing Ethos

As recognised in the literature and published evaluations of homeless health and residential services, it is critical to have 'the right type of staff experience and values' when working with people who have experienced not only homelessness but also compounded lifetime trauma and, frequently, past negative experiences of the health system. Therefore, from the outset, HHC was very intentional in its recruitment of staff for the MRC pilot. As articulated by the MRC Director of Residential Services, a staffing mix was sought that reflected:

- Familiarity with, and commitment to, **trauma-informed practice**, **cultural security,** and **inclusion** of diversity;
- **Experience in working with people who have experienced homelessness** and/or other population groups that have experienced issues that often co-occur with homelessness (such as AOD use, mental health issues), e.g., people identifying as Aboriginal or LGBTQIA+;
- An **understanding of the social determinants of health** and the intersectionality of housing, health, and homelessness;
- **Experience in the provision of healthcare outside of mainstream clinical settings**;
- Willingness to work within a **multi-disciplinary and collaborative service model**; and
- Personal values relating to the importance of resident engagement that are **non-judgemental, empathetic, respectful, and person-centred.**

To achieve this, HHC utilised intentional recruitment and employment techniques to ensure staff were the 'right fit'. As described by the MRC Manager of Residential Services, who coordinated the recruitment of MRC staff, this included:

- Interview questions tailored around scenarios and case studies to allow potential employees to explain how they would approach a situation and support a person in crisis;
- Targeted recruitment through social media/the HHC website to attract people already interested in HHC's work, rather than broad advertising on general employment websites;
- Intensive support to new employees, ensuring they understood HHC's origins and ethos;
- Pairing new employees with experienced HHC workers and requiring recruits to shadow nurses/staff at other HHC clinics to provide greater contextual knowledge of the organisation's drop-in centres and partnerships;
- Increased supervision during the initial first few months of employment to establish suitability of the new employee and to set good self-care and debriefing practices;
- Daily team meetings to check in with every staff member on-site in a safe sharing space; and
- Recognising the idea that specific skills can be taught (excluding minimum clinical registration requirements), allowing for recruitment to focus on 'the right fit', particularly those with high empathy, high emotional integrity, and a non-judgemental outlook.

Additionally, staff are provided training and professional development opportunities to provide continuous improvement of knowledge and skills. Examples of training include de-escalation training, mental heath training, Naloxone training (via the Mental Health Commission), By Name List training (via the Zero Project), and advanced-level supporting of people with mental health and AOD training.

3.4.3.2 Staff Qualities

As part of the evaluation team's remit to describe and appraise the MRC model, key themes pertaining to the attributes and characteristics of the staffing model have been analysed from data collected via qualitative interviews with a sample of residents, resident feedback forms, and the survey of referring organisations. Table 1 provides an overview of key qualities and characteristics that both residents and stakeholders have highlighted about the MRC staff.

Table 1: Staff Qualities, Characteristics, and Engagement Styles

Characteristic	Example Quote/s
Staff Qualities and Characteristics	
Passionate and dedicated to helping residents	*Absolutely brilliant. Staff are fantastic, kind, caring, welcoming, warm, no judgement. You can see there's real concern, it's not just like a job to them, it's something they're really passionate about* – **MRC Resident** *The client could not speak more highly of the staff at MRC and the accommodation provided which facilitated entry into residential rehabilitation.* **– Stakeholder Survey** *I am really glad to have met and interacted with the staff as they were very resourceful, went above and beyond, knew each of our names and situations very well and accomplished a great deal in a short amount of time*. – **MRC Resident Feedback**
Non-judgemental and empathetic	*… I've been to quite a few counsellors and psychiatrists and they really haven't been through a lot of rough stuff. Tough times. You can tell they're just working out of a textbook and you should be doing this and that… sort of not understanding that when you're on the streets, it's really hard to get yourself motivated to do anything... a peer worker can empathise a lot more and understand what you're saying to them* – **MRC Resident** *All your different personalities and quirks all working as one. Your level of professionalism under extreme circumstances, the fact that you don't judge and still can find it in your heart to look after us you all should have wings.* **– MRC Resident Feedback**
Approachable, friendly, and caring	*[Staff member] is fantastic. She goes 'hello my friend, how are you?', you know just this happy, smiley, bubbly face. It was just so nice. All the staff here are absolutely fantastic.* **– MRC Resident** *Not one staff member was uncaring. The staff did an amazing job my angels who will always have a special place in my heart forever, love you all and I'll miss you.* **– MRC Resident Feedback**
Receptive to residents' needs and feedback	*When I felt unsafe because of other client's behaviour, I told the staff and they acted immediately.* **– MRC Residents** *… I said something, and you know, and they take that onboard, they do. It's not like they just go 'oh f***ing whinging again'. No, they actually are concerned for the residents and concerned for the safety and the comfort as well for the residents here. So, absolutely, very approachable. Hundred per cent approachable.* **– MRC Resident**
Approach to Engagement with Residents	
Team cohesiveness	*Support staff were always there for me and always more than helpful & willing. Staff are well tuned as a team and operate at a high standard at all times and are ALL on the same page. Exceptional. Thank you all.* **– MRC Resident Feedback** *… there's no hierarchy or anything like that. There's none of that stuff. I haven't seen anything that would stipulate that someone else is higher in rank than anyone else. Even when there was a young [Student nurse] coming in here and learning, you could see they were really caring and loving for her… in the approach they were teaching her…* **– MRC Resident** *…its like one single team of staff* – **MRC Resident** *When I got sick and first meet all you different people, you all came together as one to help make me better again and become a strong black mother that I am. Now I will always hold a place in my heart for my newfound family and my great new friends which are now my family for life.* – **MRC Resident Feedback**
Trauma-informed approach	*I started talking to [Peer worker], I think it was the first day that I got in here. He was telling me about what he'd managed to achieve on his own… he's gone through a very, very similar circumstance. It makes me realise that it's not impossible. If he's gone about it doing it his way, then maybe there's a way that I can achieve this.* **– MRC Resident** *When I got here, I was pretty anxious and stressed. I think the first thing one of the staff did was make me a toastie when I came in, so that says it all doesn't it? Here's something to eat. It was like, oh God finally, somewhere safe.* **– MRC Resident** *It's the first time in my life I've felt safe* **– MRC Resident**
Welcoming culture	*When is staff not staff? When they make you feel like family!!! You guys have been amazing, thank you for making me feel like I had a home.* **– MRC Resident Feedback**

Box 1 provides an example of a how a hospital staff member, who had been caring for a long-term patient who experienced family and domestic violence (FDV), felt reassured and confident about the care their patient would receive at the MRC due to staff kindness and knowledge of trauma:

Box 1: Stakeholder Vignette – Reassurance that the Patient is Safe

Mid-2022 – A patient of mine had experienced FDV and hospital presentation due to FDV assault. Patient has been on the ward at [*Hospital]* for some time recovering, but due to their homelessness no safe discharge plan could be identified. My referral to the MRC was accepted and *[patient]* was provided with supportive accommodation with follow-up engagement, referrals to long term accommodation services, and FDV support.

The MRC intake and assessment team were very patient, kind, and FDV and culturally aware and informed. I felt reassured that the long-term patient, whom I had a strong rapport with, was safely discharged to MRC and would receive support there.

Note: Vignette taken from Stakeholder Survey and thus has been written from the perspective of the referrer

3.4.4 The MRC Model Flexibility and Adaptions

As the MRC is a pilot, the model of care and the requirements for residents need to be flexible and adaptive towards changing demand. Below are five examples of modifications made to the model during the first year of operation – these are examples that were particularly notable to the evaluation team, but there are many other more minor modifications that have been made to the model of care along the way, entirely congruent with the commitment to quality improvement and the pilot nature of the MRC. Indeed, a focus on quality improvement has been recognised in the recently revised US National Institute for Medical Respite as one the eight core standards for the delivery of such respite services for people who have experienced homelessness.[32]

3.4.4.1 Employment of Peer Workers

While the peer movement has been widely adopted in the mental health and AOD sectors, there are far fewer examples of this in the homelessness space, and especially in Australia. It is well recognised, however, that individuals with lived experience of an issue can offer a unique understanding and provide support based on their own experiences and interactions with the system in which they work, as well as acting as a caring and sympathetic advocate for the client/patient.[33]

The original MRC budget did not allow for funding for peer support workers, but HHC saw this as an important part of the model to be piloted. A grant application was thus submitted to Lotterywest to implement a peer support and wellbeing and life skills program support at StayWitch's and the MRC. HHC was successfully awarded this grant, and in December 2021 the MRC employed its first peer-support worker, a former HHC patient with a lived experience of homelessness, AOD use and other adversities. In August 2022, a second part-time peer worker was employed, in response to resident and staff feedback about the valuable contribution of the peer role to MRC service delivery and patient outcomes.

Key aims of MRC peer worker role:

- Build rapport and trust with residents
- support residents with their goals and confidence around recovery
- encourage and support engagement in therapeutic activities and development of independent living skills
- Advocated for and champion the voice and concerns of residents;
- Provided practical and emotional support to residents;
- Shared insights and support to other MRC staff to maintain an inclusive and culturally aware environment

In Section 6.2, the benefits of the peer worker role are expanded, but we include it here as an important example of adaptions to the MRC model of care that, in our view, has enhanced the quality and breadth of care the MRC is able to provide, in a way that is not feasible within a hospital or clinical setting.

3.4.4.2 Overnight Awake Shifts

In the original MRC tender, there was only sufficient budget for a sleep shift overnight nurse. However, it was soon realised that, due to the high needs of residents, the sleep nurse was being woken numerous times during the evening. After approximately five months of MRC operation, the sleep shift was changed to an awake shift to better support residents and their medical needs overnight.

Adapting the service and sourcing other funding to increase medical staffing during the night demonstrates the MRC commitment to maintain low barrier eligibility, and to, wherever possible, accept referrals even for people with quite high medical acuity. This speaks to the value of formally piloting and evaluating this service, as the budget for staffing and the MRC overall was set prior to data on the likely medical complexity and acuity of referred patients being available.

3.4.4.3 Resident Admission Requirements

From the start of Year 2 (November 2022), residents are required to sign a *"48 Hour Policy Agreement"* upon MRC admission. In signing this agreement, residents agree that they will not leave the MRC premise within the first 48 hours of admission, to ensure that they can be safely monitored by the medical team, and that leaving the site will forfeit their place at the MRC.

While this evaluation report is not looking at Year 2 data, anecdotal evidence from MRC staff is already indicating that, since the implementation of this policy, residents have much better adherence to their treatment, their behaviour has improved and they are more likely to complete their stay (i.e., they are less likely to break curfew or abscond).

3.4.4.4 Supporting Medical Detox

As noted earlier, the MRC model initially included an AOD in-reach service provided by RPBG from Monday to Friday. While the C-L/AOD RPBG In-Reach service was needed for many residents, the model has been adapted to be an internal service provided by MRC nurses. Additional funding was sourced to have a full time AOD Registered Nurse at the MRC and a daily GP on call.

As articulated by a review by Lee and Allsop[34] on the disconnect between AOD and mental health care within the health system, a **key goal of integration is to ensure all a service user's needs are met in a coordinated and seamless way**. This is particularly important for people experiencing homelessness who have often 'fallen through the cracks' of what is often a siloed health system.[35] Thus, the decision to make this an internal service enables better coordination with other MRC activities and increases the physical presence of AOD workers on-site. Importantly, a decision was made to upskill existing MRC staff into the AOD role, meaning that the role was filled with by someone with both experience working in the homelessness sector and understanding of the MRC model.

The increased registered nurse (RN) and on-call hours have enabled (for Year 2 of the pilot) the MRC to accept people earlier in their detox journey and with higher AOD acuity. This is a ground-breaking service, not only for WA but across Australia.

3.4.4.5 MRC Vehicle

Not having a vehicle for transportation was a limitation for much of Year 1, but HHC successfully obtained philanthropic funding for the use of a car at the MRC. This has enabled staff to drive residents to health or other appointments where public transport is not an option, or where a resident has very limited mobility. Additionally, residents are transported to housing assessments, bail reporting, court, and accommodation viewings, and other locations.

Having an MRC vehicle has also enabled staff to support residents who are nervous or anxious about attending or getting to appointments. Prior to this, residents were provided with Transperth vouchers and a map, or given a taxi voucher to assist them to their destination.

The car is now used multiple times per day, and individuals with medical appointments are prioritised (whilst taking into consideration the need to ensure residents do not develop a dependence on HHC transport options). MRC staff still assist residents to utilise the CAT bus services or provide them with a Smart Rider[f] where it is seen as beneficial to foster the independence of a resident.

Staff feedback has indicated that having an MRC vehicle has helped reduce transport and confidence barriers to attending outpatient clinics. This is salient, as non-attendance at outpatient appointments is relatively high amongst patients who are homeless.

3.4.5 Post-MRC Step-Down Care

Individuals who have received ongoing care through the MRC and who have been supported to stabilise their health may be medically ready to be discharged from the MRC but may not yet have acquired suitable discharge accommodation or other social supports such as Centrelink payments. As such, there is often a need to provide continual 'step-down' care to these residents as their support needs shift from primarily medical recovery to a broader range of physical and psychosocial issues.

StayWitch's, which opened six months prior to the commencement of the MRC, was, as noted earlier, initially utilised to provide non-medical, short-term accommodation for individuals experiencing homelessness being discharged from hospital with no safe accommodation. Since the commencement of the MRC, the StayWitch's service has been retained within the same building, but with a reduced number of beds.

Photo 5: StayWitch's Welcome Sign

In conjunction with the MRC, this service has been utilised to support residents who would otherwise have to be discharged from a medical bed into unsuitable or unstable circumstances. Once residents are medically cleared at the MRC, they may be given the option to 'step-down' to StayWitch's, which residents partially self-fund as a co-payment. Once transferred to StayWitch's, residents continue to have access to key worker support, and can make appointments with HHC GPs as required. While nursing staff no longer provide daily medical support, they are there to support these residents if their health deteriorates or if they require follow up.

Supporting residents post-medical recovery enables improved engagement in social support and case management, as often when residents first arrive to the MRC they are too unwell to fully participate in referrals to other services and social supports. Thus, step-down to StayWitch's from the MRC facilitates a period of rest, where residents can recover, out of the 'survival mode' required for daily life on the streets. The additional time spent in StayWitch's enables staff to create long-term discharge plans, link residents with ongoing case management, pursue stable accommodation, and ensure residents are provided with the tools they need for a successful discharge from the service. Without these supports in place, individuals discharged back to unsuitable circumstances would likely continue in a cycle of high ED use.

[f] SmartRider is the name of Transperth's contactless electronic ticketing system used throughout all metropolitan transport services.

Reasons for step-down to StayWitch's:

- Residents no longer require 24/7 medical respite but need additional transition time to build capacity, improve health literacy or support independent management of their health conditions and medications;
- Residents have complex health issues and require longer periods of monitoring and management – and have a high likelihood of returning to hospital if discharged to non-supported accommodation;
- Residents are awaiting suitable discharge accommodation to become available, e.g., supported accommodation due to having mental health issues or a disability;
- Residents are saving financially for compulsory, up-front bond payments for rental accommodation; and/or
- Residents are awaiting placement at residential rehabilitation facilities.

Residents' lengths of stay at the MRC and the need for the StayWitch's service is driven by the lack of available, affordable rental accommodation, and significant wait times for supported accommodation, residential rehab, and other specialised community services required by residents with more complex needs. In Year 1 of the MRC pilot;

- 32 residents were stepped down to StayWitch's, for durations ranging from 6-52 days; and
- 75% (3 in 4) of those who stepped down to StayWitch's paid the $30/night co-payment.

As noted by HHC and MRC staff:

> *Without the additional StayWitch's beds to discharge some residents to, fewer new referrals to the MRC could be accepted as beds would still be occupied by people who don't still need full medical care, but whose health and situation would deteriorate significantly if they were discharged back into homelessness.* **– Alison Sayer, Chief Operating Officer, HHC**

> *Prior to the MRC, Homeless Healthcare was already trialling the provision of some non-medical respite accommodation at the same premise, known as StayWitch's. Once the MRC commenced, StayWitch's was retained as a step-down option that has proven invaluable for residents who require a longer period of support to build their confidence and ability to self-manage their health conditions and medications. The StayWitch's step down option has also been essential for averting discharges back to homelessness, as we often have residents who no longer require medical care, but they are waiting for housing or supported mental health accommodation or a residential rehab place. We have also had some residents stay on at StayWitch's until their NDIS package is confirmed. In the view of the MRC team, being able to transition some residents from the MRC to StayWitch's has enabled continuity of care that has definitely prevented re-presentations to hospital".* **– Zoe Thebaud, Director of Residential Services, HHC**

Photo 6: MRC Key Worker

4 MRC Referrals and Admissions

This chapter firstly describes the MRC referral process and stakeholder feedback on this, and secondly presents data on the number and eligibility of referrals in Year 1 and where referrals came from. The chapter goes on to describe the admission process, the number of admissions and patterns of MRC occupancy in its first year of operation.

4.1 Referring to the MRC

4.1.1 The Referral Process

Referring a client or patient to the MRC is often a back-and-forth process between MRC staff and the referring agency (either hospital or community organisation). This enables a discussion around suitability of the referral and current MRC capacity before a service makes a referral. This can be a lengthy process due to the number of incomplete referrals that the MRC receives that require additional information (or consent) before a decision can be made. A flyer (Appendix 4) was made available across EMHS sites to staff to inform them of the service.

The offer process is depicted in Figure 8:

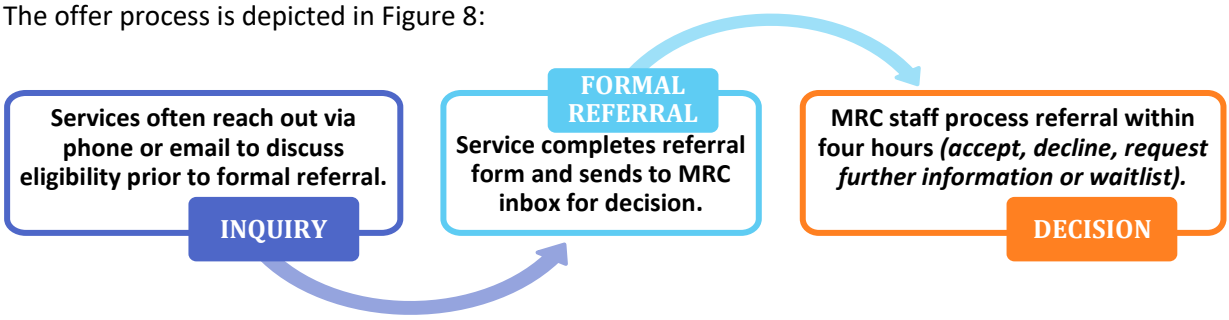

Figure 8: The MRC Referral Process

As the MRC is a new, unique service and a pilot, the evaluation has sought feedback on the referral process from the perspective of hospitals and community organistions who have or are likely to refer people to the MRC.

4.1.1.1 Responsiveness to Accepting and Declining Referrals

The MRC had two key KPIs relating to the time taken to respond to referrals:

- **KPI 2**: That at least 90% of referrals were responded to within four business hours; and
- **KPI 3**: That 90% of patients were admitted to the MRC within 24 hours of acceptance of the referral (subject to bed availability).

In Year 1, referral and admissions data confirms that the MRC met both of these KPIs, with 100% of all referrals responded to within four hours and 11/12 months having 100% admission within 24 hours of referral acceptance. The only exception was when, in one month, only 90% of accepted referrals were admitted within this timeframe due to there being COVID+ residents at the facility at the time.

From an MRC perspective, these two KPIs can, at times, be challenging as there is only a small team of clinical staff on-site at any one time and due to various other factors, including the need to review or assess (1) all referrals and potential admissions, in particular as related to the medical acuity and psychosocial needs of people being referred; (2) the availability of a suitable bed; (3) whether there are pending discharges that might free up a bed; and (4) whether there any mobility, safety or other considerations associated with a given referral.

4.1.1.2 Waitlist for MRC Acceptance

The MRC had two Operational Reporting Measures (ORMs) relating to the MRC waitlist: the average wait time for people on the waitlist **(ORM 5)**, and the reason why if they were not admitted **(ORM 6)**.

In Year 1, only one person was offered a spot on the waitlist, but they declined. Thus, there is no data to report on regarding the waitlist for this year. However, since the end of Year 1, there has been a steady, upward trend in enquiries to the MRC about patient referrals for MRC admission, with a waitlist established in November 2022 due to demand and occupancy levels (with 5-10 people on the waitlist per week since that time):

- Oct-Nov 2022: 72 hour wait time;
- Nov-Dec 2022: 1-4 days wait time; and
- Dec 2022-Jan 2023: 1-4 days wait time for hospital referrals, 2-7 days for community referrals.

However, it should be noted that sometimes individuals are waitlisted due to their specific needs being unable to be met at the time of their referral, e.g., if the universal access room is needed but occupied.

4.1.2 MRC Referrals

In its first year of operation (25 October 2021 to 24 October 2022), a total of 280 completed referrals for 231 individuals were made to the MRC (Table 2). Most individuals were only referred once (84%), but a small proportion were referred twice (13%) and a handful (3%) were referred three, four or five times (Figure 9).

Table 2: Total Number of Referrals

Year 1 MRC referrals	n (%)
Number of Referrals to the MRC	280
Number of People Referred	231
Range in Referrals per Person	1-5
Eligible Referrals Accepted	205 (93%)
Accepted Referrals Admitted	177 (86%)

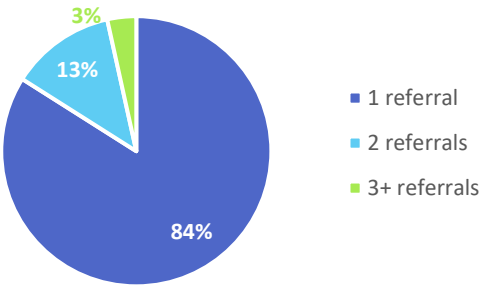

Figure 9: Number of Referrals Per Person

Figure 39 (Appendix 5) provides a comprehensive flow chart of the total number of referrals made, including if they were eligible or not, the number of referrals accepted and the number of people who actually had admissions in the first year of MRC operation. In addition, the MRC has reported an upward trend in inquiries about potential referrals or bed availability, which may or may not result in a formal referral. Over a 12-week period from September to November 2022 for example, MRC staff recorded 80 phone inquiries – an under-estimate as not all are documented, and this does not include email inquiries.

Of the 280 total referrals, 221 met the MRC admission criteria, 93% of which were accepted for admission. Overall, **it is salient to note that the number of eligible referrals that were rejected is very small**, which is in part because:

- the intentionally ***low threshold for eligibility*** of the MRC compared to many other residential health and homelessness services in Perth (e.g., people do not have to be abstinent from AOD, can have a criminal history, can have an active mental health issue);
- the MRC ethos of ***flexibility and acceptance*** and preparedness to take in residents who have been exited from other services or who have known issues relating to aggression or drug use, as an example; and
- the ***multidisciplinary and person-centred model of care***, where residents can be supported with psychosocial, legal and other issues by the key and peer workers and in-reach services, in a way that would not be possible in a hospital admission ward.

While there is no direct comparison to the Perth MRC model in Australia, data shared with Home2Health from Tierney House, a non-medical espite service run by St Vincent's Hospital in Sydney shows that in 2022 only about half of their referrals were able to be accepted, most often due to no vacancy, but 22% of referral declines were for ones assessed as inappropriate referrals.

4.1.2.1 Ineligible Referrals

Overall during Year 1 there were 35 referrals that were assessed as being ineligible, i.e., where the patient was deemed not suitable for the MRC. These accounted for 14% of all referrals received. The most common reasons for ineligibility were patients were too medically complex or unwell, or had medical needs that could not be met at the MRC; these accounted for just over half of all ineligible referrals in Year 1. It is pertinent to note that there were a number of referrals for patients who had high acuity AOD needs, or who required detox. During Year 1, the MRC was not equipped to cater for such patients. The shift to an internal embedded AOD service in Year 2 has meant that these types of referrals can now be accepted. Early evidence in the first 3 months of Year 2 indicates that being able to support AOD detox onsite has enabled acceptance of referrals that would not have been possible in Year 1.

Other reasons for ineligibility in both Year 1 and Year 2 to date included behavioural or mobility needs that could not be met at the MRC, as well as referrals for patients whose primary need was accommodation, without a clear medical need. In Year 1, the MRC also had instances where hospitals instigated a referral before a patient was actually ready for hospital discharge, which makes sense from a hospital dischsarge planning perspective but which is problematic for the MRC because, as the demand increases and the waitlist grows, it cannot hold beds.

4.1.2.2 Number of Referrals Over Time

As with any new service, both referrals and their acceptance are impacted by a number of factors, including awareness of the service, understanding of service eligibility and patients having medical or mobility needs that cannot be met by the MRC. This is visually evident in data that compares the number and patterns of referrals, and admissions month-by-month for the MRC in Year 1 (Figure 10).

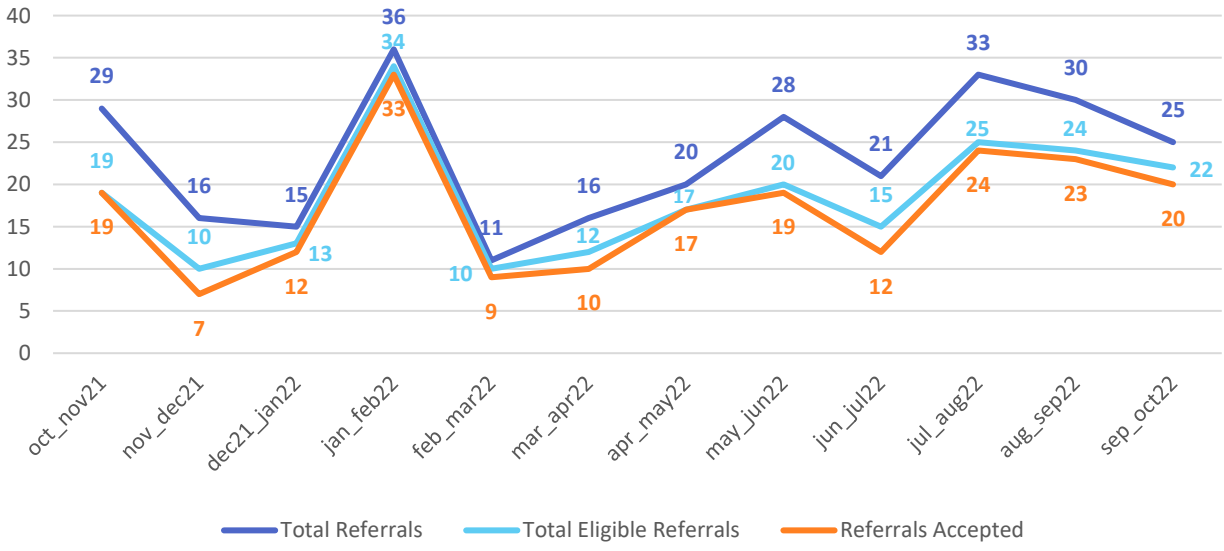

Figure 10: Total Referrals Received vs Total Eligible vs Accepted Per Month

The referral spike in January/February (as shown in Figure 10), for example, corresponds to the referral process being opened to major public hospitals other than RPH at the three-month mark. Similarly, the spike in the number of referrals around May/June 2022 corresponds to the broadening of referral pathways to all other public hospitals in the metropolitan area. Conversely, the drop in referrals and acceptances in March/April 2022 corresponds to the commencement of the COVID-19 wave in Perth,

which impacted upon health service and hospital engagement by people experiencing homelessness and posed challenges for the MRC relating to staff and resident capacity.

4.1.3 Referring Organisations

Overall, the majority (86%) of referrals came from a hospital, while 8% came from community organisations and 6% came from another HHC site (Table 3). However, it should be noted that referrals from homelessness organisations only commenced as an option on 5 May 2022 (6 months into service delivery) and these often relate to people that would have otherwise been sent to hospital by the concerned service making the referral.

Table 3: Referring Organisations

n (%)	Total Referrals	Eligible Referrals^	Eligible Referrals Accepted^^
Community Organisations^^^	**23 (8%)**	**14**	**13 (93%)**
Homeless Healthcare GP clinic/street outreach team	**16 (6%)**	**14**	**13 (93%)**
Hospital Sites	**241 (86%)**	**193**	**179 (93%)**
Armadale-Kelmscott District Memorial Hospital	7 (3%)	4	3 (75%)
Bentley Health Service	4 (1%)	3	3 (100%)
Fiona Stanley Hospital	40 (14%)	28	26 (93%)
Fremantle Hospital	8 (3%)	6	4 (67%)
Joondalup Health Campus	5 (2%)	4	4 (100%)
King Edward Memorial Hospital	1 (0%)	1	1 (100%)
Osborne Park	1 (0%)	1	1 (100%)
Rockingham General Hospital	4 (1%)	3	3 (100%)
Royal Perth Hospital^^^^	155 (55%)	130	121 (93%)
Sir Charles Gairdner Hospital	12 (4%)	11	11 (100%)
St John of God Midland Public Hospital	3 (1%)	2	2 (100%)
South Perth Hospital	1 (0%)	0	0 (n/a)

Notes: ^Eligible referrals exclude incomplete, premature and ineligible (e.g., inappropriate, no medical need) referrals. ^^not all accepted referrals were admitted as some people changed their minds or 'did not show'. ^^^only started accepting community referrals in May 2022. ^^^^RPH was the only hospital sending referrals for the first three months of operation.

4.1.3.1 Hospital Referrals

The most frequent referring hosptial was RPH, with over half (55%) of all referrals coming from this site. This is unsurprising, given that RPH is Perth's only inner-city hospital and is frequented by the rough-sleeping population clustered in the Perth CBD. RPH is also in close proximity to many of Perth's homelessness services, as well as short-term accommodation often used by people experiencing homelessness (such as backpacker hostels in the CBD). MRC referrals were also restricted to RPH for the first three months of MRC operation, giving the MRC a 'soft opening' and using the RPH Homeless Team to test and refine the MRC referral process.

> *Having a dedicated Homeless Team at RPH is beneficial for hospital staff and for the MRC, as the Homeless Team has extensive experience working with homeless patients and has worked closely with social workers and other RPH staff to raise awareness of the MRC and the eligibility of potential referrals.* **– Dr Amanda Stafford, Clinical Lead, RPH Homeless Team**

The RPH Homeless Team has some HHC nurses who also work at the MRC and this has helped facilitate referrals and increase RPH staff knowledge around patient suitability for MRC admissions. However, it is important to note that the MRC is a discharge option for only a small proportion of the total

number of the approximately 10-20 homeless (No Fixed Address) patients who attend the RPH ED daily. The MRC has a total of 20 beds, with an average stay of 10-14 days, and exists specifically to provide ongoing medical and nursing care, and not just accommodation to rough-sleeping individuals who may or may not have specific medical needs. Hence, many of the patients supported by the RPH Homeless Team are not eligible for MRC referral. In the first full month of MRC operation for example (November 2021), the RPH Homeless Team referred 8 patients to the MRC, accounting for only 6.8% of patients seen by the team in that month. As the MRC capacity and confidence in managing complex needs pateints has expanded, referrals from the RPH Homeless Team to the MRC have increased to 11.7% of all patients seen by the team (November 2022).

Referrals from other hospitals have generally increased over time, reflecting growing awareness and understanding of the MRC.

4.1.3.2 Community Organisation Referrals to Prevent Hospital Admission

In May 2022, the MRC opened to referrals from community organisations in cases where it would prevent a hospital admission or to provide support prior to a medical procedure. Priority is still given to patients being discharged from hospital, but the expansion to include homelessness and community service referrals has sometimes totally averted a hospital presentations. Box 2 provides an example of how staff at a drop-in centre noticed a regular client's health deteriorating and referred him directly to the MRC for support, thereby preventing a hospital admission.

Box 2: Case Study – Community Referrals to Avoid Hospital Admission

Background: "Dean" is in his early thirties and was referred to the MRC by staff at a drop-in centre after they noticed his health had severely deteriorated as a result of rough sleeping. He had impaired vision, recurring stomach infections and persistent skin inflammation. English is Dean's second language so he struggled to navigate the health services he needed.

Support Provided: While at the MRC, Dean received daily nursing care to treat his infected eyes, improving his vision and assisting him to return to a more independent and functional level. His recurrent stomach infected was investigated and he was diagnosed with H-pylori infection, which was subsequently treated. Dean reported that he had suffered with reflux-related pain for years and was relieved to finally feel better. His skin rash was also treated. He received intensive support from key workers on site, to have his Centrelink re-started, and was linked with a community-organisation case worker for long-term support.

Current Situation: Dean's multiple health concerns were addressed without need for a hospital admission. He was discharged to long-term, transitional accommodation with community support and has been connected with HHC GPs for ongoing care.

4.1.4 Stakeholder Perceptions of MRC Referral Process

The online stakeholder survey disseminated by the evalution team included a question about the MRC referral process. (see Section 2.2.2.2 for description of survey). Stakeholders were asked to respond to four statements about the MRC referral process using a five-point Likert scale, from strongly disagree to strongly agree. These results are shown in Figure 11, with the majority showing agreement (agree or strongly agree) towards all four statements:

- 82% agreed that there was opportunity to discuss referrals with the MRC;
- 80% agreed that there was awareness of the MRC within their organisation;
- 78% agreed they understood MRC eligibility requirements; and
- 63% agreed that the referral process was clear and concise.

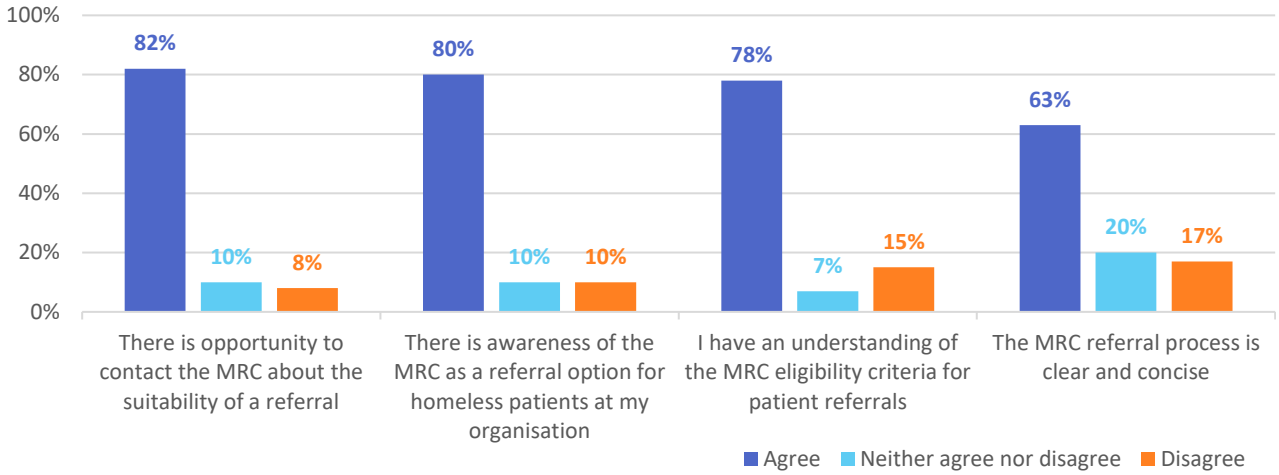

Figure 11: Stakeholder Feedback on the MRC Referral Process

These responses are overall very positive given that:

- The MRC is a new service that had to establish a referral pathway and process from scratch, and raise hospital awareness and understanding of this. It is anticipated that awareness of the MRC as a referral option will be higher than 80% for the Year 2 evaluation;
- The eligibility criteria for accepting referrals has to have some flexibility, and it is intentionally not 'black and white'; there are a range of factors that the MRC team take into account in determining the suitability of a particular referral, including the availability of suitable rooms, patient acuity and types of medical care needs. The current mix of residents at the time a referral is made is also taken into account – for example there have been referrals that were not viable for women who have experienced trauma who do not feel comfortable in a mixed gender setting where amenities are shared. It is for this reason that the MRC encourages all potential referrers to contact them by telephone first, prior to submitting a formal referral. While 78% of people indicated understanding the elibility criteria is good, it is feasible that this might increase further in Year 2 as awareness and understanding of the MRC and its referral process increases; and
- The MRC staff have noted that a lot of time was spent, in the first six months particularly, explaining the referral process and eligibility, and that the need for this has substantially decreased over time among the hospitals and the people most often referring to the MRC. Queries or ineligible referrals are more common among hospitals or organisations that have not previously referred someone to the MRC.

A number of the open-ended comments in stakeholder survey responses specifically made positive mentions relevant to the referral and admission process:

> *The staff have been very helpful when providing information on eligibility and have been very understanding of hospital deadlines and the need to fast-track referrals. I have had a great experience with this service*. – **Social Worker (Metro Hospital)**
>
> *I found the MRC very helpful in discussing potential referrals and contact was made in a timely manner… phone contact was seamless. MRC provided a patient of mine with a safe discharge plan and I found the process of referral very positive.* – **Social Worker (Metro Hospital)**
>
> *Great service, easy referral paperwork* **– Doctor (Metro Hospital)**

4.2 MRC Admissions and Occupancy

4.2.1 The MRC Admission Process

Once a referral has been accepted for admission to the MRC, the admission process depicted in Figure 12 is undertaken.

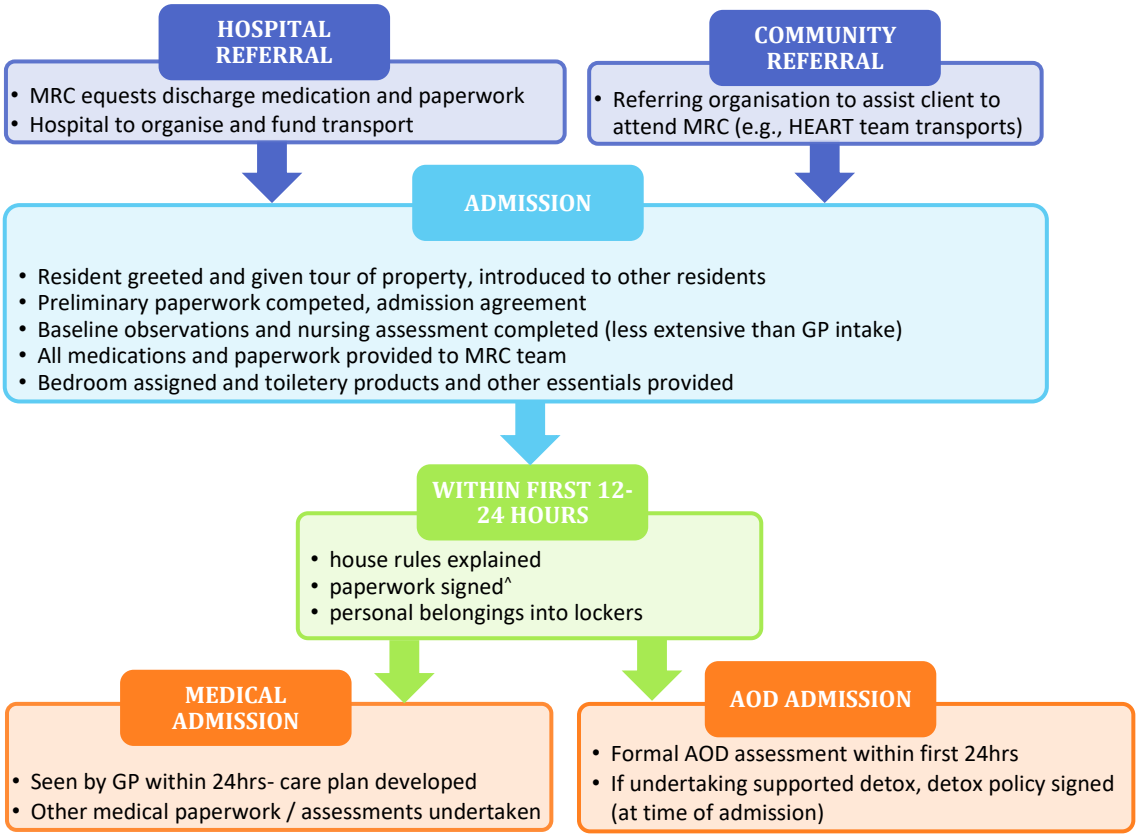

Figure 12: Admission Process

Note: ^Admission paperwork includes: MRC intake form signed, House Rules document provided, Admission and Discharge Agreement Document signed, 48hr Policy Agreement signed, and Personal Property waiver signed (if applicable).

Photo 7: MRC Bedrooms

4.2.2 MRC Occupancy

One of the MRC KPIs relates to bed occupancy of 85% (**KPI 10**). Figure 13 visually depicts the bed occupancy of the MRC and StayWitch's (which has served as a step-down option for 15% of MRC residents in Year 1) from the MRC opening (October 2021) through to December 2022. Data has been

included for two months beyond the end of Year 1, as this provides insight into the continuing upward trajectory in occupancy as awareness and referrals to the MRC have gained momentum. Additionally, **KPI 4** was met, which relates to relates to 100% of MRC beds being available.

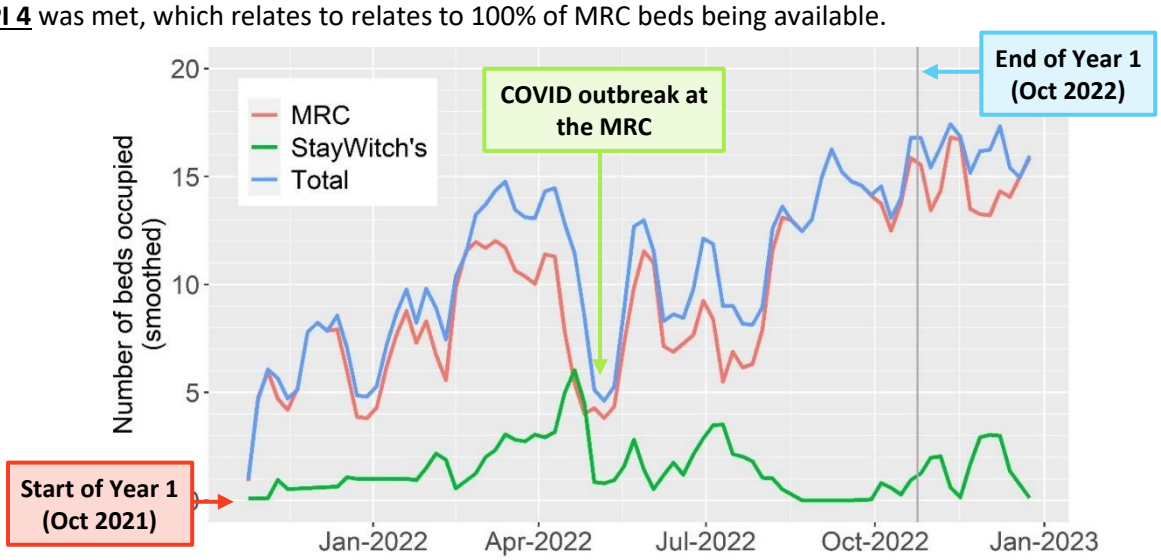

Figure 13: MRC Bed Occupancy Over Time between October 2021 and December 2022

As illustrated in Figure 13, overall there has been a steady increase in the occupancy of the MRC since it opened, corresponding to raised awareness of the MRC and increasing referrals, and the broadening of the hospitals/organisations able to refer people to the MRC over the course of Year 1 (see Section 4.1.3). The occupancy levels generally correspond to the upward trajectory in referrals since the MRC opened, as the rate of accepted referrals has remained consistent and high since commencement. The drop around May 2022 aligns with the COVID outbreak that occurred in the MRC at that time, where isolation and additional cleaning had to be undertaken, and admissions were briefly paused.

Photo 8: MRC Resident Talking with Staff

4.2.3 MRC Admissions

There was a total of 177 admissions to the MRC in Year 1 for 152 unique individuals, with each having between one and four admissions (Table 4). On average, admission length of stay (LOS) was 20 days.

Table 4: Number of Admissions and Length of Stay at the MRC

MRC Residents	n (%)	n(%) in Hospital Without MRC
Total Number of Admissions	177	
Number of individuals admitted	152	
Mean Admissions per person (range)	1.2 (1-4)	
Length of Stay per Admission^		
Average LOS	20 days	
Median LOS	14 days	
LOS Range per Admission	0 – 117 days	
Longer MRC Admissions		
Admissions >14 Days	81 (46%)	64 (79%)
Admissions >21 days	69 (39%)	57 (83%)
Admissions >28 days	47 (27%)	39 (83%)

Note: ^ two individuals were current residents at the MRC at time of analysis and their LOS was calculated as at 31 Jan 2023

4.2.3.1 LOS of MRC Admissions

The MRC had a KPI **(KPI 9)** set by EMHS relating to a 14-day average LOS and while the median LOS met this target, the Year 1 average LOS per admission was 20 days (Table 4). This is actually a short length of stay compared to many of the medical respite facilities in the US, where 88% have an average LOS greater than 14 days.[36]

Overall, there were 96 (54%) admissions that were shorter than 14 days and there were 81 MRC admissions longer than 14 days, with 47 of these lasting longer than four weeks (27% of all admissions; Figure 14). It is important to stress however, that a significant majority of the 83% of MRC admissions that were longer than four weeks **would have resulted in either continuous and frequent ED presentations or lengthy inpatient admissions in the absence of the MRC** (Section 7.3.3).

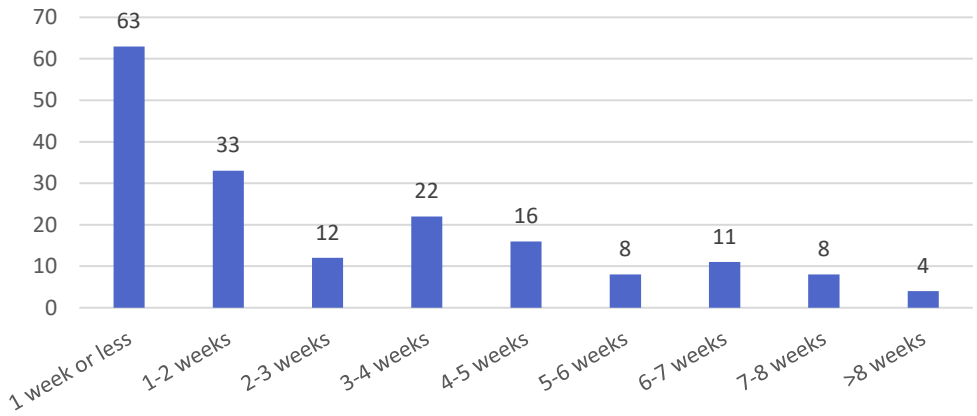

Figure 14: Length of MRC Admission by Weeks

Note: two individuals were current residents at the MRC at time of analysis and their LOS was calculated as at 31 Jan 2023, both had been residents for >8 weeks at this time.

There were clear, common reasons that contributed to these lengths of stay beyond 14 days. Of the 81 MRC admissions >14 days in length, the following contributing factors were identified, with around two-thirds (62%) of long admissions relating to 3+ different reasons (Figure 15):

- waiting periods for accommodation/housing to become available to enable safe discharge (69 admissions, 85%);
- complex ongoing medical needs (68 admissions, 85%);

- identification/diagnosis of new health issues or substantional deterioration of health during admission (47 admissions, 58%);
- waiting periods to access AOD rehabilitation (19 admissions, 23%);
- waiting periods to access National Disability Insurance Scheme (NDIS) supported accommodation (9 admissions, 11%);
- waiting periods for Centrelink and other psychosocial support (8 admissions, 10%).

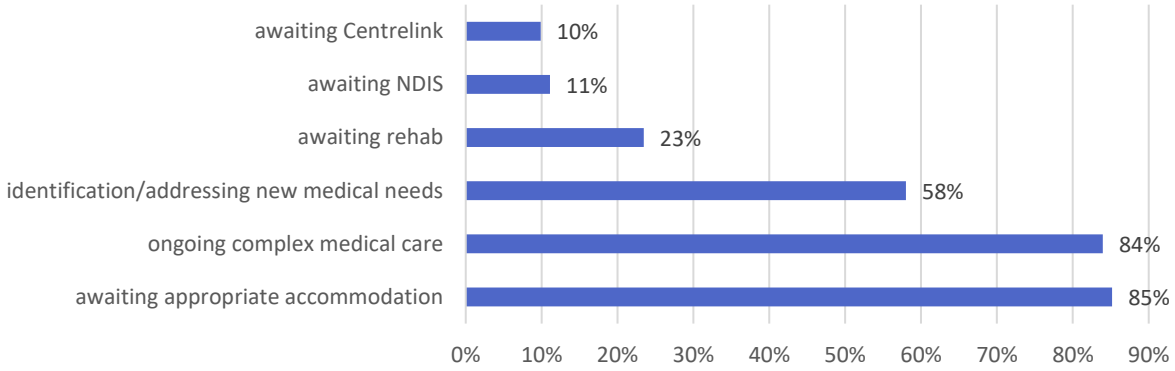

Figure 15: Reasons for Long MRC Admission

Note: Of the 81 MRC admissions >14 days long, 91% related to at least two of these reasons, 62% related to three or more of these reasons, 17% related to four or more of these reasons, and 1% related five of these reasons.

For the 47 MRC admissions that were longer than four weeks, the reasons for this were typically multiple, commonly due to a combination of ongoing medical needs and the wait time for suitable accommodation, supported NDIS accommodation or a place in residential rehabilitation. Box 3 provides an example of how a long MRC admission prevented a lengthy hospital admission for an individual with treatment-resistant schizophrenia who was awaiting supported NDIS accommodation.

Box 3: Case Study – Long MRC Admissions and Preventing Extended Hospital Stays

Background: "Samuel" is in his early sixties and has treatment-resistant schizophrenia and insulin-dependent diabetes. Prior to hospital admission, he was experiencing homelessness and social isolation, compounded by his lack of insight into his mental health and inability to properly manage his diabetes. Samuel's first admission to hospital was for several months, during which, hospital staff successfully obtained an NDIS package. The NDIS package was exhausted much faster than anticipated so he was forced to return to hospital when the NDIS supported accommodation service was unable to continue providing the level of care required. The MRC was contacted by the hospital with a request for an admission to support community-based assessments for NDIS and to provide medical care whilst waiting on the NDIS package to be updated.

Support provided at the MRC: MRC and hospital staff worked collaboratively to obtain a higher-care NDIS package. Although Samuel's stay at the MRC was longer than 14 days, it was assessed that he otherwise would have have needed to remain in hospital for this period. While at the MRC the various assessment for NDIS were able to be completed and he was supported to manage his diabetes.

Current situation: Following a six-week admission to the MRC, Samuel was assisted into high-support NDIS accommodation. Samuel would have been unable to manage his insulin or safely care for himself without this MRC admission providing respite care before his NDIS package and accommodation became available.

4.2.3.2 People with Multiple MRC Admissions

Whilst most (88%) residents only had a single admission, for some individuals multiple admissions were required (Figure 16). For some, their chronic multimorbidities and histories can mean they had different admissions for differing reasons. For others, multiple admissions contributed to rapport building between the resident and the MRC team, and lead to better engagement and management of their complex health issues (i.e., may be more likely to complete their admission at the MRC the second time around).

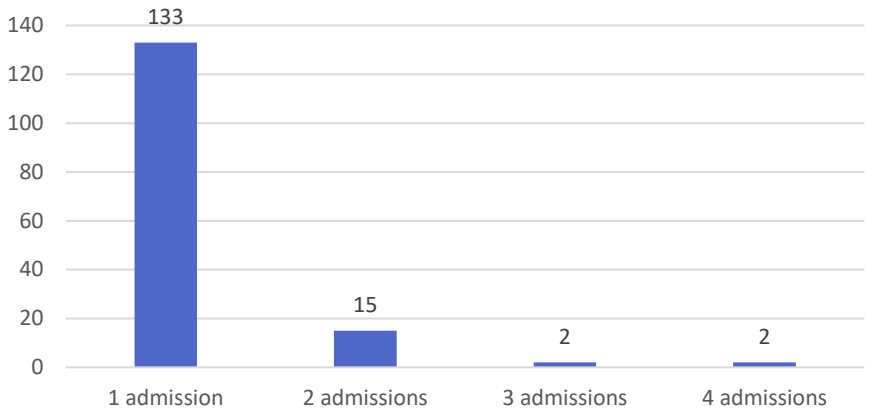

Figure 16: Admissions Per Person in Year 1

Note: Data presented based on 152 unique individuals

Box 4 provides an example of one resident whose multiple admissions at the MRC facilitated increased trust and engagement, to improve her health over time.

Box 4: Case Study - Need for Multiple MRC Stays

Background: "Daisy" is an Aboriginal woman in her late twenties with a long history of homelessness and trauma. She has been homeless since the age of 15 and grew up being moved between foster care and child protection services. She has numerous medical conditions, including hep C, type 2 diabetes, as well as severe, chronic mental health conditions. Daisy's physical and psychiatric health conditions are further complicated by a long history of substance use. Her diabetes has caused numerous hospital admissions and is exacerbated by her life on the street where she is reliant on high-sugar foods and is unable to safely store her insulin. Daisy has difficulty adhering to a medication regime for her diabetes, resulting in regular ED presentations for diabetes associated complications, as well as presentations for psychiatric support in moments of crisis.

Support Provided by MRC: Daisy has had four separate MRC admissions, largely to support her recommencing prescribed medications and continue ongoing diabetic education (to improve health literacy and understand the importance of these medications). Most recently, Daisy was admitted to the MRC after diabetes-related complications meant she had to wear a "moon-boot", and medical staff felt this would not have been achievable for her without supported care to facilitate proper recovery. During this admission, MRC staff supported Daisy with the use of her moon-boot by assisting her to mobilise safely within the facility and even decorating the moon boot, on Daisy's request, to encourage its use. Additionally, under the care of HHC GPs, her medication was reviewed and she was commenced on a new diabetes treatment option which reduced the need for injected insulin. Daisy was receptive to this option as she reported it felt more manageable to her.

Current situation: Although Daisy has ongoing presentations to ED for her mental health and other chronic conditions, her admissions to the MRC play a role in the long-term work of ending her cycle of homelessness. Daisy's case highlights how, for many residents, the journey out of homelessness is not linear and it may take several stays at the MRC for residents to recover physically, emotionally and psychologically from their many complex experiences. The ongoing rapport developed with the MRC staff and broader HHC team continues to contribute to improved engagement in medical care than when Daisy was first introduced to the service.

4.2.4 Discharge Destination and Outcomes

The discharge destinations and outcomes observed in the data for Year 1 are shown in **Error! Reference source not found.**, and each major discharge category is discussed.

Table 5: Discharge Location from MRC, Per Admission

Discharge Location	N (%)^
Completed MRC Stay	
Friends and Family	2 (1%)
Left Area (i.e., moved interstate or overseas)	5 (3%)
Long-Term Stable Accommodation (including supported)	11 (6%)
Private Accommodation	12 (7%)
Residential Rehabilitation	8 (5%)
Short-term and Transitional Accommodation	8 (5%)
StayWitch's Non-Medical Respite	27 (15%)
Other	3 (2%)
Early Exits	
Exited by MRC team	21 (12%)
Returned to Hospital	24 (14%)
Self-discharged from MRC	53 (30%)
Prison	1 (1%)
Total	**175**

^ Excludes two admissions, where individuals remained current residents of the MRC

4.2.4.1 Discharges to Housing and Accommodation

A core aim of the MRC from the outset has been to avoid discharging residents into homelessness. It is pertinent to note that the extreme lack of suitable housing precludes discharge to stable housing for all MRC residents. Overall, in Year 1, 13% of residents were discharged directly into some form of stable housing (public housing, private rental or supported accommodation) and 5% were discharged to transitional or short-term accommodation, which aims to be a bridge for people experiencing homelessness until more permanent housing is available.

Quite often residents have been ready to be medically cleared for MRC discharge but no suitable accommodation is available, or the resident is waitlisted for a place in residential rehab or supported mental health accommodation. The MRC team has thus utilised StayWitch's (the non-medical beds at the MRC property) to accommodate 15% of discharges, where residents no longer require medical support but require more time for suitable accommodation to be found (See Section 3.4.5 for information on StayWitch's and the benefit of step-down support).

Photo 9: Staff Farewelling One of the Longest Staying MRC Residents who was Permanently Accommodated

4.2.4.2 Discharges to AOD Rehabilitation

Among the cohort of people admitted to the MRC, there are high rates of AOD use and dependence. As such, supporting residents to consider or prepare for residential rehabilitation is a common part of the care provided by MRC staff. The role of the MRC in supporting people to prepare medically and psychologically for residential rehabilitation has emerged as a significant way in which the MRC is filling a gap that previously hampered AOD recovery for some people experiencing homelessness. For example, many rehab services have strict criteria not only in relation to alcohol and illicit drug use, but also pertaining to opioids and other prescription pain medications. Others also have strict rules against tobacco use. A significant element of the MRC staff workload to date has been supporting residents to detox, or withdraw safely from substances (including alcohol, tobacco, illicit drugs and prescription opioids), and in many cases to create pain management plans that do not rely on prescription medications which are prohibited by the rehab services. This work has increased since the expanded capacity, introduced in late 2022, to support on-site medical detox within the MRC.

In Year 1, 5% of residents were discharged directly to residential AOD rehabilitation services. To facilitate this, some MRC residents have been initially discharged to StayWitch's so that they can be supported and accommodated until a space in residential rehabilitation becomes available.

4.2.4.3 Discharges to Hospital

Reflecting the complex health needs of many MRC residents and the role that the MRC has played in diagnosing and monitoring health conditions, one in seven (14%) residents were discharged from the MRC to hospital (Table 5). In some instances, these residents were subsequently able to be re-referred from hospital back to the MRC (see Section 0 regarding repeat admissions).

4.2.4.4 Self-Discharges from the MRC

Staying at the MRC is voluntary and in the Year 1 MRC cohort, 30% of admissions resulted in self-discharge (with 19% of those who self-discharged having had stays longer than three weeks). This may at first glance seem high, but it is very similar to the rate of self-discharge reported in one of the few published studies that has transparently reported on self-discharge from homelessness medical respite care (31%).[37] The most common reported reasons for self-discharge in Year 1 were:

- Reuniting with family or partner;
- Going to stay with family or friends;
- Cultural obligations (e.g., Sorry Business);
- Struggling with the MRC environment or "terms of residency", such as being denied entry after breaking curfew and then not retuning in the morning;
- Challenges associated with congregate living (e.g., house dynamics and clashing personalities)
- Or unknown reasons.

While the term 'self-discharge' is used here (congruent with the literature), in reality some residents go off-site and just don't return, and the MRC regularly stores belongings for residents who have left without notice, waiting for them to return to collect them. While MRC staff will record a reason for self-discharge if known, this often has to be recorded as unknown. Where a resident leaves without warning, but staff are concerned for their wellbeing, a welfare check will be be arranged (for example if they have impaired decision-making or health has deteriorated).

It is salient to note that self-discharge is not at all unexpected, as this is a population group that already has a much higher rate of 'discharged against medical advice' in hospital settings than the general population. Moreover, while the MRC has sought to be low-barrier to entry and to limit rules for residents, and while the use of alcohol and drugs is prohibited on-site, residents are able to 'use' off-site and, in line with trauma-informed practice, MRC staff do not undertake AOD testing on-site. However, there are rules in place regarding curfew and behaviour towards staff and fellow residents,

and residents under the influence will not be let back on-site if doing so will negatively impact upon other residents. Some residents have struggled with these expectations, and this has been a factor associated with individuals leaving at their own discretion.

Sometimes residents self-discharge for positive reasons, for example instances where staff have observed that a resident has been able to reconnect with a partner or family members while at the MRC and returns to live with them.

There are additional factors that contribute to residents' decisions to self-discharge, that are beyond the control of the MRC. High levels of anxiety while awaiting housing or AOD rehabilitation and the long wait times for these services can be a source of frustration or distress that precipitates an individual deciding to leave the MRC. Here the impacts of trauma, mental health or AOD use, on coping with uncertainty or disappointment should not be under-estimated.[38] Sometimes a second MRC admission alleviates these anxieties as residents know what to expect and may feel more "ready".

4.2.4.5 People Exited from the MRC

From the outset the MRC has sought to be low barrier/low threshold and to not have the level of rules and restrictions that would occur in a hospital or conventional, clinical residential setting. All residents are made aware however on admission, that there are some key expectations that apply to all residents, relating to respect for others and their property (staff and other residents), non-violence/aggression, returning back to site by curfew time (but preferably by dinner time so that residesnts can have a warm meal and have their observations taken and medications administered) and not using substances onsite/impacting the recovery of fellow residents. Due to this low-barrier ethos, across Year 1 the MRC has admitted a number of people who struggle with living in communal environments, even with minimal rules and restrictions, as well as a number of people who are known to have been excluded from other homelessness accommodation services. Inevitably, with accommodating formerly homeless individuals in close proximity in a property that has only shared bedrooms, bathrooms and communal meal areas, there are frictions.

While there is a deep understanding of the complexities of residents' experiences and the way this contributes to the challenges of communal living, firm boundaries must be set in order to maintain a safe environment for all. The MRC team are highly experienced at supporting people in crisis and working from a trauma-informed perspective that is not focused on enforcing a strict set of rules. However, for the facility to run smoothly, and for both residents and staff to feel safe, there is a set of guidelines that residents are expected to adhere to. Residents are provided several opportunities to stay at the MRC if there are minor lapses in following these guidelines, however, if the behaviour is persistent or puts others at risk, then residents are exited for the overall wellbeing of the facility. Overall in Year 1, 12% of the people admitted to the MRC had to be exited by MRC staff. The most common reasons for this were:

- Aggressive behaviour/assault;
- Alcohol or drug use on site;
- Repeated intoxication or drug use that impacts on other residents or their respite recovery;
- Behavioural issues impacting on other residents; and
- Unknown.

Where possible, MRC staff avoid exiting residents, and they did not take this step lightly. In practice, residents are provided with the opportunity to change their behaviour before being asked to leave. Interestingly, some of the 'success' case studies of MRC residents relate to people whose first admission resulted in an exit, but who engaged more positively and experienced more positive outcomes during their second visit. One example of this is provided in Box 5, where a resident was exited on his first admission due to continued intoxication, behavioural issues and impacting other

residents, and then went on to have a more positive, second MRC admission where he engaged with staff and was motivated to make changes.

Box 5: Staff Vignette – Exited from MRC, Followed by Positive Second MRC Admission

Male with a history of chronic depression, suicidality and high ETOH use was referred to the MRC after a psychiatric admission in late 2021. He stayed at the MRC for around two weeks but was very disengaged from care. He didn't want to discuss his alcohol use or be referred to any services for support. Unfortunately, he had to be asked to leave the MRC because he was returning intoxicated most nights and eventually alcohol was found in his room. Nine months later, he came to stay at the MRC again, after a suicide attempt and time spent in hospital. This time, he was in a very different place, he wanted things to get better. He spoke with staff about his drinking and started on anti-craving medications. He worked with the key workers to complete housing applications and was eventually discharged to long-term accommodation, with ongoing community mental health support

Note: Vignette provided to evaluation team by MRC staff and thus has been written from the MRC perspective. **ETOH:** Ethyl Alcohol

Since implementing the 48 hour policy (discussed in Section 3.4.4.3), staff report fewer incidences of exiting residents as it has facilitated a period of "enforced rest" and enables residents to engage with staff.

Photo 10: Residents Hanging Out in the Dining Room

5 Who has the MRC Supported and What Were Their Needs?

This chapter describes the demographics, goals, and health and social needs of the 152 residents who were admitted at least to the MRC in Year 1. Further, details relating to the specific types of support (medical and psychosocial) that were provided to residents are outlined.

5.1 Resident Demographics

Overall, the majority of the 152 individuals who were admitted at least once to the MRC in Year 1 were male (72%), corresponding to the over-representation of men in the homeless population generally in WA and nationally.[39] One-third (33%) of individuals admitted identified as Aboriginal and/or Torres Strait Islander (Table 6). This too is reflective of other available Perth data on the proportion of people who are homeless who identify as Aboriginal.[39] The average age of people admitted to the MRC was 46 years (range: 21 – 75 years).

Table 6: MRC Resident Demographics

MRC Residents	n (%)
Unique People Admitted to MRC	152
Gender	
Male	110 (72%)
Female	40 (26%)
Transgender/Non-Binary	2 (1%)
Age at First Contact	
Mean age	46 years
Range	21 – 75 years
Aboriginality	
Non-Aboriginal and/or Torres Strait Islander	102 (67%)
Aboriginal and/or Torres Strait Islander	50 (33%)

Over two-thirds (68%) of people supported by the MRC had experienced homelessness for longer than six months, and just over half (54%) had experienced chronic or recurrent homelessness prior to MRC admission (Figure 17).

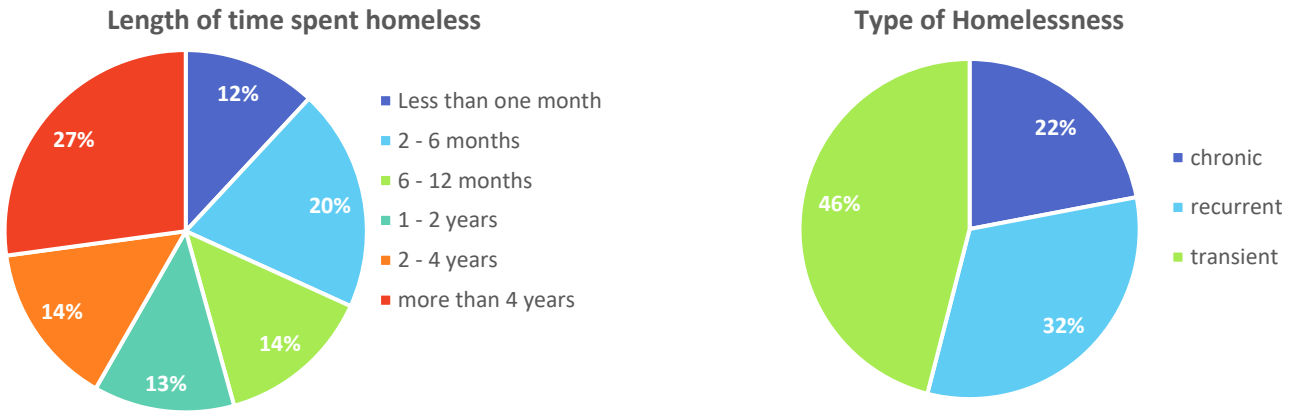

Figure 17: Time Spent Homeless and Type of Homelessness Experienced Pre-MRC Admission

Note: Length of time homeless missing for 1 person and "type" of homelessness missing for 2 people

5.2 Resident Goals During MRC Stay

Supporting people to work towards their personal or recovery goals is a key part of the day-to-day role of the MRC key workers and peer workers. As part of the admission process, all MRC residents are encouraged to identify some key goals that they want to focus on. Residents often reflect further on this and will identify other goals once they have settled in. The most common goals specifically articulated by residents in Year 1 around the time of admission are summarised in Table 7 below.

Table 7: Common Resident Goals

Health Goals	Psychosocial Goals	
• Cutting down or abstaining from AOD use	• Accessing Centrelink and other govt services (e.g. MyGov)	• Resolving fines/debts and other legal issues
• Improving mental health and emotional wellbeing	• Accessing ID documents (including bank accounts)	• Reconnecting with family and reunification with children
• Improving health	• Developing a CV/resume	• Reconnecting phones
• Sorting out dental issues	• Applying for priority housing waitlist and finding accommodation	• Returning to community/Country

Note these are limited to goals that were formally documented as part of the MRC admission data and it is recognised that people at the MRC often have hopes or goals that they want to work towards that are not necessarily verbalised or written down as a formal goal.

In addition to goals articulated by residents at intake or early in their MRC admission period, MRC staff have commented that over the course of their stay, people often identify other issues that they want to work on. These typically evolve over time as their health stabilises and their basic needs are met – such as sleep, shelter, food and hygiene.

From interviews with residents and staff, it is clear that people often feel overwhelmed at first by the challenges of multiple health, social, and housing issues. Part of the role of the key workers and peer workers at the MRC is to support residents to tackle their goals or issues incrementally, identifying small things at first that can be done to progress towards a longer-term goal.

> *If someone's goal is to get public housing, we might support them to check if they are on the priority waitlist, update their phone or mailing address so that they can be contacted about housing, or set up a bank account so they can start saving for a rental bond. Or if a goal is to find a job, the first step might be to support a resident with computer skills so that they can create a resume and search for job vacancies online* - **Key Worker, MRC**

> *It feels less overwhelming if residents can break down their goals into smaller achievable steps – so if their goal is to stop drinking or to stabilise their diabetes or reconnect with their children, the MRC staff and environment provides a safe space, and the support to work out manageable steps they can take each day. People seem to find this less daunting and it helps them to keep going, to maintain their hope* **- Nurse, HHC**

The following chapter discusses how residents were specifically supported to deal with life, health and housing needs while at the MRC, including, but not limited to, support relating to their specified goals.

5.3 Resident Health Needs

There is extensive literature highlighting the exceedingly poor health outcomes amongst people experiencing homelessness in Australia and internationally, including significantly premature mortality, high rates of comorbid health conditions and chronic disease, intertwined AOD and mental health issues, and a high prevalence of disease risk factors.[40-43] This in turn is associated with frequent

acute hospital use and it is well recognised in the medical respite literature that the populations served by respite centres have multiple, complex health needs.[11]

As shown in this evaluation, the initial reasons an individual is referred to the MRC is often akin to the tip of an iceberg and generally relates to their most recent hospital presentation(s). As depicted in Figure 18, beneath this typically sits a larger number of health issues people have previously attended hospital or outpatient care for. When the past medical history of MRC residents is reviewed by the HHC GPs, a wide range of other previous diagnoses and health issues are commonly identified, which are often being suboptimally managed or treated. The thorough health assessments undertaken while people are at the MRC often lead to new diagnoses or treatment of risk factors that are precursors to disease. The MRC also provides a rare opportunity for residents themselves to step back from daily 'survival mode', enabling them to recognise and address other neglected mental, physical, and emotional health concerns.

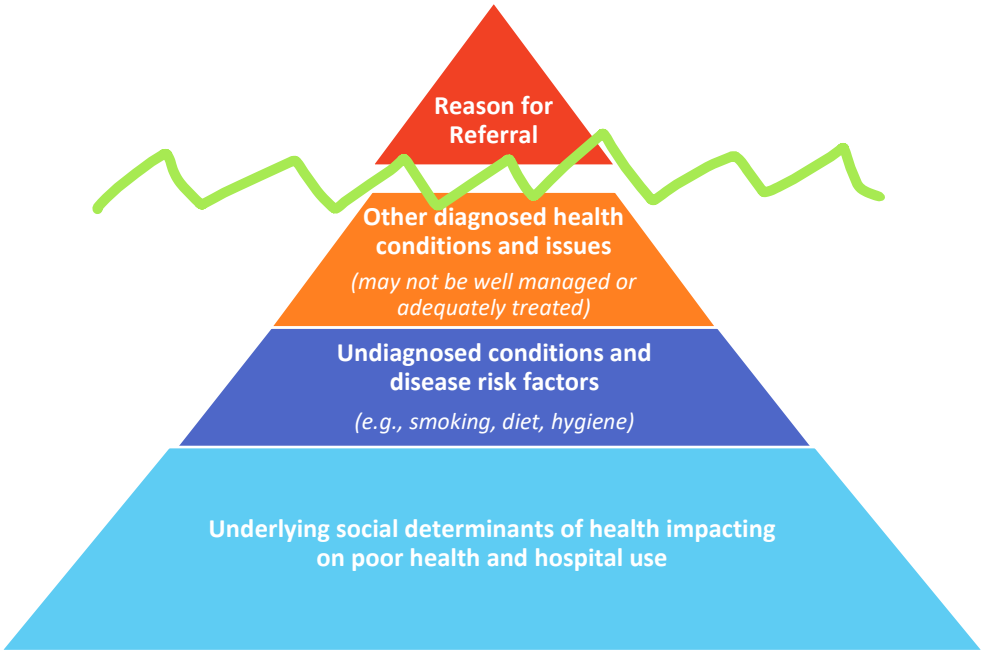

Figure 18: Referring Reasons are Just the Tip of the Iceberg

In this section we discuss:

- health issues specified as reasons for MRC referral on the referral forms of admitted residents;
- health conditions and diagnoses from medical history and MRC primary care data; and
- prevalence of multi-morbidity.

Other insights into the health conditions and needs of MRC residents are included in Chapter 7, where the most common reasons for hospital use prior to the MRC are presented.

5.3.1 Main Reasons for MRC Referral

The MRC referral forms, issued to hospital and community services, ask referrers to outline the main reasons for referral to the MRC. These vary considerably in the level of detail provided, particularly when completed by non-medical workers. Sometimes just one or two immediate health concerns are specified, while on other referrals there is more detail about the reasons for referral and specific support needs of the individual. The most common reasons for referral recorded in Year 1 are summarised in Table 8.

Table 8: Common Reasons for Referral to MRC

MRC Referral Reasons	
• Care following health episode (e.g., stroke)	• Mental health step down
• Wound care	• Nausea and vomiting
• ETOH withdrawal/ AOD support	• Pain management
• Facilitate access to rehab in the home (RITH)	• Post-operative care
• Medical observation for post-hospital recovery	• Respiratory conditions
• History of repeat ED presentations	• Stabilisation of diabetes
• Infection management (including IV antibiotics)	• Safe discharge and support following FDV
• Management of chronic conditions	• Recovery from assault/injury
• Medication review and management	• Commencement of depot

These reasons for referral reflect that referring hospital/organisations have developed a good overall understanding of the purpose of the MRC, with most referrals relating to one or more of the following:

- Post-hospital care to facilitate recovery;
- Earlier discharge from hospital than would otherwise be possible (in the abscense of the MRC);
- Stabilisation of health issues;
- Provision of medical care that does not require an acute bed (e.g., wound care, IV antibiotics); and
- Assessment and addressing of issues that are driving recurrent hospital use

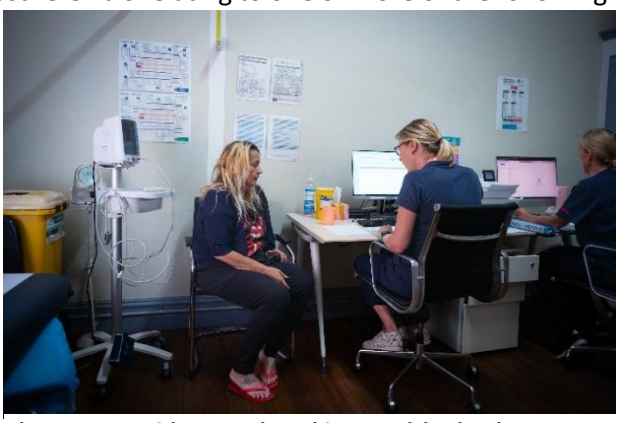

Photo 11: Resident Undertaking Health Check

5.3.2 Health Conditions and Diagnoses

As part of the MRC intake process, MRC medical staff review the past medical history and current known health conditions of residents. This is informed by discussions with each resident as well as existing medical records (primary-care records, My Health record, hospital discharge information).

The most common diagnosed health conditions among MRC residents in Year 1 are summarised below (Table 9). Note, these likely underestimate the overall proportion of people with certain conditions, as not all residents engaged with clinical staff, or they left after a short period before medical histories could be completed. They do, however, give an indication of the greater incidence of certain health conditions within this population, with MRC residents experiencing schizophrenia at a rate 40 times higher than observed the general Australian population (20% compared to 0.5%), and depression at a rate 2.1 to 3.6 times higher (29% compared to 8-14%).[44]

Table 9: Proportion of People with Different Health Diagnoses

Top MH and AOD Diagnoses	n (%)	Top Physical Health Diagnoses	n (%)
Alcohol use disorder	62 (41%)	GORD	38 (25%)
Depression	44 (29%)	Hepatitis C	31 (20%)
Anxiety	37 (24%)	Chronic pain	29 (19%)
Other drug use	35 (23%)	Diabetes	29 (19%)
Schizophrenia	30 (20%)	Hypertension	26 (17%)
Amphetamine use disorder	26 (17%)	Asthma	22 (15%)
PTSD	16 (11%)	Coronary disease	21 (14%)

Note: **AOD:** alcohol and other drugs; **MH:** mental health; **GORD:** gastro-oesophageal reflux disorder; **PTSD:** post-traumatic stress disorder.

5.3.3 Multi-Morbidity

Using an established methodology to determine multimorbidity by Barnett et al.[45] the number of 43 chronic or long-term health conditions were calculated for each resident. While this list of conditions by Barnett does not include all chronic health conditions that a person can experience, they do capture conditions that are most likely to impact upon a patient's need for treatment, their likelihood of reduced function or reduced quality of life, and their risk of future morbidity and mortality.

Using primary care health data from HHC more broadly, most patients who were admitted to the MRC in Year 1 had complex health needs, with almost all (94%) having at least one chronic health issue and over a third (39%) having five or more such issues as captured in the Barnett Methodology. Again, these rates of multi-morbidity are significantly higher than those observed amongst the wider Australian population, with 80% of MRC residents having 2 or more chronic health conditions, compared to an observed rate of 25.7% amongst the general Australian populace.[46] High rates of physical health conditions, AOD-use disorders, and mental health issues were also observed amongst MRC residents (Table 10: 76%, 66% and 60% respectively).

Table 10: Multi-Morbidity of MRC Residents

	n (%)
At least one AOD condition	100 (66%)
At least one Mental Health condition	91 (60%)
At least one Physical Health condition	116 (76%)
Dual Diagnosis (MH + AOD)	70 (46%)
Tri-morbidity (MH + AOD + PH)	58 (38%)
0 chronic conditions	9 (6%)
1+ chronic condition	143 (94%)
2+ chronic conditions	122 (80%)
5+ chronic conditions	59 (39%)
10+ chronic conditions	6 (4%)

Notes: **AOD:** alcohol and other drugs; **MH:** mental health; **PH:** physical health

An example of an MRC resident with many co-occurring medical conditions, significantly impacted by his housing situation and limited access to healthcare, is described in Box 6.

Box 6: Case Study – Co-Occurring Chronic Health Conditions Stabilised at MRC

Background: "Bob" is a man in his late 60s who has been homeless the past two years. He is estranged from his family, disconnected from support and unemployed due to health and social issues. He was struggling to manage his multiple complex health issues while homeless, including heart failure, hypertension, sleep apnoea, diabetes and chronic foot ulcers. Due to these conditions, he has had a cycle of increasing hospital presentations since 2019, including 10 ED presentations and 39 inpatient days. Prior to the MRC he was sleeping in a car with his CPAP machine.

Support Provided by MRC: During an RPH presentation in March 2022, he was referred to the MRC. Here, Bob was supported with daily care for chronic wounds, his anaemia was investigated, and he received medication support for untreated health conditions. Bob was also provided advice on smoking cessation, particularly due to his respiratory and cardiac conditions. MRC staff supported Bob to attend day surgery and outpatient appointments with pre/post care at the MRC. Bob received intensive health literacy support to manage his own wound care.

Current situation: Bob was discharged from MRC to transitional accommodation and is currently living there, while still being able to see HHC GP at weekly onsite clinic.

Note: **CPAP:** Continuous positive airway pressure

5.4 Resident Psychosocial Needs

The underlying causes of poor health among people experiencing homelessness are often rooted in the social determinants of health, including poverty, trauma, emotional or sexual abuse, discrimination, social isolation and of course a lack of safe, stable housing.[42] Thus, supporting residents to identify and address psychosocial needs is integral to the MRC model of care. Many of the immediate needs of people when they first arrive to the MRC, resonate strongly with Maslow's Hierarchy of Needs (Figure 19)[47]. Helping people to meet basic needs regarding regular meals, good nutrition, sleep, clothing and safety is the critical first rung of support provided to all residents.

Figure 19: Maslow's Hierarchy of Needs

Common underlying psychosocial issues experienced by the cohort of people supported at the MRC in Year 1 include high rates of:

- Trauma (including intergenerational, physical, sexual, neglect, emotional, witnessing traumatic events);
- Social isolation and exclusion;
- Family and domestic violence (FDV);
- Child removal from parents (themselves or having their own children removed);
- Poverty;
- Racism and other types of discrimination;
- Legal and justice-system issues;
- Incarceration;
- Relationship/family breakdown or estrangement.

One resident reflected on how they would use the ED to satisfy the most basic of fundamental needs, shelter and sleep:

> *During summertime, I would sit up all night. A couple of times when I was homeless - you know before COVID and all that came in - I used to go to the hospital and sit down in the waiting room. Not to see a doctor or anything, I'll pretend I'm going to see a doctor. I'll sit out the back and sit on the stairs and have a little sleep. I'll wait till the sun came up, then I'm gone.* **– MRC Resident**

As noted by one of the MRC staff, residents often arrive to the MRC with nothing:

> *Often people arrive from hospital with literally the clothes they are wearing, or their sole belongings in a small shopping bag* – **HHC Nurse**

These underlying issues all contribute to declining physical and mental health among people experiencing homelessness and can exacerbate recurrent hospital usage. Box 7 provides an example of the complex psychosocial needs of one MRC resident whose cycle of homelessness and recurrent hospital use was caused by FDV, PTSD and significant trauma:

Box 7: Case Study – Support to Escape Domestic Violence and Regain Independence

Background: "Orla" is in her early fifties, whose recurrent experience of homelessness and high hospital use is as a result of complex, underlying psychosocial factors – including FDV, PTSD, multiple mental health diagnoses and harmful substance use. Prior to MRC admission, Orla had been living with her son and was subjected to financial, emotional and physical abuse. This resulted in her rough sleeping in 2021, with no mobile phone and no access to her own finances. In late 2021, she presented to ED in crisis, reporting suicidality due to lack of stable accommodation and general deterioration of her mental health. Orla was referred to the MRC for intensive psychosocial support, as well as management of her generally poor health.

Support Provided by MRC: On arrival to the MRC, Orla was fearful and distrustful of services due to the significant trauma she had recently experienced. Slowly, the MRC staff built trust and rapport, which enabled them to engage her in wrap-around medical and social support. MRC key workers assisted Orla to regain access to her own bank accounts and Centrelink payments, as well as linking her with a counselling service to provide support for survivors of FDV. Not having had regular access to a GP, Orla's overall health was poor. At the MRC, she received preventative health screenings, was stabilised on her regular medications, and health education was provided to assist her to understand and manage her chronic health conditions. Once medically cleared from the MRC, Orla was transferred to a StayWitch's bed while awaiting appropriate supported accommodation. While in StayWitch's, Orla continued to receive psychosocial support and was supported to access bond assistance so that she could move into private rental accommodation. On discharge, she remained linked to HHC via the After Hours Support Service (AHSS), which helped her transition to her own accommodation.

Current Situation: In the eight months since leaving the MRC, Orla remained in her private accommodation and was regularly supported through home visits by the AHSS and a HHC case worker. She has engaged with community-based AOD, mental health and FDV support, and a local GP.

In addition to the prevalence of multiple health conditions described in the previous chapter, individuals referred to the MRC are often in the midst of dealing with significant stressors, such as relationship breakdowns, legal issues or financial difficulties, and these also take their toll on people's health and wellbeing. Box 8 provides an example of one MRC resident whose AOD use had led to deteriorated health, breakdown of his marriage and unemployment.

Box 8: Case Study – Support to Repair Relationships

Background: "Richard" is a man in his 50s who was brought to hospital following a motor-vehicle accident. He had been sleeping in his car and, when his car was impounded after he drove while intoxicated, Richard had nowhere to go. His injuries from the accident were minor, but his hospital admission was complicated by his poor overall health, exacerbated by his homelessness and lack of regular healthcare. Richard was malnourished and had significant complications due to nutritional deficiencies. He had extensive psoriasis, exacerbated by heavy, chronic ETOH use and extreme stress associated with his current situation. He had recently lost his job due to his ETOH use and his marriage had broken down, precipitating his homelessness.

Support Provided: Richard was admitted to the MRC, where he received intensive, wrap-around medical support to manage his comorbid health concerns. His nutritional status was stabilised with close monitoring and support, and his psoriasis was treated daily by nursing staff and resolved. He was given extensive health education and support to improve his health literacy, to enable him to manage his health more independently moving forwards. During his admission, Richard was also given intensive support for his substance misuse and assisted to explore options for recovery. MRC key workers assisted Richard to engage with Street Law, and supported him to attend court and set up a payment plan to pay off fines. Once his acute medical needs were stabilised, Richard was supported into StayWitch's self-funded accommodation, while awaiting placement in residential rehabilitation. During this wait, he maintained his abstinence from alcohol use and was successfully transferred to long-term rehabilitation.

Current Situation: MRC staff were recently given an update regarding Richard's progress and were advised that he had successfully completed the rehabilitation program, enabling him to reconnect with his wife and repair their relationship. Richard returned to live with his wife and has returned to work as an electrician.

6 Types of Support Provided to Residents

There are two key types of support that were provided at the MRC that are reported in this Chapter:

- **Medical support** provided by GPs, nurses, and in-reach allied health services; and
- **Social support** provided by key workers and peer workers.

6.1 Medical Support and Resident Outcomes

The multidisciplinary medical team provides medical support to residents in many ways as outlined in Figure 20 and discussed throughout this Section. Support goes beyond direct medical care into broader advocacy, care coordination, and education for residents to support their recovery journey.

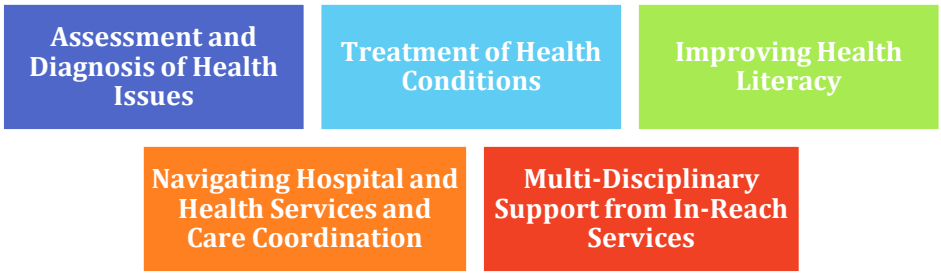

Figure 20: Types of Health and Medical Support Provided to Residents

6.1.1 Assessment and Diagnosis of Health Issues

Many MRC residents have not had recent or regular primary-care access, and hospital ED presentations or admissions have predominantly addressed their most acute health issues. The health assessments undertaken on MRC admission and while people are at the MRC are thus comprehensive enough to capture a vast array of health needs and medical history.

On admission:

- Nurses take baseline observations of all MRC residents on admission, including blood pressure, heart rate, oxygen saturation, temperature, body mass index (BMI), and COVID-19 screening. If any observations are not within normal ranges, the resident will be subsequently reviewed by a GP;
- A comprehensive health assessment is commenced, including checking for any open wounds, and gathering information on their medical history (past and current), allergies, current medications, AOD use, mental health status and risk factor screening; and
- Additionally, nurses assess residents regarding their understanding of why they were in hospital and why they have been referred to the MRC, to gauge what sort of health education may be required for them.

Photo 12: MRC Nurse Undertaking Health Assessment with Resident

During intake:

- GPs are provided with admission summary from nurses, a copy of the MRC referral, any medical records provided by the referring

hospital (if applicable) or My Health Record,[g] contributing to a comprehensive medical intake alongside an RN;

- Additional assessments are undertaken by GPs or nurses as required, i.e., if a resident has a history of a chronic health condition, then they will undergo more regular checks and monitoring related to that condition (e.g., someone with cardiac disease would have their blood pressure monitored regularly); and
- Pathology tests and investigations may be instigated by GPs where applicable to support the diagnosis or treatment of health issues.

6.1.1.1 Investigations Undertaken

In Australia pathology and screening plays a critical role in diagnosis and informs decisions around the optimal treatment for patients. In the MRC Year 1 cohort, the HHC GPs requested investigations for two thirds (66%) of residents; the majority were blood tests. Common pathology tests ordered included tests for infectious or sexually transmitted diseases, blood-glucose monitoring, liver function tests. Radiology and cancer screening tests comprised most of the non-pathology investigations, including x-rays to explore chronic pain and investigate old untreated injuries (Table 11).

Table 11: Primary Care Health Assessments and Investigations

For Everyone:	Where Applicable for Specific Residents:		
• Medical history • Current diagnoses/conditions • AOD use & history • Smoking status • Risk-factor screening • Baseline observations (BP, BMI, heart rate, temperature)	**Pathology:** • Full bloods • Bloodborne viruses • STI testing • Liver function • Blood glucose level • Vitamin/iron deficiency	**Radiology:** • X-ray • CT scans • MRI • Abdominal ultrasound	***Cancer Screening:*** • Mammogram • Bowel cancer • Cervical cancer • Skin checks • PSA

Notes: **AOD:** alcohol and other drugs; **BMI:** body mass index; **BP:** blood pressure; **CT:** computerised tomography; **MRI:** magnetic resonance imaging; **PSA**: Prostate specific antigen; **STI:** sexually transmitted infection.

6.1.1.2 Identification of Previously Undiagnosed Health Issues

As many MRC residents have not had access to regular primary care or health screenings, the MRC plays a critical role in the identification and diagnosis of previously undiagnosed or untreated health conditions. After an initial "settling-in" period at the MRC, the medical team work hard to ensure that other health concerns (i.e., conditions beyond the primary admission reason) are investigated, diagnosed, and treated.

> *People are often referred to the MRC for acute yet uncomplicated reasons such as wound care or AOD support. What we frequently observe is that in the days following admission people start to open up about the complex traumas they've experienced, or about being driven to self-medicate with illicit substances to survive being on the streets. It is not uncommon for people's health to initially appear to deteriorate as all areas of their health are addressed and people feel safe enough to engage in more than their acute health care needs. This then creates a space for recovery and to interrupt cycles of ED presentations* – **Zoe Thebaud, Director of Residential Services, HHC**

One resident reflected on how despite seeing many doctors, they were only ever treated for their presenting issue (in their case their mental health) and that an infected spider bite was missed as no one had ever performed any additional investigation or assessments to identify other issues:

[g] My Health Record is Australia's national digital health record

[I was in hospital for my] Anxiety, depression, alcohol withdrawal… I had a whitetail spider bite and was covered in scabies from living on the streets… but I'd been to see doctors - a doctor in a hospital, another hospital and they hadn't picked up on it. **– MRC Resident**

Thus, the length of an MRC admission can, therefore, extend beyond the original 14-day maximum stay to enable other health concerns to be addressed. Addressing underlying needs, particularly when it comes to traumatic experiences, is not possible in the hospital setting due to time constraints and bed demand. One critical benefit of the MRC is that there is time for these issues to emerge and be addressed beyond just the presenting issue at the MRC:

… just having a chance to actually get in touch with them opportunistically, just because they happen to be here. It's like, "oh, we found this old blood test and noticed this abnormality. Let's follow it up now." Whereas that's hard to do if they're street-present… **– MRC Nurse**

…[residents] come with one health condition, but then we get a little extra information from previous GPs they've seen, or we dig into their My Health Record and find out that they still need ongoing follow-up support for conditions A, B and C – so let's tackle that while they're here as well... **– MRC Key Worker**

I think it's an opportunistic thing as well. Usually, they will come in with some sort of – maybe wound care or something. Then we notice, yes, they have a history of depression or anxiety or PTSD, whatever it may be, and that they are actually still struggling with it. But they've not been linked with a counsellor or psych or anything like that, or having any sort of ongoing mental health support. **– MRC Key Worker**

6.1.1.3 Comprehensive Health Assessments

The MRC had a set KPI **(KPI 11)** of commencing a comprehensive health assessment with 100% of residents within 24 hours of a resident's arrival. This assessment includes physical, mental, psychosocial and AOD issues to determine the health needs and goals of residents and to identify any risks so that mitigation strategies can be implemented. The MRC met this KPI, with 100% of residents having a plan commenced within 24 hours of arrival.

6.1.2 Treatment of Health Issues

This section has been separated into the treatment and management of:

6.1.2.1 Physical Health

The most common types of health management and treatment provided at the MRC to date include:

- ***Pain management***: The GP prescribes and reviews medication for residents experiencing pain, nurses monitor and administer analgesia and advocate where current medication is not sufficient or needs adjustment. This includes reducing use of strong prescription opioids if the resident has been on high doses for long periods. Referrals to pain clinics/specialists and liaison around pain management plans;
- ***Medication prescribing/administration***: Prescribing by GP, and medication administration, education, and support undertaken by nurses (e.g., depot injections and STI treatments). Implanon insertion by GPs;
- ***Medication reviews, titration, and management****:* Medication reviews undertaken by GP (including consolidation of medication if no regular GP monitoring of polypharmacy);
- ***Chronic health disease management:*** such as diabetes management and associated consequences;

- ***Wound care***: including ongoing chronic wound management, venous and arterial ulcers, diabetic foot ulcers, trauma wounds;
- ***Primary-care plans:*** Developed by GP for either mental health or chronic disease management; and
- ***Monitoring overall health conditions***: detection of deteriorating health and where hospital admission may be required.

Wound care is one of the most common reasons for MRC admission, as risk of infection while rough sleeping (and thus hospital readmission) is high:

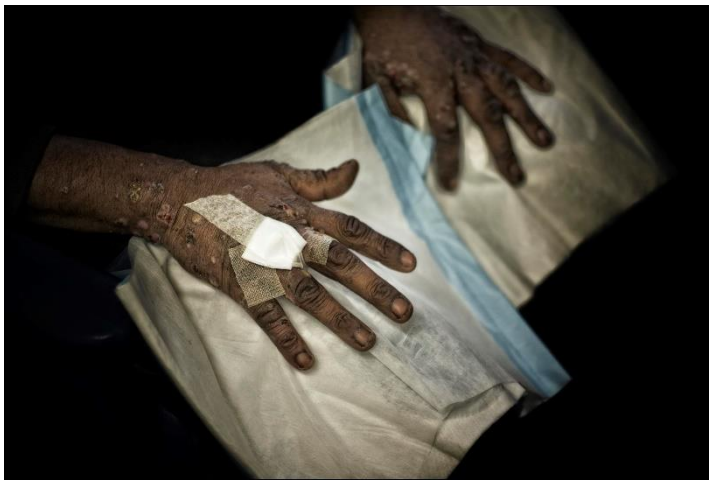

Photo 13: HHC Patient Receiving Wound Care

> *a lot of [residents] when they're discharged from hospital initially need their wound dressing done. So daily or every second day… and it's still in that period where it's quite high-risk for infection. Having that initial period where we can keep on top of the dressing changes, because a lot of the time, especially at drop-in centres, you see patients come in and they've left a dressing on for days on end, because they've just not been able to access anywhere to get it changed. Then they end up getting an infection anyway and then may have to go back to hospital…* **- MRC Nurse**

6.1.2.2 Mental Health and AOD Misuse

The most common types of mental health and AOD management and treatment at the MRC include:

- ***AOD use/dependence assessments***;
- ***Daily psychosocial support*** for complex mental health needs;
- ***Referrals*** to long-term mental health and AOD services for continuity of care post short-term stay at MRC. This includes collaborating with and strengthening existing engagements with other service providers (e.g., Community Mental Health, Mobile Clinical Outreach Team (MCOT));
- ***Prescription/management of Community Program for Opioid Pharmacotherapy (CPOP)***, including methadone, suboxone, and buprenorphine. This is a particularly unique service that the MRC offers as many practices don't offer daily dosing of opioid substitutions. Includes liaising with clients' existing CPOP providers and supporting to attend pharmacy daily;
- Clinical support for ***withdrawal management and detox process***: overseen by GP with daily management by the AOD team and nurses; and
- ***Safety planning and crisis management*** to determine risk to self (including risk of self-harm and suicidal ideation).

AOD dependency is common within homeless populations, often associated with trauma and co-occurring with mental health issues (dual diagnosis). In the MRC Year 1 cohort two thirds (66%) of residents had one or more AOD misuse disorders recorded in their HHC medical history. The MRC has supported many residents to address AOD dependence, including referrals and preparation for residential rehabilitation programs which, if successfully completed, will break the cycle of recurrent hospital use associated with AOD. Box 9 provides an example of how a resident with chronic alcohol dependence was supported to access rehabilitation and maintain sobriety.

Box 9: Case Study - Stabilising Health and Psychosocial Issues

Background: "Drew" is an Aboriginal man in his mid-forties who was referred to the MRC in mid-2022. He was initially admitted for 36 days for management of end-stage alcohol-related liver cirrhosis complications. During this admission, his health was stabilised, health literacy improved and he was successfully discharged to residential rehabilitation. While at rehab, he sustained an injury resulting in a hospital admission. Following hospital discharge he was unable to return to rehab due to his health status and need for strong painkillers. He presented to another metro ED, disorientated due to his liver cirrhosis and in extreme pain.

Support provided at the MRC: When Drew was admitted to the MRC for a second time, he was malnourished, in extreme pain, struggling to manage his health and highly distressed at having to leave rehabilitation. The MRC team worked closely with AOD services to develop a plan for him to return to rehab. His pain medications were reduced safely and he was medically cleared for return to rehabilitation by HHC GPs onsite at the MRC. Due to the Christmas period, there was an extended wait time for bed vacancies at all residential rehabilitation services. As a result, Drew stayed at the MRC for a total of 70 days. The long duration of this admission was to prevent discharge to the streets, which would likely have precipitated a relapse in alcohol use, further deterioration of his health and more time in hospital.

Current situation: Drew he feels confident that if he had not been able to return to the MRC, he would have relapsed into alcohol use and been unable to return to rehabilitation.

> *if it wasn't for this place I would still be on the street, not able to get into rehab, because there was nowhere for me… It has been a godsend so I can get on with my journey*. **– "Drew"**

Drew was successfully discharged back into AOD rehabilitation, after maintaining what he reported to be his *"longest ever period of abstinence from alcohol use."*

6.1.2.3 Preventative Health Screening and Interventions

In addition to specific treatments and monitoring of health conditions, the medical team at the MRC also provide preventative health-related support. This help includes:

- ***Tobacco-related:*** Smoking assessments, provision of nicotine replacement therapy (NRT) for nicotine dependence and motivational interviewing to support residents to quit (when wanted by the resident);
- ***Vaccinations:*** COVID-19 and flu vaccinations have been provided for residents where requested (via the Hub[h] as limited capacity to store vaccines at the MRC). If other immunisations due, this can be progressed;
- ***Cancer prevention education and screening***: Including cervical, bowel, breast cancer screening, health education relating to cancer prevention;
- ***Contraception***: discussions around types of contraception and the role in preventing STIs;
- ***Diabetic education:*** not only around proper monitoring of Blood Sugar Levels and how to administer insulin, but dietary education and awareness of risks and complications of untreated diabetes;
- ***Footwear education:*** Many residents (even when given shoes) won't wear them because they're used to being barefoot. Education is provided on the importance of wearing shoes in relation to damage to feet, infection, blisters and burns, especially for people with diabetes;
- ***Harm reduction***: education on how to use substances more safely (i.e., not sharing needles) and naloxone education;
- ***Oral/Dental Hygiene Education:*** education via Oral Health Centre of WA with carry-on education by MRC clinical staff; and
- ***Respiratory related:*** Including asthma care plans and education, lung-function assessments such as spirometry.

[h] The Hub is Homeless Healthcare's operation centre, where clinics are run (woman's clinic, GP, allied health services), the admin team sit, and the base of mobile operations for individuals with current or pasted lived experiences of homelessness. To see more visit: www.homelesshealthcare.org.au/the-hub

6.1.3 Improving Resident Outcomes

6.1.3.1 Self-Rated Health

In total, 118 residents completed at least one self-rated health ranking as part of questions asked at MRC admission, and there were 43 completed responses to the same question at discharge. The two graphs presented in Figure 21 depict the the difference in response to self-reported general health and mental health at admission and discharge.

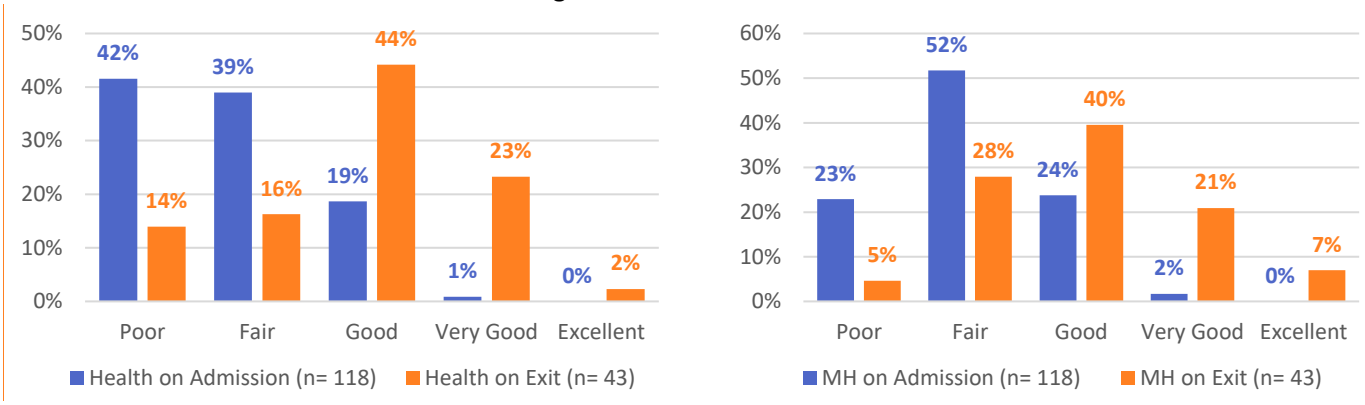

Figure 21: Self-Rated General and Mental Health on Admission to and Exit from the MRC

As the majority of residents have only completed the question at one time point (mainly on admission), Figure 22 presents the shift in responses for 42 individuals who completed the question at **both time points**. Of these 42 individuals, two thirds (67%) reported improvements in their physical health and almost two thirds (62%) reported improvements in their mental health. A third (31%) reported no change in either the physical or mental health, and hardly any residents reported a decrease in either physical health (2%) or mental health (7%).

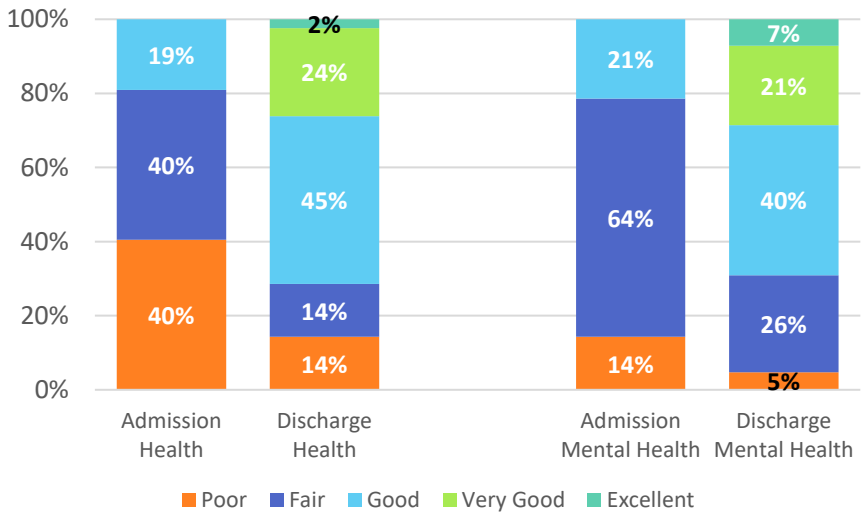

Figure 22: Self-Reported Health Improvements

6.1.3.2 Health Literacy of Residents

Health-education and health-literacy improvement is embedded into part of every interaction with residents by the nursing team. Many people experiencing homelessness have multiple chronic health conditions and have cycled in and out of the health system for many years.[44, 48] The therapeutic nature of the MRC enables staff the time to sit with residents to discuss their conditions and answer any questions they may have. As many MRC residents have liver disease or cirrhosis, care is taken to explain to residents the risks, complications, management, and prognosis related to this diagnosis and what it actually means for the individual. Additionally, supporting people who have been given a terminal

prognosis to better understand and process what this means is an important role that nursing staff fulfil for residents. Residents are also educated on how to identify what it looks like when they're becoming unwell and when they may need to go to hospital.

Improving health literacy of residents has also been identified as a key intervention to be provided by medical respite services internationally.[11] Two examples of residents who were supported with improving their health literacy are presented below in Box 10 and Box 11.

Box 10: Case Study – Increasing Health Literacy and Engagement

Background: "Felicity" is a woman in her late forties who has a history of homelessness and challenges with AOD use. On admission to the MRC, Felicity disclosed that she had not prioritised self-care as she did not expect to live much longer.

Support provided: The MRC team spent time supporting Felicity to become engaged in the management of her own health. As her health stabilised and health literacy increased, Felicity began making changes to her health and discussed dietary changes with the GPs and nurses, as well as increasing her exercise. Previously a heavy smoker, Felicity quit smoking while at the MRC with support from the MRC team and NRT provided on site. Felicity became highly involved in cooking at the MRC to broaden the range of healthy meals that she knew how to cook to regain her passion for healthy food.

Current situation: Felicity was discharged from the MRC and is now housed in a private rental; she has returned to employment and continues to proactively manage her health.

Box 11: Case Study – Increasing Health Literacy Around Diabetes Management

Background: "Mike" is in his late forties and moved to Perth from over East to find stable employment. After finding FIFO work in WA his employment was compromised due to his poorly controlled diabetes, which caused him to fail his mandatory physical-health assessment. His loss of employment resulted in a loss of accommodation and contributed to a downward spiral with his mental health and heavy daily alcohol use, resulting in presentation to ED in crisis.

Support Provided: Mike was referred to the MRC from hospital and admitted for stabilisation of his diabetes, mental health support and assistance to engage in AOD services. While at the MRC, Mike disclosed to staff that he had previously been unable to take responsibility for management of his diabetes due to limited understanding, his ongoing struggle with alcohol use, and a lack of stable accommodation. With intensive support from MRC medical staff, Mike was educated about his diabetes and supported to take ownership over this aspect of his health. He progressed from observing the nurses when they monitored his blood sugar, to checking his sugar levels himself, using his own machine accessed through the National Diabetes Services Scheme. Mike developed an understanding of the safe parameters for blood glucose levels and began titrating his own insulin doses under the guidance of HHC GPs. Mike was linked with community mental health support to manage his mental health moving forwards.

Current Situation: Once Mike gained understanding of his diabetes and confidence managing his own medication regime, he was able to re-engage in work. He was discharged from the MRC and found FIFO work in his field. He maintained engagement with HHC GPs in community for ongoing monitoring of his diabetes.

Photo 14: Residents Cooking

6.1.4 Care Coordination and Advocacy

Medical staff support MRC residents to attend various health appointments, to return to hospital when they clinically deteriorate, and with their coordination of care to better improve overall health outcomes and engagement with treatment.

6.1.4.1 Referrals, Advocacy, and Support for Residents

In addition to direct medical treatment, diagnosis, and education, clinical MRC staff also provide residents with a lot of additional support and advocacy including writing referrals, care planning/coordination and input into applications (Table 12).

Table 12: Referrals and Clinical Correspondence

	Types of Support and Referrals	
Referrals	• AOD residential rehabilitation • AOD programs • Allied Health (e.g., physiotherapy, OT, audiology, optometry, podiatry) • Antenatal AOD programs • Central Referral System for public outpatient clinics	• FDV services • Medical specialists (e.g., hepatology, orthopedics) • Mental Health services • Specialist Aboriginal Mental Health Services
Multi-disciplinary care planning	• AHSS nursing care plans • co-ordinate and confirm discharge/follow-up plans from inpatient teams happen • Chronic Disease Management Plans • Mental Health Care Plans	• Liaison with hospital medical staff and outpatient clinics • Multi-disciplinary case conferences • Medication reviews
GP input to support applications	• ACAT • Centrelink • Criminal injuries compensation claim • Community disability housing program • Disability support pensions • NDIS applications	• Public Advocate/Trustee • Subsidised transport scheme (e.g., for patient with wheelchair) • Priority Housing Review • Supported mental health accommodation

Notes: **ACAT:** Aged Care Assessment Team; **AHSS:** After-Hours Support Service; **AOD:** alcohol and other drugs; **FDV:** Family and domestic violence; **NDIS:** National Disability Insurance Scheme.

Due to the therapeutic nature of the MRC, staff work with residents to determine the types of services they want to engage with, and can provide referrals and support letters to facilitate this engagement:

> *…a lot of our clients have dual diagnosis - with mental health and the addiction and we're able to get on top of those and actually link them with whichever service they prefer and get that ball rolling to get them into rehab …* – **MRC Nurse**

However, it has been noted how time intensive some of the assessments requiring support letters or medical information can be on clinical staff, and that as a:

> *…DSP and Brief Risk Assessments for housing take up quite a lot of time... They are effectively unpaid and a pretty substantial part of the MRC work* **– MRC GP**

6.1.4.2 Chronic Disease Management Plans

As part of the Australian Government's Better Access Initiative[49] to bolster community access to comprehensive chronic disease management and coordinated mental health care, GPs can develop Care Plans for their patients to receive subsided care. Chronic Disease Management Plans and Mental Health Care Plans are funded by the Medicare Benefits Schedule (MBS) and are developed collaboratively between GPs and the MRC resident. Whilst some MRC residents were already known to HHC, many people experiencing homelessness do not have a GP or see a GP regularly, and this has

been common among people referred to the MRC. As noted by HHC CEO in the quote below, the MRC provides an opportunity for primary care assessment and engagement, including the development of primary care plans where applicable.

> *Many of the people referred to the MRC have been presenting to hospital with health conditions that can be more comprehensively managed by primary care, but not having a regular GP is a significant barrier to this. While at the MRC, the HHC GPs are able to discuss with residents the option of having a chronic disease management plan or mental health care plan – these care plans are developed with the patient and facilitate coordinated care, and are covered under Medicare. MRC patients can continue to see HHC GPs at its various community clinics, and care plans can enhance the continuity of primary care for chronic disease or mental health after MRC discharge. These comprehensive coordinated care plans are often addressing health issues that have often been undiagnosed or inadequately treated for many years.* **– Dr Andrew Davies, Homeless Healthcare CEO**

Amongst MRC residents, approximately one in six (16%) had either a Chronic Disease or Mental Health Care Plan developed either while at the MRC, or in follow up appointments at the HHC Hub or community mobile clinics (Table 13).

Table 13: Types of GP Care Plans

Type of Care Plan	n
Chronic Disease Management plan	15
Mental Health Care plan	13
Both chronic disease and mental health care plan	4

6.1.4.3 Support with Making and Attending Appointments

A significant and very time-consuming part of the MRC staff role is supporting residents to find out when and where their outpatient appointments are, and ensuring they attend. This often involves:

- ***Liaison with specialist outpatient departments***: liaising with multiple different services to determine correct information including contacting hospitals on residents' behalf if they don't feel confident to do so, or if they have poor literacy. Particularly endocrinology and hepatology to ensure coordination of care and follow up treatment is being accessed as required;
- ***Reminding residents of appointments***: appointments are entered into a shared calendar, so staff know what is happening and when;
- ***Assisting residents with transport***: Only recently the MRC has obtained a car to transport residents directly to appointments (where appropriate and staff are available). For Year 1 of the MRC, residents were provided SmartRiders and a printed map and timetable of service times, but they would have to navigate to appointments on their own; and
- Additionally, staff also spend a lot of time advocating to get residents ***back onto outpatient lists*** when they've been discharged from a clinic for not attending their appointments. This ties into one of the MRC KPIs of improving outpatient appointment attendance.

6.1.4.4 Care Coordination Across Services

Trying to maintain continuity of care with existing services that residents are already engaged with also takes considerable time and navigation. For example, if a resident already has a community case worker, they are supported to maintain these connections/relationships to stay actively involved with the external services. This not only ensures that the resident will have community support when they exit the MRC, but also ensures that the support provided by MRC staff doesn't double up on the work they've already done. Specific examples of resident care coordination has included:

- Communication with referring hospital staff, specialists, allied health to ensure that residents are following their discharge plans and attending outpatient appointments;

- Doing referrals to other services where required, ensuring that residents have access to require health services post-MRC;
- Liaising with MCOT and other community treatment teams; and
- Working with NextStep to ensure that residents CPOP are properly prescribed and managed while at the MRC.

Box 12 demonstrates one example of a resident who was able to gain access to key services as result of coordination and cross service linkage by MRC staff:

Box 12: Case Study – MRC Advocacy and Coordination with Services

Background: "Roland" is an Aboriginal man in his early forties who has a long history of transient homelessness, following displacement from Country and community. He had a below-knee amputation because of his poorly controlled diabetes and was lost to outpatient follow up for rehabilitation, resulting in a lengthy cycle of hospital readmission and discharge back to the streets of Perth. Unable to return to the Pilbara due to lack of required healthcare services, Roland was stuck sleeping rough in his wheelchair, slowly causing deterioration to his already poor health.

Support received by the MRC: Roland was referred to the MRC for management of his diabetes, and ongoing support for his below-knee amputation. During his admission at the MRC, he was supported with diabetes education and supported to access his own equipment to monitor his blood glucose levels safely.

With support from MRC key workers, he had photo ID organised, was approved for Subsidised Transport Scheme for wheelchair taxi transport and had NDIS services put in place. Under Medicare, with "No Fixed Address" he did not meet eligibility criteria to begin the process of being fitted for a prosthetic leg. However, MRC staff advocated for the MRC to be listed as a primary address and supported Roland to attend hospital outpatient appointments, in preparation for the fitting of a prosthetic leg. Following multiple case-conferences between hospital staff and HHC GPs and nurses, as well as Roland's newly appointed NDIS service coordinator, Roland was accepted for a planned hospital admission in a rehabilitation unit for prosthesis fitting, gait training and physiotherapy. This was achieved by providing the MRC as a listed address for discharge. Roland received his prosthetic leg and was able to learn to walk again.

Current situation: Roland was able to access further physiotherapy to assist with learning to use his prosthesis. His mental health, self-esteem and level of independence improved markedly throughout his stay at the MRC, through the process of accessing his leg and the care he deserved.

Box 13 provides an example of MRC staff liaising with other health services, to ensure that the specific, complex needs of one resident could be met safely, by acquiring the correct medical equipment for his needs, reducing the barriers to him accessing care.

Box 13: Case Study - MRC Accommodations and Care Coordination to Meet Resident Needs

Background: "Rhys" is a man in his late 40s, who was admitted to hospital due to complications of his chronic health conditions, exacerbated by acute stress related to the loss of a parent and subsequent loss of accommodation. Rhys was referred to the MRC for support of his complex health needs, impacted by his morbid obesity, along with psychosocial support through his grieving process, and assistance with accommodation.

Support Provided: Through close liaising with the Hospital, special arrangements were made to ensure Rhys was safely supported at the MRC, both psychosocially and physically. This included arrangements for a bariatric hospital bed and shower-chair to be loaned to the MRC for the duration of his stay. Medically, Rhys was supported with daily wound care and health education, including nutritional support and management of his chronic, untreated hypertension.

Psychosocially, Rhys was supported to collect his belongings from his previous accommodation, prior to a forensic clean and re-possession of the property by the owner. Rhys was supported by key workers with financial matters, particularly the costs associated with cleaning and vacating this property.

Rhys was referred to community mental health services for long term follow up and support with his complex grief. Long-term plans were also made to support Rhys to lose the weight required for hernia repair surgery, and to ensure his health was stable enough for this necessary procedure.

Current situation: From the MRC, Rhys was supported into long-term accommodation, with HHC GP follow up in community.

6.1.4.5 Continuity of Care with HHC Post-MRC

Photo 15: HHC Patient Being Seen in a Community Clinic

Prior to MRC admission, 46% of people (n=70) had some form of contact with HHC in the two-years prior to their first referral to the MRC. This did not necessarily mean regular GP care, as some people had only had interim contact with HHC via street health outreach or a drop-in clinic. As improving access to and engagement with primary care is one of the aim of the MRC model of care, and congruent with the Sustainable Health Review, the evaluation team looked at patterns of HHC engagement after discharge. Almost two thirds (64%, n=98) of individuals who had been at the MRC continued to receive primary care from HHC post MRC discharge. This includes some individuals who previously had no GP, and had indicated that their primary source of healthcare was hospital. There are also positive examples of MRC residents who have commenced seeing HHC regularly at its Hub clinic, enabling longer term support and routine monitoring of their various health conditions.

6.1.5 Multidisciplinary Involvement of In-Reach Health Services

A critical and very intentional part of the MRC model was the provision of a health clinic space onsite to allow services to attend and treat residents onsite. Going to *"where people are"* is a critical element of overall HHC service delivery as it reduces barriers to healthcare access and facilitates trust and rapport building with patients.[49] Critically, as many MRC residents have multiple, complex health needs, having multidisciplinary services that in-reach into MRC ensures access to wider health treatment and management.

> *… we had the HEART team come in and link with patients. They actually come into the MRC and sit down and see the patients… they're able to sit down and have meetings and to catch the patients. Because I know it can be hard to find patients if they're street present. So to actually make appointments and further progress whatever links they're having socially, it's great.* **– MRC Nurse**

Examples of health services that provided clinics/appointments for residents at the MRC in Year 1 include AOD services, various allied health services, aged care, and disability services:

- The C-L/AOD In-Reach Team undertook AOD assessments, provided counselling and liaised with HHC in referring people to community AOD services *(discussed later in this section);*
- Cyrenian House regularly attend the MRC to complete intake interviews, assessments, and run group AOD support sessions;
- Palmerston provides one-on-one support/assessments as required for people entering their residential rehabilitation services;
- MCOT attend the MRC to support people in crisis or to see people they are supporting in the community;
- Dental students ran weekly oral health/hygiene sessions shortly after the MRC opened for a period of approximately six months;
- Aboriginal mental health service (Wungen Kartup) attends the MRC to meet with people they are providing long term support to on an as required basis;

- ACAT providers attend the MRC to undertake assessments and liaise with MRC team around residential placements;
- NDIS service providers attend MRC in the instances where people have been recently put on NDIS or services re-established for assessments and reviews;
- RITH provide rehabilitation/physiotherapy sessions for people not yet discharged from their service; and
- HHC podiatrist attends on an as required basis to provide podiatry care to people on GP management care plans with chronic health issues.

The above is not a comprehensive list of the types of services that have provided in-reach health support for residents, with one resident recently having a neuropsychologist and speech pathologist visit them at the MRC for an appointment.

> *… [Resident] had a physio and an OT come and assess him once a week or once a fortnight, to do ongoing exercises, because he had a stroke. So, he's got weakness in his left side and they're practicing skills for eating food or cutting food up with a knife, to improve his hand dexterity. So they were able to provide that ongoing care with him… they actually managed to complete the whole service and he was discharged from them in the end.* – **MRC Nurse**

6.1.5.1 C-L/AOD In-Reach Service

The Consultation-Liaision Alcohol and Other Drugs (C-L/AOD) In-Reach Service which forms part of the new Mental Health Division of RPBG, provided an AOD in-reach service to the MRC in Year 1. Its remit was to provide multidisciplinary assessment, advice, brief intervention and evidence-based management, and discharge planning for patients with substance use disorders and also for those with comorbid mental health disorders. Overall, 64 people (42% of Year 1 residents) were actively supported by the C-L/AOD In-Reach Service at least once.

Table 14: Referrals and episodes of support by the C-L/AOD In-Reach Service

	N
Total e-referrals by MRC to C-L/AOD In-Reach Service	85^
Number of unique individual residents referred	72
Total number of residents with 1+ active engagements with C-L/AOD In-Reach Service	64
Range in active engagements per person	1-14

^Note: Residents may have multiple e-referrals

Types of assessments and support provided to MRC residents by the AOD in-reach team frequently included, but were not limited to:

- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) & check-up support;
- Smoking cessation & NRT support;
- Intravenous Drug Users Harm Reduction Plans;
- Clinical Institute Withdrawal Assessment for Alcohol;
- Alcohol withdrawal symptoms support and pharmacotherapy prescriptions;
- Hepatitis C and other blood-borne virus assessment & support;
- Aged Care Assessment Team (ACAT) screening;
- Mental Health assessment & harm-reduction support; and
- Self-help support, including 'Here's to your Health' booklet, 'A Better Night's Sleep', and other resources.

Box 14 provides an example of how the C-L/AOD In-Reach Service team supported a resident with his alcohol dependency, connected him with a multitude of services and supported and eventually facilitated access into a residential rehab program.

Box 14: Case Study – Supporting Recovery Through AOD In-Reach

Background: "Joseph" is a male in his mid-forties with extensive history of homelessness and heavy alcohol dependency, as well as advanced liver cirrhosis caused by hepatitis C. Joseph had originally moved to Perth over a decade ago looking for a fresh start but fell into homelessness and alcohol use quickly upon arrival. With no social support, Joseph continued to rotate in and out of hospital and crisis accommodation. Joseph has had previous successful rehabilitation stints in the past but was drinking heavily prior to MRC admission and was non-compliant with treatment for his advanced liver cirrhosis.

Support Provided: Joseph was referred to the MRC after he presented to ED with a severe foot ulcer caused by walking around without shoes. Once at the MRC, Joseph actively engaged with MRC caseworkers, and expressed a desire to engage with the C-L/AOD In-Reach Service team to address his alcohol dependency. AOD staff supported Joseph with his recovery efforts, linking him to counselling services, providing him resources on reducing alcohol-related risk and harm and connecting him with the Drug and Alcohol Support Hotline and encouraged him to attend AA.

Throughout his MRC admission, Joseph remained highly motivated to maintain sobriety. He was supported to re-establish his MyGov account and Centrelink payments, resume treatment for liver cirrhosis, and reconnected with his estranged family. As his physical health improved, Joseph regularly went out for walks throughout the neighbourhood, and proudly reported to not feel any temptation to consume alcohol, even when encountering acquaintances whom he would previously drink heavily with.

Current Situation: Joseph was supported into transitional accommodation where his foot has healed, and he remains and committed to his liver treatments. Joseph has recently secured a placement at residential rehabilitation centre.

The C-L/AOD In-Reach Service providers worked in conjunction with MRC staff to refer residents to a number of appropriate AOD services and community support organisations (Table 15).

Table 15: AOD Support Services Referrals

Types of Support	Service Providers
Community AOD counselling and support services	Palmerston, Cyrenian House, Ruah AOD Services, Community Alcohol and Drug Services, NextStep AOD Services, Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery Services, Drug and Alcohol Support Hotline, Hello Sunday Morning Alcohol Support Group
AOD residential rehabilitation	Cyrenian House Serenity Lodge, Tenacious House, Palmerston, Harry Hunters, Bridge House, Shalom House
Mental Health support	Mental Health Emergency Response Hotline, City East Community Mental Health Service
Other support services	Multicultural Futures, Women and Newborn Drug and Alcohol Services (WANDAS), Wungening Alcohol and Other Drugs Support Service

One of the key challenges for the C-L/AOD In-Reach Service team was the availability of residents during planned visits to the MRC. Due to the home-like environment of the MRC, many residents would come and go during the day, often to attend to external appointments (i.e., Centrelink, medical appointments, accommodation interviews) and would miss the C-L/AOD In-Reach Service, or would have left the MRC before sufficient engagement (either self-discharged or were asked to leave by MRC staff). For the second year of the MRC pilot, this AOD in-reach service ceased, and the scope of the MRC service contract with HHC was expanded to include the delivery of an internal comprehensive AOD service at the MRC, including capacity in Year 2 to support medical detox where required.

6.2 Social Support

As well as attending to the significant medical concerns of residents, the MRC model also provides an opportunity to address underlying psychosocial needs which often drive hospital use and poor health. Prior to their arrival at the MRC, residents have often spent significant periods of time experiencing homelessness and in day-to-day survival mode and as such, few have been able to prioritise their own social and emotional needs during this period.

Building off national and international evidence that found people experiencing homelessness benefited from the coupling of medical and social care within respite facilities,[50,15] a holistic and multidisciplinary approach to supporting individuals was embedded within this model. Thus, both key workers and peer workers were employed to complement clinical staff. Overall, 106 residents (70%) engaged at least once with the peer workers and 127 (84%) residents engaged at least once with the key workers. Where individuals were not supported by either was because they were too unwell, were exited from the MRC early, or did not wish to engage.

The types of psychosocial support and engagement between residents and the peers and key workers are outlined in Figure 23, and described further throughout this section.

Figure 23: Overview of Social Supports Provided

6.2.1 Emotional and Wellbeing Support

Data were captured around the ways in which the peer workers engaged with residents, with 83% engaging to build trust and rapport (often through chatting, yarning, or playing cards for example). While 79% of residents came to the peer workers with their worries or to share their problems with a sensitive and empathetic ear (Table 16). A further 50% of residents also engaged with peer workers to help establish and work towards personal recovery goals such as AOD treatment, secure housing, or improved mental health.

Table 16: Peer Worker Engagement Types with Residents

Type of Engagement	N (%)^
Rapport/trust building	88 (83%)
Listening to worries/problems	84 (79%)
Support around resident's own recovery goals	53 (50%)

^Note some individuals may have been provided the type of support and engagement on more than one occasion

While this data already indicates a high level of resident engagement, it must be noted that it is often difficult to effectively capture the true extent and impact of the peer workers' efforts due to the highly informal and ad-hoc nature of support provided. A single engagement with one resident may include hours of in-depth discussions and support before the resident is ready to share their experiences and needs with the peer support workers. Additionally, engaging with the peer support workers is entirely voluntary at the MRC, and the level of engagement by residents is highly dependable upon a number of variable factors, including their physical and mental health upon discharge from hospital. Thus, while this data indicates that supporting residents' emotional wellbeing is a core tenant of the peer support role, the true extent of engagement and support provided is likely underreported.

6.2.1.1 Trust and Rapport Building

Peer and key workers spend a large amount of time building trust and rapport with residents when they arrive at the MRC. For many, previous negative experiences with the health system including judgment and stigmatisation from providers can lead to mistrust and scepticism that they will receive a different type of support to previous experiences. As noted by two key workers, it can often take weeks for a resident to feel settled and to start sharing with MRC staff:

Photo 16: MRC Resident and Support Worker

> *…building trust obviously takes time, sometimes people come in here who are chronically homeless and have zero trust. So sometimes it takes two weeks for them to open up to us and start telling the truth. Which is understandable, I wouldn't trust anyone either if had been living on the streets… or when they've been surviving for so long, they come through [the doors] and are emotionally exhausted when they get here, because they can turn that survival mode off, they're not numb anymore…* - **MRC Key Worker**

This sentiment of breaking down walls and relating to residents has been praised by other MRC staff:

> *I love having [peer worker] here so much. I think he's able to get the sort of knowledge from the patient that we might not be able, because there might be a barrier from a clinical perspective and he's able to chat with them as a peer… I think it's good not only for the patients, but for staff as well. I feel like I've learnt so much from just talking with [peer worker] that I might not know, because patients might not be keen to discuss certain topics…* **– MRC Nurse**

6.2.1.2 Practical Support to Foster Trust

One way in which workers are able to opportunistically engage with residents and slowly build trust and rapport is during transit between service providers. With the MRC now having access to a car, workers can drive residents to appointments (e.g., Centrelink interviews, rehabilitation meetings or visiting outpatient supports):

> *Yeah, the doctors and nurses have all made my appointments and got me back on track with my care… they're very thorough here…they've kind of taken all that on and made my appointments… then the peer-support workers here are helping me to get the documents I need together… it's a one stop shop*. **– MRC Resident**

> *I guess there really is no excuse for them not to attend medical or other appointments, especially now we have a car to take them in... We'll take them to Centrelink and be there to help advocate for them or ask questions with them, or we'll take them to collect scripts, or take them back to hospital if need be to avoid calling an ambulance.* **– MRC Key Worker**

6.2.1.3 Listening to Worries and Problems

The peer support workers have played a pivotal role fostering connections and understanding with residents just by taking the time to sit, chat, and share their experiences. One resident reflected how spending time with one of the peer workers has motivated them to make change:

> *That was a bit of a turning curve for me… I was feeling pretty low those first days. I was feeling s**t and seeing someone that was far ahead in the process was a bit of an eye-opener as well. Sometimes you can feel like there is no end goal, or it's too far away. Even him telling me that he's not perfect and this and that, it was a big thing.* – **MRC Resident**

This ability to relate and share experiences means that the peers can also provide support with other areas of need such as referrals and connecting with external support services:

> *for the people here I would describe it is a way for breaking barriers sort of thing. You get a lot of people that will come here, and they call the nurses Miss. It's like a prison thing. They can relate to you, and you can say "stop doing that". They'll tell you a lot of things that they won't tell the other staff. So you can help with their referrals and stuff like that...* **– MRC Peer Worker**

6.2.2 Engaging in Meaningful Use of Time Activities

As a part of a Lotterywest grant, funding was provided to HHC to initiate a wellbeing and life skills program at the MRC, which sought to engage residents in a number of therapeutic and preventative health activities during their stay. These activities, which ranged from regular exercise groups to cooking and computer classes, were designed to equip residents with important life skills and improve their overall physical, mental, and emotional wellbeing. The MRC workers were integral to the facilitation of these activities, with their ability to bond and build rapport with hesitant residents proving useful for encouraging participation and getting residents 'out of their shells'.

6.2.2.1 Exercise & Physical Activity

In an effort to encourage healthy movement and improve residents' physical wellbeing, the MRC commenced an exercise program in early 2022, with twice weekly walking sessions facilitated by volunteers from the not-for-profit organisation 'On My Feet'. Through this program, residents were able to get out into the surrounding neighbourhood and parklands, undertake regular group exercise and socialisation, before concluding with a group coffee catch-up at a local café. These sessions proved particularly valuable as a way for residents to not only engage in low-impact exercise, but to also connect with other individuals with previous experiences of homelessness and share unique insights and motivational support.

> *I find it crazy because the support [On Your Feet] can offer is different at each stage of your recovery. We were chatting about everything yesterday, and how good I felt at that group and then coming back [to the MRC]… I was just on such a buzz, I felt great and it made me realise that [On Your Feet] is going to be a big part of my journey* **– MRC Resident**

Other residents noted that walking sessions were a great way to socialise with fellow residents, to keep themselves occupied during the day, created routine, and assisted them with their AOD recovery.

> *[On Your Feet] was really good. I was excited about it all day and it gave me a reason not to even think about drinking or using, because I had to be sober and clean because there were going to be Year 11 students there.* **– MRC Resident**

More generally, MRC staff continue to actively encourage residents to undertake a range of appropriate physical activities during their stay, including light social walks in the adjacent park, or making use of available basketball and table-tennis equipment at the MRC.

6.2.2.2 Fostering Life Skills

A key component of the role that the MRC workers play is empowering residents to develop confidence and life skills that will prepare them for a more stable life beyond homelessness. MRC staff engaged residents in numerous activities to help equip residents with everyday skills useful to their recovery journey after discharge. Residents have been able to engage in a number of cooking, gardening, and nutrition-based activities designed to develop practical skills and improve understandings around healthy eating and nutrition. With the help of a professional nutritionist, peer-support workers have

utilised the MRC's kitchen facilities to deliver cooking sessions aimed at introducing healthy recipes to residents, developing their cooking abilities, and encouraging residents to reflect on their understanding of healthy eating.

Residents cook, eat, and clean together, providing an excellent avenue for socialisation, and discussion and rapport building as well. The recent construction of an outdoor pizza oven has proven to be a valuable addition to the MRC, with make-your-own pizza nights becoming a popular way of welcoming new residents and encouraging socialisation.

> *Lot of people want to help cook, it gives them a sense of purpose. Especially when people first get here, often people feel like they should be helping out, but we try to reassure them that they don't need to, but if they want to help out with cooking that is good.* **– MRC Key Worker**

With the support of the Lotterywest grant, funding was also provided to support the establishment of a small MRC community garden, which again provides an excellent opportunity for resident engagement and socialisation, whilst also delivering a number of restorative benefits to residents and staff. Fresh produce from the garden has been incorporated into cooking and nutritional classes, and many residents have adopted duties tending to and caring for the garden.


Photo 17: MRC Community Garden

6.2.2.3 Creative Therapy Sessions

Creative activities such art, music, and photography have also been incorporated into the wellbeing program at the MRC due to the significant therapeutic and reflective benefits they can bring.[51] Lotterywest funding was used to purchase a small amount of art and drawing supplies, while community donations provided musical instruments such as a guitar, keyboard, and a didgeridoo specifically gifted to one resident from a respected Aboriginal community Elder.


Photo 18: MRC Residents and Staff Participating in Art Sessions

MRC staff also engaged residents in other activities (e.g., knitting, puzzles, and large jigsaws), which proved to be another effective way of fostering social interactions and personal reflections.

> *… when I first started doing a jigsaw, there was a few of us doing it and the support workers were coming in and the nurses were coming in… one or two at a time and helping. So, for me, on a mind and spirit level, it was quite cathartic. As if I was putting the pieces of my life back together and… it's kind of like one piece at a time and if it didn't fit – like in real life - the pieces that don't fit are gone and the pieces that do fit, yeah…* **– MRC Resident**

Art has been a particularly valuable avenue for expression and reflection for the MRCs' Aboriginal residents, with many taking up traditional art paintings and several pieces being donated to, and now on display at the MRC by residents.

Photo 19: MRC Resident Artwork

6.2.3 Supporting Residents to Achieve Goals

6.2.3.1 Empowering Residents to Think About the Future

An important aspect of the MRC model of care is to create a therapeutic recovery environment in which people who have typically been immersed in day-to-day survival or 'fight or flight' mode, can see and explore a future beyond homelessness, and equip themselves with the confidence and skills to achieve this. The ability for medical respite to provide rest and restitution to facilitate self-reflection and feel hopeful for the future has also been noted in international literature:

> *…a medical respite care stay can contribute to the creation of a temporary condition in which the basic needs of the homeless people are met, enabling them to be more hopeful and to think more positively about the future* - **Pederson et al. 2018**[52]

On admissions to the MRC, residents set their own health and other psychosocial goals to complete while at the MRC (see Section 5.2 for most common resident goals). Residents are encouraged to think about their future and what they want to achieve, and staff support them towards these. Table 17 provides some examples of residents' goals and how they are hopeful for the future post-MRC.

Table 17: Examples of Hope for the Future

Theme	Example Quote
Accommodation and Pets	*I'm nearly 65 this year. I've hooked up with My Aged Care… my provider's looking for a little place for me. I'm hoping to get a little dog… It's companionship and even though I can't walk far… It's a little bit to motivation to get going. For now, that's my goals. I don't want a big place, just a little somewhere that's my own and I don't have to move from.* **- MRC Resident**
Education and Training	*I'm thinking about studying, going to uni and doing counselling*. **- MRC Resident**
Employment, Education, and Accommodation	*I've got six months in Palmerston program and then have got transitional housing for 12 months, so I've got two years in my head that's what I'm thinking, and god willing I will get through that. I've already got a part-time job with chef when I get out that's there all ready to go, and I'm thinking about studying, going back and doing my diploma, finishing off my diploma and then getting into uni.That's a prerequisite to being in the transitional housing is that you're either working or studying. So, that's my long-term goals there. I'm already on a priority list with Homeswest.* **- MRC Resident**
Sobriety and Rehab	*Through events and circumstances, I ended up here realising that I need to go to rehab. I've gotten some brilliant support from the people here and also through [rehabilitation centre] and I managed to get in quite quick.* **– MRC Resident**

6.2.3.2 Support Accessing ID and Completing Paperwork

On a more practical level, MRC staff provide a significant level of assistance to residents with a range of technical and administrative needs, such as IDs, finances, and appointment setting. Time at the MRC offers the perfect opportunity for staff to assist residents to navigate complex bureaucratic processes or other needs typically neglected whilst living on the streets. The loss of ID is a common challenge for people experiencing homelessness, with many of the MRC residents supported to obtain ID during their admission. As articulated by one MRC worker:

> *Basically, at the moment there is only one person with 100 points of ID, everyone else needs to start from scratch*. – **MRC Key Worker**

As Table 18 shows, 35% of people have been supported to access a form of ID (i.e., birth certificate, drivers' licence), 32% were supported to access their healthcare cards and 20% with their Medicare card. Additionally, residents were supported to apply for a wide range of services including Centrelink, Priority Housing list (for Social Housing) and the NDIS. Overall, 63% were supported with applying for at least one type of ID or completing at least one application throughout their admission. It should be noted that many individuals did not require support with these applications for reasons such as they already had completed applications (separate to MRC), they did not consent to be added to certain lists or they weren't eligible for a service (i.e., non-resident are not eligible for Welfare payments).

Table 18: Engagement Activities Residents Were Supported With at MRC

Engagement Activity Supported With	N (%)	Residents who didn't require n(%)
Accessing ID and Documents		
ID (e.g., birth certificate, bank account)	53 (35%)	
Healthcare Card	49 (32%)	
Medicare Card	30 (20%)	
Completing Applications		
Centrelink (including getting reinstated and MyGov Assistance)	61 (40%)	59 (39%)
Added to By Name List	14 (9%)	83 (55%)
Completed VI-SPDAT	14 (9%)	32 (21%)
Priority Housing (including application, interviews, and reviews)	44 (29%)	79 (52%)
NDIS	10 (7%)	37 (24%)

Notes: **NDIS:** National Disability Insurance Scheme; **VI-SPDAT:** Vulnerability Index Service Prioritisation Decision Assistance Tool

Obtaining ID is important for a number of reasons, but particularly for this cohort as their lack of ID prevents them from applying for Centrelink, opening a bank account, and applying for priority housing. This can cause huge delays in accessing vital income and housing support, and contributes to residents having longer admissions at the MRC/StayWitch's. As demonstrated by Box 15, for one individual who arrived at the MRC with 0 points of ID, considerable work was undertaken by the key workers to source copies of various forms of ID before a Centrelink application could be lodged.

Box 15: Case Study – Supporting Residents to Access Multiple IDs

Background: "Mav" is a male in his late fifties who had previously never experienced homelessness. He was admitted to the MRC from hospital, following the diagnosis of terminal cancer, with neurological complications that significantly altered his functional ability. On admission to the MRC, it was identified that all forms of ID had expired, including his Medicare card, and that his bank account had been recently closed. This meant Mav had zero points of valid ID, and was unable to receive Centrelink payments or access a Health Care Card.

Support Received: Thanks to the collaborative effort of the MRC Key workers, Street Law and Services Australia, Mav now has a copy of his interstate birth certificate, a new Medicare card, a new bank account (and card), a Health Care Card and has submitted an application for Jobseeker and DSP so he will soon have access to finances.

Current situation: After nearly four months, Mav is still a current MRC Resident. He receives intensive daily nursing support to manage his frequent seizures, which are a complication of his condition, as well as close liaison with specialist outpatient teams. In addition to his complex medical needs, his stay has been impacted by numerous challenges in obtaining his legal documents, copies of valid IDs, accessing Medicare and Centrelink. These challenges have included the complexities of obtaining documents from the Eastern States and banks changing policies in light of the Optus and Medibank hacks, which has prevented the use of photo IDs created by hospital social workers or community workers in lieu of official Australian ID.

Notes: ^ As at end January 2023. **DSP:** Disability Support Pension.

While there are huge bureaucratic delays in accessing multiple different organisations/services to obtain ID for residents, an additional challenge is faced surrounding the cost of obtaining these documents. Currently the MRC does not have budget for brokerage funds, and have to source donations, grants, or crisis payments to cover the cost of application (e.g., a WA Photo Card costs $30.90 for a replacement or $46.80 for a new application[53]). Another challenge relates to the time taken for IDs to arrive at the MRC, as articulated by a key worker, often residents have moved out and then have to be tracked down to ensure they receive their ID:

> *…we've been applying for birth certificates, [but] by the time the birth certificate comes they've usually moved onto somewhere else…* – **MRC Key Worker**

6.2.3.3 Housing and Accommodation Support

The MRC has a "no discharges to homelessness" policy, thus, if beds are available, they discharge residents into their StayWitch's beds (the non-medical beds at the MRC) until appropriate accommodation is secured. This is integral to the person-centred model of care that the MRC was established on, with many residents expressing the relief such an approach brings.

> *I couldn't handle being on the street again. That's a very scary thought, that one. But just knowing I'm safe here, that makes one hell of a difference. They said I can stay until there's somewhere else, until I've got a place, and it just takes a lot of worry away.* **– MRC Resident**

It is not surprising, that one of the most common goals for residents during their stay is finding suitable accommodation post-MRC. MRC staff therefore provide a significant level of support to residents around exploring and securing potential housing options. Almost one-third (29%) of supported residents sought assistance from MRC staff with priority public housing applications (Table 18), including collecting documents for submission and assisting residents to attend interviews. In other instances, residents were accompanied to property viewings by peer-support workers, or taught how to navigate online accommodation sites such as REIWA and Booking.com. This extensive support

ensured the MRC have consistently met their KPI **(KPI 6)** which sought to ensure 100% of residents formally exited had an appropriate accommodation plan upon exit (excluding those who self-discharged early, or who had to be exited due to behavioural issues before completion of stay).

6.2.3.4 Employment, Education, and Training Support

Desktop computers and other office resources were purchased to create a dedicated work and learning space at the MRC. Staff regularly provide computer literacy workshops to residents, demonstrating ways in which residents can effectively navigate complex online platforms such as MyGov, Medicare, or the Australian Tax Office.

Key workers and peer workers supported residents to find employment opportunities, including preparing and updating their resume, helping them navigate Seek.com.au, completing pre-work training modules (including applying for work licenses/certificates such as a White Card), and exploring education options such as TAFE.

Box 16 provides an example of someone who was admitted to the MRC for wound-care post-surgery that was supported to return to work on discharge:

Box 16: Case Study – Supporting Residents back into Employment

Background: "Elliot" is a man in his forties, who had received minimal support following his release from a two-year prison sentence. On release, he reported doing "cash-in-hand" jobs for people he knew to self-fund short-term accommodation in backpackers for several weeks. In this time, he sustained an injury to his left wrist, requiring hospital admission for surgery. On discharge from hospital, he was advised that he could not return to work for 6 weeks and, as a result, was no longer able to afford his short-term accommodation. At time of discharge from hospital, he had no money and no accommodation options.

Support Received: Elliot was referred to the MRC for wound care and short-term accommodation. During his stay, he received daily medical care to heal the wound, and support to attend outpatient plastic department appointments. He was closely reviewed by HHC GPs onsite and eventually was able to be medically cleared to return to work. This included providing supporting documentation to his employer.

Current situation: As a result of daily nursing care, Elliot's hand fully recovered, and he was able to return to work. This enabled him to access self-funded rental accommodation on discharge from the MRC, returning to work and stable accommodation.

6.2.3.5 Financial and Budgeting Support

Many people supported through the MRC arrive in a precarious financial situation, with high levels of accumulated debts, fines, and debt-collector demands. Simultaneously, many have limited access to Centrelink or NDIS support due to incomplete applications, or a lack of evidence and appropriate ID. Given these financial issues can be significant risk factors associated with a return to homelessness,[54] financial support is therefore a common task for MRC staff, with more than 40% of supported residents seeking assistance with Centrelink applications, and 7% supported with NDIS applications (Table 18). Staff also work with residents to help create debt repayment plans, and advocate on behalf of residents to debt collectors and other financial providers.

Financial counsellors have also been engaged by the MRC to deliver financial awareness training sessions at the MRC, and have helped residents develop the necessary skills to organise their financial situations, create budgets, and understand their financial rights and responsibilities.

6.2.4 Connecting Residents with Services and Support Beyond the MRC

Supporting residents to engage in other health and social services is critical for their recovery journey post-MRC. The MRC model does not have an outreach component, so workers are unable to continue to support people once they are back in the community. Thus, an important role of the key workers is to link residents with the types of services they need.

Overall, a total of 119 (78%) MRC residents were connected with at least one external service by key workers. The majority were connected with one or two services, while two individuals were connected with 10 different services (Figure 24). Overall, these 119 individuals were connected with 100 different services, spanning health, housing, legal, aged care, disability and many others. Examples of the organisations can be found in Table 40, Appendix 5.

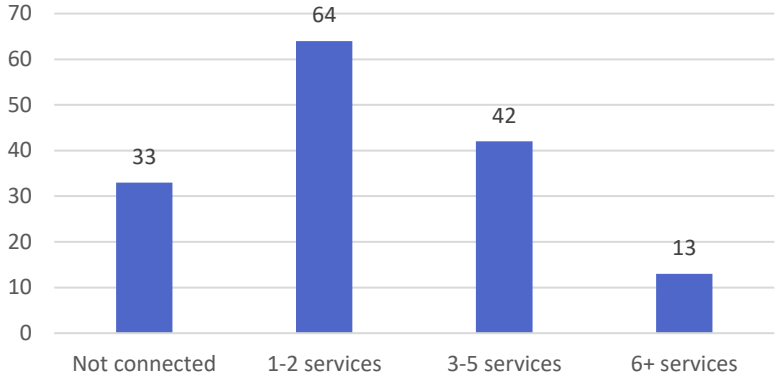

Figure 24: Number of External Services Residents were Connected to

6.3 Where Were Residents at the End of Year 1?

One of the key overarching aims of the MRC in the 1st year of operation was to improve residents' social outcomes by facilitating their transition out of homelessness. MRC staff worked to support residents to prepare them for life after discharge, including assisting residents onto the priority public housing waitlist, securing short-term accommodation (i.e., transitional accommodation or residential treatment), and supporting individuals seeking private rental accommodation.

However, at the end of Year 1, the best-known whereabouts for 50% of MRC residents was unknown, reflecting the complexities in providing continuity of support for this highly transient population group (Figure 25). For those with known housing status, 19% were accommodated; either permanently housed or in transitional accommodation, with 15 individuals still residing at the MRC. Overall, 7% had gone back to hospital, and 5% were couch surfing with friends or family.

Only 5% of individuals with known whereabouts had returned to rough sleeping, while sadly 3% of residents had since died.

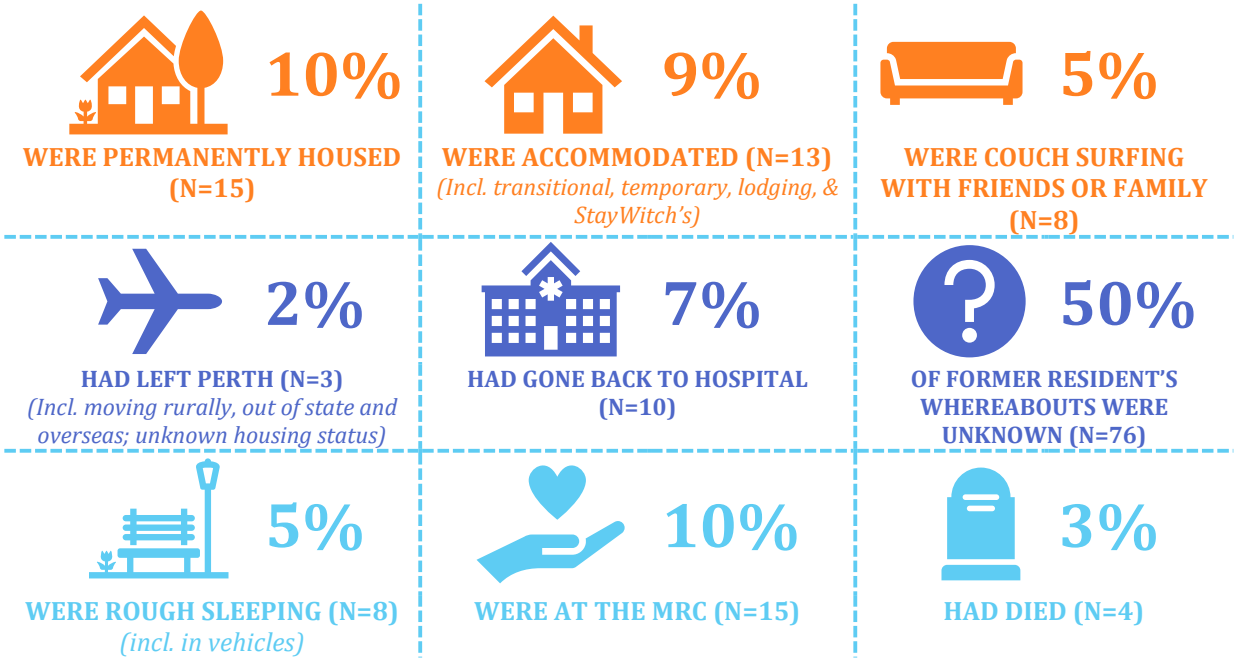

Figure 25: The Best-Known Whereabouts of Year 1 MRC Residents, as at 24th October 2022

7 Impact on Health Service Use

Reducing high rates of hospital use associated with homelessness is one of the key rationales for medical respite care.[32] Reducing hospital readmissions is also one of the outcomes associated with Strategy 4 of the SHR,[17] under which the recommendation to establish the Perth MRC sits. While there is growing international evidence from medical respite evaluations demonstrating reductions in hospital use and length of stay,[9-11, 55] this is not always the case, as the health of many people admitted to respite care is already significantly deteriorated and long-term multi-morbidity is pervasive.[11]

This chapter contains three sections:

7.1 Describes the ***patterns of hospital use of*** the Year 1 admitted MRC cohort ***in the three years prior to MRC admission***. This contextualises the magnitude of hospital use already accumulated by people who are admitted to the MRC.

7.2 Reports the hospital use of the Year 1 admitted MRC cohort ***prior to and following their MRC admissions***, with respect to changes in ED presentations, ambulance arrivals, inpatient admissions, length of hospital stay and re-presentation and re-admission to hospital. Outpatient appointment data pre- and post-MRC admission are also presented.

7.3 Provides commentary on the ***overall impact that the MRC has had on hospital and health service use*** for the Year 1 MRC residents. This section demonstrates the value of having the MRC as a discharge destination, compares MRC operational costs against expected hospital costs associated with remaining in hospital, and presents feedback from Stakeholders.

7.1 Health Service Utilisation Pre-MRC Admission

People experiencing homelessness are, on average, relatively high users of hospital services. Exemplifying this, of the Year 1 admitted cohort (n=152), **over the 3-year period leading up to first MRC admission**:

- over 1 in 3 (41%) had 10 or more ED presentations;
- over 1 in 6 (15%) had 10 or more arrivals to ED via ambulance;
- over 1 in 3 (43%) had 5 or more inpatient admissions; and
- over 1 in 3 (42%) had 25 or more bed days.

7.1.1 ED Presentations Pre-MRC Admission

Leading up to MRC admission, 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 admission (Table 19). This pattern is congruent with other research and evaluations undertaken by Home2Health, which have consistently demonstrated the deterioration of health and the associated escalation of hospital use of people experiencing homelessness the longer they remain homeless.[20, 21, 54, 56]

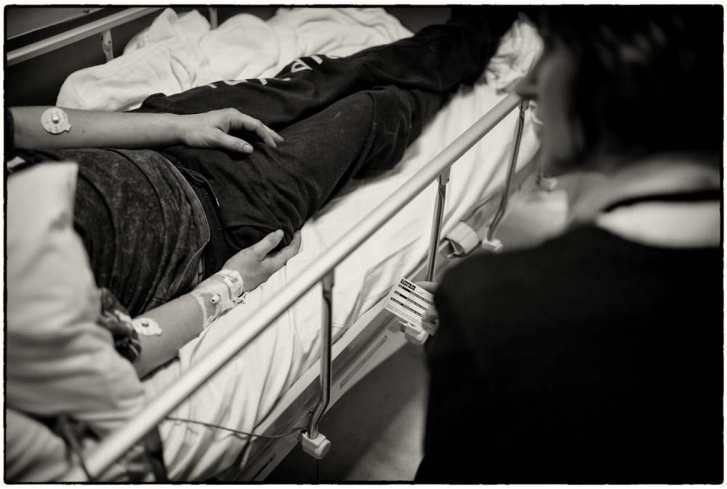

Photo 20: MRC Nurse In-Reach into RPH Homeless Team in ED

Overall, 96% of MRC residents presented to the ED at least once in the three years prior to their first MRC admission, for a total of 1,830 presentations, or **four ED presentations per person, per year** over that period.

Table 19: ED Presentations in the Three-, Two- and One-Year Periods Prior to First MRC Admission

	3 Years Prior	2 Years prior	1 Year Prior	Total
Total People with 1+ Presentation	81 (53%)	86 (57%)	145 (95%)	**146 (96%)**
Total ED Presentations	380	448	1,002	**1,830**
Mean^ (SD)	2.5 (3.8)	2.9 (4.6)	6.6 (9.2)	**12 (14)**
Range	0 – 21	0 – 25	0 – 68	**0 – 90**
N(%) presentations resulting in leave events^^	21 (6%)	64 (14%)	126 (13%)	**211 (12%)**

Notes: ^ Calculated per person based on the cohort of n=152 admitted individuals. ^^ e.g., did not wait, discharge against medical advice.

The literature shows that people experiencing homelessness have a relatively high likelihood of **leaving the ED before being seen** or treated,[57, 58] and this phenomenon is exemplified in Table 19, with 12% of ED presentations amongst the Year 1 admitted cohort in the three-year period prior to first MRC admission being classified as 'did not wait' or another leave event (e.g., discharge against medical advice). This is not surprising, given that 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 previous experiences of 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 to leave against the advice of medical professionals, despite their being considerably unwell. Leaving ED without being seen or treated contributes to the cycle of ED re-presentation by people experiencing homelessness.

7.1.2 Ambulance Arrivals to ED Pre-MRC Admission

Previous Australian research has shown that people experiencing homelessness are more likely than the general population to present to ED via ambulance.[59] Overall, in the three years prior to their first MRC admission, 80% of residents took an ambulance to hospital at least once, with one individual doing so 44 times in the year directly prior to admission (Table 20). On average, the Year 1 admitted cohort took 5.2 ambulances to ED per person over three years, for a total of 788 occasions.

Table 20: Ambulance Arrivals in the Three-, Two- and One-Year Periods Prior to First MRC Admission

	3 Years Prior	2 Years Prior	1 Year Prior	Total
Total People with 1+ Arrival	59 (39%)	66 (43%)	105 (69%)	**121 (80%)**
Total Ambulance Arrivals	150	202	436	**788**
Mean^ (SD)	1 (1.7)	1.3 (2.3)	2.9 (5.4)	**5.2 (7.2)**
Range	0 – 9	0 – 14	0 – 44	**0 – 46**

Note: ^ Calculated per person based on the cohort of n=152 admitted individuals.

7.1.3 Inpatient Admissions Pre-MRC Admission

Larger numbers of inpatient admissions, a higher likelihood of re-admission and longer lengths of stay for people experiencing homeless, relative to the general population, have been consistently reported in international[60] and Australian[19, 29, 61] research.

Overall, 95% of MRC residents had at least one inpatient admission in the three years prior to MRC admission, for a total of 873 admissions spanning 5,971 bed days (including non-psychiatric and psychtric days). Further, there was a clear pattern of escalating inpatient hospital use leading up to

first MRC admission, with the average number of inpatient admissions per person and the numbers of both psychiatric and non-psychiatric bed days all peaking in the year directly prior (Table 21).

Table 21: Inpatient Admissions in the Three-, Two- and One-Year Periods Prior to First MRC Admission

n (%)	3 Years Prior	2 Years Prior	1 Year Prior	Total
Admissions				
Total People with 1+ Admission	66 (43%)	71 (47%)	141 (93%)	**144 (95%)**
Total Admissions	174	191	508	**873**
Mean^ (SD)	1.1 (2)	1.3 (2.2)	3.3 (4)	**5.7 (6.2)**
Range	0 – 13	0 – 12	0 – 29	**0 – 33**
Days Admitted				
Total Psychiatric Days	271	395	1,046	**1,712**
Total Non-Psychiatric Days	745	798	2716	**4,259**
Total Bed Days	**1,016**	**1,193**	**3,762**	**5,971**
Mean LOS (SD) (days)	4.1 (7.7)	4 (7.9)	5 (12.9)	**4.6 (11.1)**
Range in Days Per Admission	1 – 57	1 – 83	1 – 202	**1 – 202**

Note: ^ Calculated per person based on the cohort of n=152 admitted individuals.

7.1.4 Costs Associated with Hospital Use Pre-MRC Admission

The disproportionately high health service use by people experiencing homelessness has enormous economic implications for the health system. In addition to the 'bed day' cost associated with high rates of ED presentations and lengthier inpatient admissions, the prevalence of homelessness amongst hospital patients has significant implications for ED wait-times, patient flow, discharge planning and staffing and resource demands.

Based on the ED presentation and inpatient use data presented in the previous sections, an estimate of the 'cost to the health system' over the three-year period prior to MRC admission has been computed using the most recently released:

- average ED presentation and inpatient bed day costs for WA public hospitals reported in Round 24 of the IHACPA;[25]
- average psychiatric bed day cost reported in the 2022 AIHW Expenditure of Mental Health-Related Services Report,[26] and;
- average cost of an ambulance arrival, calculated based on Part E, Section 11 data tables in the 2023 Report on Government Services.[27]

Table 22 shows the estimated costs associated with the hospital use of the Year 1 admitted cohort over the the three-year period prior to first admission. The total estimated cost over that period was over $17 million, or almost $113,000 per person or over $37,500 per person, per year.

Table 22: Aggregate Health Service Costs Associated With Hospital Use in the 3-Years Pre-First MRC Admission

n (%)	Days/ Presentations	Unit Price	Aggregate Cost	Cost p/person	Cost p/person p/yr
ED Presentations	1,830	$922	$1,687,260	$11,100	$3,700
Ambulance Arrivals	788	$929	$732,052	$4,816	$1,605
Psychiatric Days Admitted	1,712	$1,675	$2,867,600	$18,866	$6,289
Non-Psychiatric Days Admitted	4,259	$2,787	$11,869,833	$78,091	$26,030
Total			**$17,156,745**	**$112,873**	**$37,624**

7.1.5 Reasons for Hospital Use Pre-MRC Admission

As noted in Section 5.3, the health profiles of the 152 patients admitted to the MRC in Year 1 were complex, with mental health and AOD issues featuring prominently. This complexity is also reflected in the most common ED and principal inpatient diagnoses amongst the Year 1 admitted cohort over the three-year period leading up to first MRC admission (Table 23), amongst which four of the top five ED diagnoses and three of the top five principal inpatient diagnoses were mental health- and/or AOD-related.

Table 23: Top 10 Most Common Reasons (Diagnoses) for Hospital Use Pre-MRC Admission

	Top Presenting Issues at ED		Top Reasons for Inpatient Admission
1.	Acute alcohol intoxication	1.	Acute alcohol intoxication
2.	Acute stress reaction	2.	Alcohol withdrawal
3.	Suicidal ideation	3.	Symptoms and signs involving emotional state
4.	Alcohol withdrawal	4.	Chest pain
5.	Chest pain	5.	Type 2 diabetes mellitus with foot ulcer
6.	Cellulitis (upper limb)	6.	Alcoholic gastritis
7.	Abdominal pain	7.	Cutaneous abscess (upper limb)
8.	Concussion	8.	Head injury
9.	Issue of repeat prescription	9.	Alcohol dependence syndrome
10.	Alcohol dependence syndrome	10.	Emotionally unstable personality disorder

7.1.6 Outpatient Appointments Pre-MRC Admission

Table 24 shows the number of outpatient appointments scheduled for the Year 1 admitted cohort over the three-year period leading up to first MRC admission. Both the total number of scheduled appointments and the proportion of the cohort with at least one appointment scheduled for them increased over time. However, it is pertinent to note that that a relatively high proportion of scheduled appointments were not attended (7% over the period). This result is consistent with the literature, which notes that people experiencing homelessness face barriers to outpatient attendance and have higher non-attendance rates than the general population.[62-64]

Table 24: Outpatient Appointments in the Three-, Two-, and One-Year Periods Prior to First MRC Admission

n (%)	3 Years Prior	2 Years Prior	1 Year Prior	Total
Total People with 1+ Appointment	65 (43%)	86 (57%)	100 (66%)	**120 (79%)**
Total Outpatient Appointments	455	576	896	**1,927**
Mean (SD)	3 (9.7)	3.8 (7.2)	5.9 (11)	**12.7 (20.5)**
Range	0 – 104	0 – 48	0 – 94	**0 – 110**
Number (%) of Appointments Not Attended	52 (11.4)	26 (4.5)	53 (5.9)	**131 (6.8)**

7.2 Changes in Health Service Use Pre-to-Post-MRC Admission

Examination and comparison of the pre/post hospital use of medical respite residents can proceed in multiple ways. In particular, the literature describes two potential 'post' periods, beginning on (a) the date of **admission** to, and (b) the date of **discharge** from, respite.[5, 65] Reasons for the use of these approaches vary by case, and depend on both the metric examined and interested stakeholders. For example, from the point of view of the health system it may be of interest to examine the propensity of patients to be **readmitted to hospital from the date of admission to respite** (Method 1, Figure 26), while the longer-term effectiveness, or impact, of the program might best ascertained through **examining hospital use post-discharge from respite** (Method 2, Figure 26).

Thus, this section examines changes in ED presentations, ambulance arrivals, inpatient admissions, hospital re-presentation rates and outpatient appointments pre/post both the MRC admission **date** and the MRC admission **period**. As depicted in Figure 26, the 'pre' period is the same for both approaches, with only the alignment of the 'post' period differing:

Figure 26: Two Approaches to Examining Hospital Use Pre/Post First MRC Admission

For each approach, three follow up time periods are considered: 1 month, 3 months and 6 months pre/post. The numbers of individuals in the associated cohorts were:

Method 1 (pre/post date): 152, 139 and 103, respectively (100%, 91% and 68% of the Year 1 admitted cohort, respectively); and

Method 2 (pre/post period): 150, 127 and 94, respectively (99%, 84% and 62% of the Year 1 admitted cohort, respectively).

The amount of follow up for each individual was limited by the end date of the available hospital data (31 Dec 2022), which was more restrictive for when examining the admission period.

7.2.1 Changes in ED Presentations

7.2.1.1 Changes in ED Presentations Pre/Post MRC Admission Date

Pre/post the MRC admission **date**, reductions in the numbers of ED presentations were observed over each follow up period. Amongst the 1-month follow up cohort (n=152), 45% fewer individuals had at least 1 ED presentation and the total number of ED presentations decreased by 46% between the 1-month pre-to-post periods. Somewhat smaller reductions were observed for the 3- and 6-month follow up cohorts. Substantial reductions in the numbers of both ED presentations and ambulance arrivals were observed for the 6-month pre/post cohort (n=103) post-MRC admission date (Figure 27).

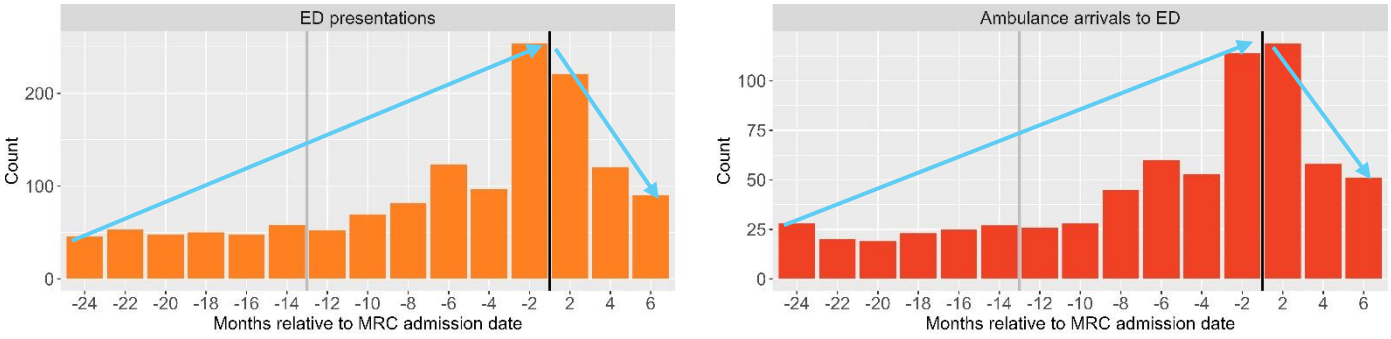

Figure 27: Changes in ED Presentations and Ambulance Arrivals Pre/Post MRC Admission Date

7.2.1.2 Changes in ED Presentations Pre/Post MRC Admission Period

The Year 1 admitted cohort also experienced reductions in the numbers of ED presentations pre-to-post the MRC admission **period** (Table 41, Appendix 5). Amongst the 1-month follow up cohort (n=150), 46% fewer individuals had at least 1 ED presentation and the total number of ED presentations decreased by 38% between the 1-month pre-to-post periods. Similar reductions were observed for ambulance arrivals, and somewhat smaller reductions for both ED presentations and ambulance arrivals for the 3- and 6-month follow up cohorts. Substantial reductions in the numbers of both ED presentations and ambulance arrivals were observed for the 6-month pre/post cohort (n=94) post-the MRC admission period (Figure 28).

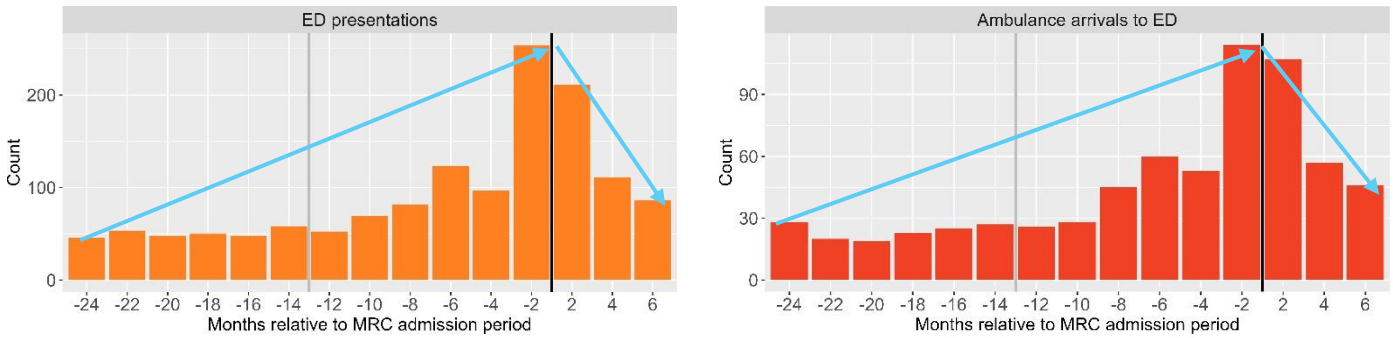

Figure 28: Changes in ED Presentations and Ambulance Arrivals Pre/Post MRC Admission Period

7.2.2 Changes in ED Re-Presentations

Figure 29 shows the proportion of the Year 1 admitted cohort with 1-month follow up (n=152) who had at least one 7-, 28- and 90-day ED re-presentation pre/post their first MRC admission **date**, and corresponding figures for the sub-cohorts of patients who either (1) were discharged to StayWitch's or (2) self-discharged or were exited. Regardless of both the cohort and the length of the re-presentation period, the proportion of patients with at least one re-presentation was lower following admission into respite. However, as might be expected, greater reductions were observed for patients who were subsequently discharged to StayWitch's, and smaller reductions for patients who either self-discharged or were exited.

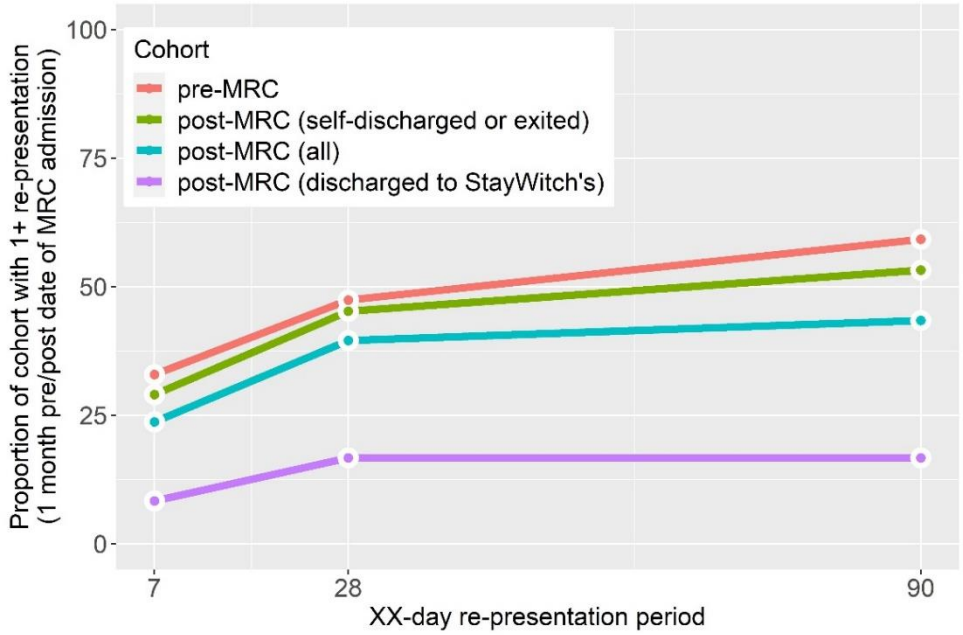

Figure 29: MRC Residents with One or More ED Re-Presentation One Month Pre/Post MRC Admission Date

Quantifying these reductions further, between the 1-month pre/post date of MRC admission periods, the number of people re-presenting to ED at least once within 7 days of their previous presentation reduced substantially by 27% and the proportion of 7-day re-presentations that resulted in inpatient admission reduced by 32% (Table 42, Appendix 5). Similar results were observed for both 28- and 90-day re-presentations.

7.2.2.1 Who Went Back to Hospital During/From their First MRC Admission?

Of the Year 1 admitted cohort (n=152), 31% (n=47) either returned to hospital at least once during their first MRC stay (n=31; 20%) or were discharged to hospital from that stay (n=20; 13%). These figures reflect not only the degree of effort that is required on the part of MRC staff to stabilise the

health of residents, even after they have been discharged from hospital, but also the fact that admission to the MRC cannot be considered to be a long-term solution to all the health, social and other issues that people experiencing homelessness are dealing with on an ongoing basis. The most common reasons for the presentations and discharges of MRC residents to hospital were either short- or long-term deteriorations in health or planned admissions, e.g., as arising through the process of 'forming', wherein MRC staff (and others) advocated for certain patients to be admitted for extended stays, e.g., in order that extensive psychiatric evaluations could be undertaken.

7.2.3 Changes in Inpatient Admissions

7.2.3.1 Changes in Inpatient Admissions Pre/Post MRC Admission Date

Pre/post the MRC admission **date**, reductions in hospital admissions, the number of people admitted at least once and the overall number of inpatient days were observed. For example, in the 1-month post-MRC admission date, the cohort of 152 individuals who had 1 month of follow up experienced a reduction in total inpatient days of 44%, while the number of people admitted to hospital at least once reduced by 64% and the total number of admissions reduced by 60%. These reductions are again reflected in Figure 30, which shows a substantial reduction in inpatient days for the 6-month follow up cohort two years pre-to-six months post-their date of first MRC admission.

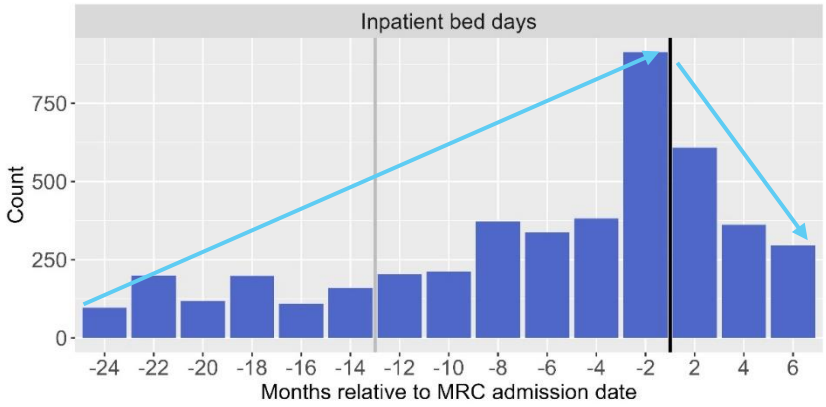

Figure 30: Changes in Inpatient Bed Days Pre/Post the MRC Admission Date

7.2.3.2 Changes in Inpatient Admissions Pre/Post the MRC Admission Period

The Year 1 admitted cohort also experienced reductions in both the numbers of inpatient admissions and the number of inpatient days pre/post the MRC admission **period** (Table 43, Appendix 5). For example, amongst the 1-month follow up cohort (n=150), the number of people who were admitted to hospital at least once decreased by 58%, the total number of admissions decreased by 52% and the number of inpatient days more than halved (53% reduction). Further, this trend continued, with the numbers of inpatient days decreasing by 44% and 33%, respectively, for the 3- and 6-month follow up cohorts in the 3- and 6-month periods following MRC stay. Figure 31 illustrates these decreases, showing a substantial reduction in inpatient days for the 6-month follow up cohort two years pre-to-six months post-their first MRC admission.

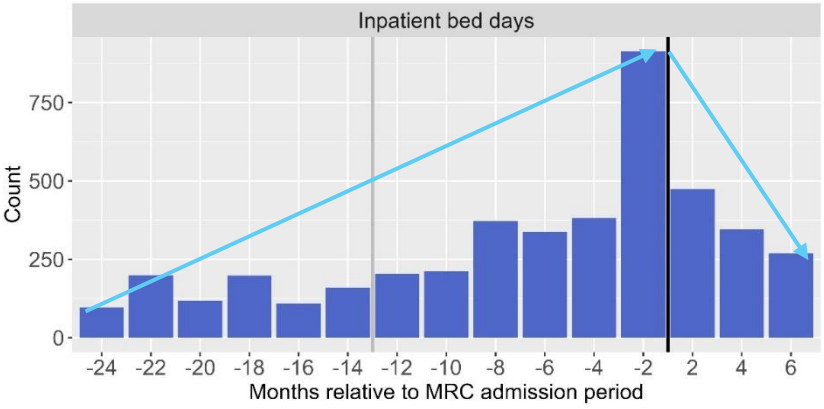

Figure 31: Changes to Inpatient Bed Days Pre/Post the MRC Admission Period

7.2.4 Changes in Costs Associated with Hospital Use Pre/Post MRC

As noted previously, one of the key rationales for medical respite care for people experiencing homelessness is the potential for reductions in hospital use. Economic analyses can examine whether:

1. Changes in acute hospital use (comparing the periods prior to and following MRC admission) are associated with reductions in the overall cost to the health system, vis-a-vis fewer ED presentations and/or admitted inpatient days;
2. The cost of MRC service provision can be partly or fully offset by cost decreases associated with reductions in the use of higher-cost hospital beds and resources; and
3. Greater engagement in primary care or community health services following MRC admission has the potential to prevent or reduce the use of higher-cost acute healthcare.

In this report, preliminary analyses have been undertaken relating to the first two points above. While the scope to undertake these analyses has been limited by the availability and duration of follow up data for all Year 1 residents of the MRC, the overall results are indicative of positive decreases in hospital use that equate to substantial associated reductions in costs to the health system.

Having said this, we acknowledge that the 'cost savings' associated with reductions in hospital use are not literally savings that accrue in the bank balances of Government Departments. However, there is increasing scrutiny on government agencies to deliver their services 'within budget', and, in the health system, for example, reducing demand on ED and/or inpatient bed days is a critical metric in this regard.

Optimal use of scarce health system resources is paramount, whether measured with respect to reduced demand on hospital beds, improved bed-flow facilitated by earlier discharge pathways, or reduced clinical and administrative burdens for hospital staff. Relatedly, homelessness is associated with other pressures on the alloction of health system resources (Table 25).

Table 25: Impact of Homelessness on Health System Resources

ED	Inpatient	Outpatient
↑ rate of leaving ED without being seen or treated[66]	↑ length of stay for mental health admissions[67]	↓ attendance at scheduled outpatient appointments
↑ wait times in ED[19, 68]	↑ rates of self-DAMA[69]	
ED presentations that are classified as social or behavioural	Delayed discharge due to the absence of safe or suitable accommodation options[70, 71]	
	Ineligibility for hospital or rehabilitation in the home programs and similar	

Reflecting the two approaches to calculating use of hospital services pre/post each MRC admission, the estimated impacts of changes in hospital use for the Year 1 MRC cohort are computed pre/post both the MRC admission **date** and the MRC admission **period.**

7.2.4.1 Costs Associated with Changes in Hospital Use Pre/Post the MRC Admission Date

From a health system and hospital perspective, a key anticipated benefit of medical respite care for patients experiencing homelessness is that there will be reductions in re-presentations to ED, inpatient use and inpatient re-admissions. Taking into account the sometimes dramatic reductions in hospital use that occur during the MRC admission period itself, the following total and per-admission pre/post MRC admission **date** reductions have been estimated (Table 26).

Table 26: Estimated Cost Reductions Post-MRC Admission Date

Follow up cohort	Estimated cost reduction	Based on	% cost reduction compared to pre-admission date
1m (n=152)	• $2.31 million in total; or • $15,216 per admission	• 107 fewer ED presentations; • 74 fewer ambulance arrivals; • 13 fewer psychiatric bed days; and • 762 fewer non-psychiatric bed days	80%
3m (n=139)	• $2.45 million in total; or • $17,602 per admission	• 105 fewer ED presentations; • 35 fewer ambulance arrivals; • 84 fewer psychiatric bed days; and • 781 fewer non-psychiatric bed days	52%
6m (n=103)	• $2.07 million in total; or • $20,127 per admission	• 90 fewer ED presentations; • 30 fewer ambulance arrivals; • 80 fewer psychiatric bed days; and • 656 fewer non-psychiatric bed days	40%

Thus, even if only considering the first MRC admission for each member of the Year 1 admitted cohort, the reductions in hospital use in the first month following admission to the MRC alone were associated with reductions in associated costs to the health system of $2.31 million, which is a greater amount than the costs associated with running the MRC over its entire first year of operation – approximately $2 million.

7.2.4.2 Costs Associated with Changes in Hospital Use Pre/Post the MRC Admission Period

The reductions in hospital use observed amongst the Year 1 admitted cohort post-first MRC admission **period** were associated with the estimated total and per-admission reductions in hospital costs shown in Table 27. As alluded to in the previous section, these reductions were lower than those occurring immediately following the MRC admission **date**, which is expected given that most residents remained in the MRC for at least a few days, during which time they were generally not using hospital services.

Table 27: Estimated Cost Reductions Post-MRC Admission Period

Follow up cohort	Estimated cost reduction	Based on	% cost reduction compared to pre-admission period
1m (n=150)	• $1.58 million in total; or • $10,589 per admission	• 106 fewer ED presentations; • 41 fewer ambulance arrivals; • 99 additional psychiatric bed days; and • 578 fewer non-psychiatric bed days	57%
3m (n=127)	• $1.9 million in total; or • $14,969 per admission	• 59 fewer ED presentations; • 16 fewer ambulance arrivals; • 47 fewer psychiatric bed days; and • 629 fewer non-psychiatric bed days	43%
6m (n=94)	• $1.58 million in total; or • $16,838 per admission	• 66 fewer ED presentations; • 17 fewer ambulance arrivals; • 9 fewer psychiatric bed days; and • 535 fewer non-psychiatric bed days	33%

7.2.5 Did Some People Experience Greater Changes in Hospital Use than Others?

Whilst pleasing overall decreases were observed in the numbers of ED presentations, inpatient admissions and bed days amongst the Year 1 admitted cohort pre-to-post both the MRC admission **date** and **period**, it is important to also look beyond these overall trends. As seen in a recently published literature review of medical respite for people experiencing homelessness,[11] and in

Home2Health's previous evaluations of the RPH Homeless Team,[20] HHC,[21] and the 50 Lives 50 Homes program,[54, 56] the impact of interventions on hospital use can be mixed. People experiencing chronic homelessness often already have advanced and/or multiple chronic health conditions prior to intervention, regardless of whether that intervention is health- or housing-based. Moreover, as discussed elsewhere in this report, discharge options for MRC residents are often sub-optimal due to the dire shortage of suitable housing, supported accommodation and even transitional accommodation in Perth, and due to there being waitlists for AOD residential rehabilitation. This situation inevitably negatively impacts upon the health of some residents, regardless of the quality of the healthcare provided during their MRC admissions.

Thus, overall trends in hospital use can sometimes mask what is occurring at the individual level, and, as such, the evaluation methodology of the MRC includes examination of individual-level patterns of hospital use. Specifically, the proportions of residents who experienced increases, decreases or no change in their hospital use pre-to-post MRC admission have been calculated (Table 28). Such individual-level analysis is also important for the present evaluation as the Year 1 admitted cohort is relatively small, with only 94 of the 152 Year 1 residents having six months of follow up, meaning that lengthy hospital admissions or high rates of hospital use amongst only a few individuals can disproportionately affect results and skew representations of effectiveness. Given the complex multimorbidity and acuity of health issues observed among the Year 1 admitted cohort, it was hypothesised that there would be some individuals whose hospital use either did not change or increased pre-to-post MRC admission.

Amongst the Year 1 admitted cohort who had at least 1 month of follow up post-the admission **period** (n=150), it was observed that, between the 1-month **pre- and post-admission** periods:

- 3 in 5 (60%) individuals had fewer ED presentations;
- Over 1 in 3 (36%) individuals had fewer ambulance arrivals to ED;
- About 3 in 5 (59%) individuals had fewer inpatient admissions;
- About 1 in 20 (6%) individuals had fewer psychiatric bed days; and
- Over 2 in 3 (68%) had fewer non-psychiatric and total bed days.

By comparison, just 16% of individuals had increased ED presentations, 11% had increased ambulance arrivals, 8% had increased inpatient admissions, 4% had increased psychiatric bed days, 11% had increased non-psychiatric bed days and 13% had increased total bed days, while the remainder of the cohort experienced no change in their levels of utilisation (Table 28).

Table 28: How Did Individual Hospital Use Change in the 1 Month Pre/Post MRC Admission?

	Decrease	Increase	No Change
ED Presentations	**60%** (n=90)	**16%** (n=24)	**24%** (n=36)
Ambulance Arrivals	**36%** (n=54)	**11%** (n=16)	**53%** (n=80)
Inpatient Admissions	**59%** (n=88)	**8%** (n=12)	**33%** (n=50)
Psychiatric Bed Days	***6%*** *(n=9)*	***4%*** *(n=6)*	***90%*** *(n=135)*
Non-Psychiatric Bed Days	***68%*** *(n=102)*	***11%*** *(n=17)*	***21%*** *(n=31)*
Total Bed Days Admitted	**68%** (n=102)	**13%** (n=20)	**19%** (n=28)

Triangulating observations from the hospital data, patient medical histories, MRC team data and interviews with staff, it was observed that individuals who had increased hospital use typically fell within one or more of the following categories (Table 29).

Table 29: Common Reasons for Increased Hospital Use During and Post-MRC Admission

Reasons for hospital use (ED or inpatient) while at the MRC	Potential reasons for increased hospital use following MRC admission
• Deterioration of mental or physical health that necessitated medical care beyond the capacity of MRC setting • Identification of undiagnosed health condition that required hospital intervention • Planned hospital admission for a necessary procedure or surgery that may not have been possible while someone was street present (e.g., colonoscopy, hip replacement)	• Acute or late-stage nature of chronic health conditions or cancers • Difficulty adhering to health condition management or medication regime • Self-discharge from MRC prior to being medically cleared • Poor engagement with primary care and reliance on ED for healthcare

Psychiatric admissions are a clear example of where the overall number of admitted days post-MRC stay was not representative of the overall trend amongst the cohort. For example, amongst the Year 1 admitted cohort with 1 month of follow up, the number of psychiatric bed days increased by 125% post-first MRC stay (Table 43, Appendix 5). However, as noted in Table 28, the proportion of the cohort with decreased numbers of psychiatric bed days was actually larger than that with increased numbers (6% versus 4%), while 90% of the cohort experienced no change in their use. Thus, the increase in the total number of psychiatric bed days can be explained by a small number of individuals having long mental health admissions, including two which were instigated by MRC staff due to escalating concerns about the deteriorating mental health of residents. One of these scenarios is described in Box 17, where the intervention of MRC staff positively led to a full psychiatric assessment of one individual that had not occurred during her many hospital presentations while homeless. The lady in question is now stably housed and engaging with community mental health services, with associated decreased hospital use.

Box 17: Case Study - Additional Hospital Admission Due to Deteriorating Health

Background: "Wendy" is a female in her mid-fifties with a history of homelessness and complex trauma. In the six-months prior to MRC admission, she had 30 ED presentations, and eight inpatient admissions (totalling 12 inpatient days). Most of this hospital use was attributed to drug induced psychosis in hospital records. As this presentation of psychosis was repeatedly attributed to substance use, Wendy had not received a full psychiatric review on her ED visits. Typically, Wendy would be discharged from ED to no fixed address, Safe Night Space, or she would DAMA. However, the delusions and paranoid thoughts she experienced resulted in challenging behaviours that impacted on her ability to stay in many homeless accommodation services, with Wendy being 'blacklisted' from several of these. Wendy was referred to the MRC by RPH Homeless Team for management of chronic wounds to her legs, and psychosocial support.

Support provided at the MRC: By day four of her MRC admission, the MRC team became increasingly concerned about her delusional thoughts and paranoia. It was determined that she needed a full psychiatric review to get a higher level of mental health support. The Mental Health Act was enacted, and Wendy was transported back to RPH hospital for a full psychiatric assessment. This led to an 18-day mental health admission to address her psychosis.

Current situation: Wendy is now housed, regularly sees a GP to monitor and support her mental health, and had only one ED presentation since the hospital mental health admission instigated by the MRC. In the six-months prior to her MRC admission, her ED and inpatient bed admissions equated to a cost of $61,104.^ The cost of an inpatient bed is 7x that of an MRC bed day. Whilst her 18-day psychiatric admission instigated by the MRC equated to a cost of $18,864,^^ this has been demonstrated to have reduced the cycle of high ED utilisation she was in, with only one hospital ED presentation in the last six-months.

Notes: ^ Based on average ED cost to a WA Public Hospital of $922 per presentation and average cost of Inpatient admission of $2,787 per day.[25] ^^ Based on average cost of psychiatric inpatient admission of $1,675 per day.[26]

Another factor conflating the overall examination of hospital use amongst the Year 1 admitted cohort pre-to-post MRC stay is the range of discharge destinations amongst the cohort. As noted in Table 5, a relatively large proportion of Year 1 residents self-discharged, while others were 'exited' by MRC staff for reasons such as aggression and intoxication. Preliminary analyses undertaken for the Year 1 admitted cohort for this evaluation suggested that the observed decreases in hospital use were smaller for those residents who self-discharged or were exited than for those who didn't/were not; however, the results of these analyses are not reported due to being impacted by the small numbers of individuals in each group. They will be pursued further for the Year 2 evaluation report.

7.2.6 Changes in Outpatient Appointments

Referrals to, and engagement with, outpatient health services is of interest in this evaluation, as:

- there are many barriers to specialist services and community-based health care amongst populations of people experiencing homelessness;
- the MRC has facilitated the diagnosis of health conditions that would benefit from specialist outpatient clinics; and
- outpatient and community clinics are far more cost-effective than hospital ED presentations or inpatient admissions.

> *Specialist outpatient services are an important part of the patient's healthcare journey and are often the interface between acute and primary care (outside of the ED), and are an important component of efficient hospital patient flow process and access to specialist care.*
>
> - **SHR Background Paper**[72]

An increase in the proportion of the Year 1 admitted cohort who had at least one scheduled outpatient appointment was observed pre-to-post MRC admission, across all three follow up time periods. Specifically, in the 1-month, 3-month and 6-month periods following first MRC admission, the proportions of MRC residents with appropriate follow up who had at least one scheduled outpatient appointment increased by 82%, 50% and 42%, respectively (Table 44, Appendix 5).

An increase was also observed in the number and breadth of outpatient appointments in the various post-MRC follow up periods. Table 30 lists the most common categories of outpatient referrals and appointments for the Year 1 admitted cohort, post-date of first MRC admission.

Table 30: Types of Scheduled Outpatient Clinic Appointments Post-MRC Admission

Types of Outpatient Clinics	
1. Obstetrics & Gynaecology	11. Endocrinology
2. Cardiovascular	12. Medical Specialist
3. Respiratory	13. Gastroenterology
4. Renal	14. Communicable Diseases / Infectious Medicine
5. AOD	15. Cancer
6. Mental Health	16. Orthopaedics & Physical Trauma
7. Neurology & Pain Management	17. General Medicine
8. Allied Health	18. Rehabilitation / Home Care
9. Dental	19. Palliative & Gerontology / Aging
10. Surgery & Preparation for Surgery	20. Aboriginal Health

Whilst in this report only quantitative results comparing numbers of outpatient appointments pre-to-post the MRC admission **period** have been reported, it is relevant to note that some outpatient clinic appointments occurred during the MRC admission itself. Anecdotal evidence provided to the evaluation team suggests that improved rates of attendance were observed for these appointments, as MRC staff were able to assist residents in several ways, including through:

- Submitting referrals for MRC residents to WA health outpatient clinics;

- Supporting residents to find out about or keep track of their outpatient appointments (which is difficult if they don't have a diary, phone or email address); and
- Supporting residents to get to outpatient appointments (including through providing advice regarding no-cost transport and encouraging attendance where residents are anxious, etc.).

7.3 Impact of the MRC on Hospital and Health Service Usage

As noted throughout this report, one of the rationales for providing medical respite for people experiencing homelessness is to enable the discharge of patients who would otherwise need to remain in hospital because of the lack of safe discharge accommodation options, and/or their need for continuing medical care. Accordingly, the MRC serves as a discharge destination for people who:

- cannot receive hospital- and rehabilitation 'in the home'-type healthcare by virtue of not having a home;
- have no safe discharge accommodation options; and/or
- would otherwise be discharged to environments (e.g., street, squats) that impede recovery from the health issue that led to their hospital admission.

The potential for the MRC to improve patient flow and discharge pathways is particularly salient on several current WA policy fronts:

- The burden of longer-stay patients on the WA public hospital system is highlighted in a recently released report by the WA Auditor General.[28] This report notes that there is an enormous economic cost borne by the public hospital system associated with patients who are medically able to be discharged but who have to remain in hospital even though they no longer need acute hospital care;

> *People staying in hospital after they are medically ready to leave is not good for them or for our health system. They are not in the right place for the care they need and extended stays block access to care for other patients.* - **Office of the Auditor General, 2022[28]**

- Optimising patient care and healthcare delivery is topical in WA health and in the literature internationally. Whilst there is no standard definition of optimisation in this context, in this report it is used to refer to the notion of achieving high-quality patient outcomes through efficient use of healthcare resources. Having people remain in an acute hospital clinical setting for longer than they need to is therefore the antithesis of optimisation from both the patient and bedflow perspectives,[73] and economically it is not cost effective where healthcare needs could be met at a lower cost outside of the acute hospital setting; and
- Shifting the burden of healthcare delivery from acute, expensive hospitals to community health, primary care and via a sharper focus on prevention are all themes within the SHR.[17]

7.3.1 Comparative Cost per Bed Day

In addition to the examination of hospital costs associated with reductions in hospital use amongst the Year 1 MRC cohort (Section 7.2.4), this section compares the cost of a MRC bed day to that of a hospital-admitted bed day, and presents crude costings associated with the extent to which the MRC has facilitated quicker patient discharges and/or provided post-hospital medical care where lengthier hospital admissions would otherwise have been required.

When comparing the average cost of a bed day at the MRC with the average cost of a WA public hospital bed day (Figure 32):

- A single day/night admission (general) in a WA public hospital is around 7x more expensive (if the MRC is at 85% capacity, and 8x more expensive if MRC at full capacity); and
- The bed day cost for a psychiatric inpatient admission is around 4x more expensive.

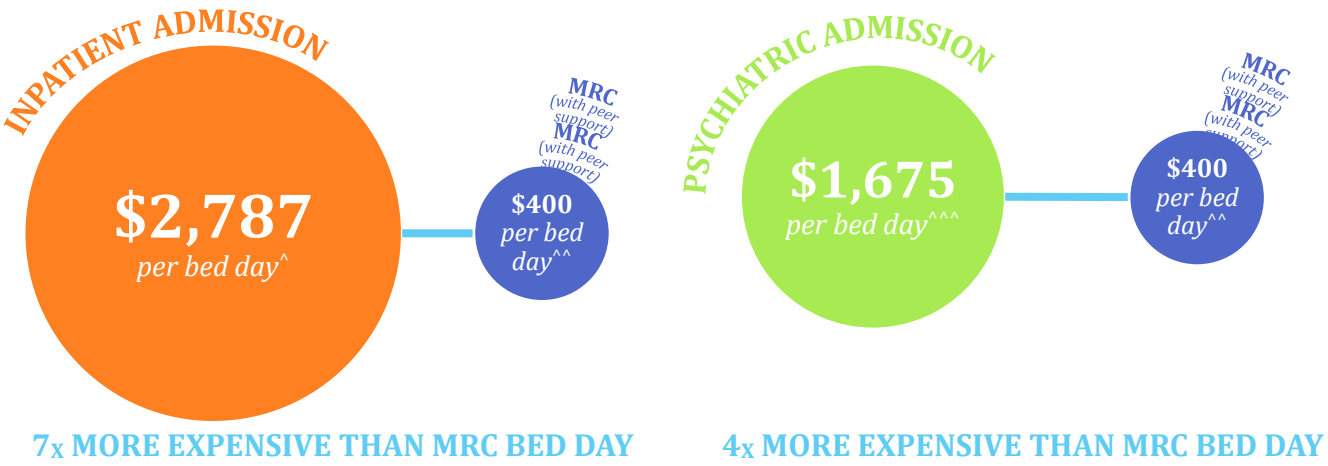

Figure 32: Comparison Costs of MRC Bed Day and Average WA Hospital Bed Day

Notes: ^ Based on average cost of Inpatient admission of $2,787 per day.[25] ^^ Based on 85% MRC capacity with peer support. ^^^ Based on average cost of psychiatric inpatient admission of $1,675 per day.[26]

As shown in Table 31, using the annual operating budget of the MRC ($2.44mil), the cost per bed day for 85% and 100% MRC bed occupancy has been calculated, both with and without the peer support role (which is currently funded external to the MRC operating budget).

Table 31: Comparative Cost Per Bed Day Based on Differing MRC Capacity and Support Models

	Cost Per Bed Day	Cost for 14 Bed Days
MRC at Full Capacity		
100% Bed Capacity	$323.24	$4,525.36
100% Bed Capacity w Peer Support	$339.68	$4,755.52
MRC at Minimum Capacity		
85% Bed Capacity	$380.29	$5,324.06
85% Bed Capacity w Peer Support	$399.63	$5,594.82
Hospital Costs		
Inpatient Admission[25]	$2,787	$39,018
Psychiatric Admission[26]	$1,675	$23,450

7x more expensive than MRC bed
4x with peer support *(85% capacity)*

7.3.2 Has the MRC Facilitated Earlier Hospital Discharge/Prevented Longer Admission?

In this Year 1 evaluation, we have only been able to investigate this empirically for the cohort of MRC residents who had MRC admissions >14 days (n=81); this was chosen because the initial MRC KPI was for an average length of stay, but it became evident early on, that many of the patients staying longer than 14 days at the MRC were doing so because of medical reasons and health complexity. More specifically, as discussed in Section 4.2.3.1, for all patients with an MRC admission of >14 days, clinical staff at the MRC documented whether the admission was associated with either:

- An earlier hospital discharge (i.e. patient would have had to remain in hospital longer if the MRC had not been an option);
- Medical care in a lower cost/day setting that would otherwise have required a longer acute hospital admission (such as daily IV antibiotics or surgical recovery);
- Monitoring of health issues at the MRC that prevented ED presentation or recurrent inpatient admission.

The Clinical Lead of the RPH Homeless Team also assisted the evaluation team to identify MRC residents with >14 day admissions who would otherwise have had longer hospital admissions:

A female patient who has experienced long term homelessness had escalating ED presentations and inpatient admissions associated with a spinal abscess and chronic leg ulcers. She had a serious infection, her spinal cord was damaged, and she was in a wheelchair awaiting an NDIS package. Without the MRC this patient would definitely have had to stay in hospital the entire period while awaiting the NDIS package - **Dr Amanda Stafford, Clinical Lead, RPH Homeless Team**

In the example provided above, the patient had a 105 day admission at the MRC which would have equated to a cost of $292,635, in comparison to MRC's estimated $41,961 (14% of the cost). Box 18 provides an example of an individual who had two MRC admissions, both enabling him to be discharged from hospital to an environment where he could receive medical care and other supports to stabilise his health.

Box 18: Case Study - The Role of the MRC in Reducing Hospital Use

Background: "Justin" is a male in his mid-forties who has been homeless for more than four years and has a two-decade history of alcohol dependence. This has contributed to his increasing trajectory of hospital presentations since 2018, with 24 ED presentations and 79 inpatient days over a four-year period (equiv. cost to health system of >$240,000).^ Whilst expressing motivation to change his alcohol use behaviour for years, he had been unable to do so while rough sleeping, with relapses frequently triggered by relationship breakdowns and lack of social support. Justin struggles to adhere to medication and treatment regimens for his diabetes, liver cirrhosis, Hep C and foot ulcers.

Support Provided by MRC: Justin was discharged from hospital to the MRC in late 2021 for supported respite and daily wound care following an inpatient admission for systemic infection due to chronic foot ulcers associated with his diabetes. In the absence of the MRC, he would have required a longer hospital admission, and if discharged to the street, the risk of re-infection and re-presentation to hospital was considered high.

Along with daily wound care and medical management of his comorbidities, the MRC Team supported Justin to attend outpatient appointments and connected him to the AOD in-reach team.

Once his health was stabilised, Justin was discharged from the MRC to supported accommodation. However his health began to deteriorate, in part due to a relapse of heavy alcohol use. Justin was admitted back to hospital, where he spent time in the intensive care unit. Justin was too unwell to be discharged to his previous accommodation, and so was re-referred to the MRC for step-down medical care, Hep C treatment and AOD support. Again this facilitated earlier hospital discharge, and provided critical medical care, at a lower cost/day than an acute hospital bed.

Current situation: Once medically stable Justin was discharged from the MRC to an AOD residential rehab facility, where he remained for a period of eight months, during which time he did not present to ED and had no hospital admissions. A recent self-discharge and deterioration of his health status led to a hospital admission, however Justin is committed to re-engaging with the rehab facility when his health allows.

^ Note: Based on average ED cost to a WA Public Hospital of $922 per presentation and average cost of Inpatient admission of $2,787 per day.[25]

Of the 81 MRC admissions >14 days duration, it was determined that 79% (n=64) of these admissions would, in the absence of the MRC, have otherwise been associated with a lengthier hospital admission.

For these 64 MRC admissions, the evaluation team then drew on a range of available evidence and data to see where the 'hospital use prevented' could be quantified. This was able to be done for 42 MRC admissions (i.e., 66% of those assessed as constituting a substitute for hospital use or having prevented a lengthier hospital admission). The following estimates of reduced or prevented hospital use are thus conservative, as are based only on those admissions for which there as sufficient data.

From available evidence, we estimate that at a minimum, the MRC facilitated the following number of earlier hospital discharges or substituted for lengthy hospital admissions:

- 12 MRC admissions were for patients who otherwise would have had to **remain in hospital for the entire (or the majority) of days spent at the MRC** (e.g., had medical needs that had to be attended to, such as daily wound care, end of life care, post-amputation care and management of other chronic conditions that would have not been possible without accommodation); and

- 4 MRC admissions which **enabled earlier discharge** from hospital admission (e.g., accidents and injuries that would have required admissions without MRC or psychiatric admissions that would have continued without a discharge location).

Additionally, the MRC also acted as an exit point for the recurrent, revolving door of hospital use and homeless in the following instances (limited to admissions with available data):

- 6 MRC admissions **prevented at least 1 recurrent hospital admission** (based on prior patient patterns of inpatient days admitted in the 6 months prior to MRC admission); and
- 20 MRC admissions **prevented at least 1 ED presentation** (based on prior patterns of ED presentations in the 6 months prior to MRC admission).

The role of the MRC in breaking the cycle of recurrent hospital use is depicted in Figure 33:

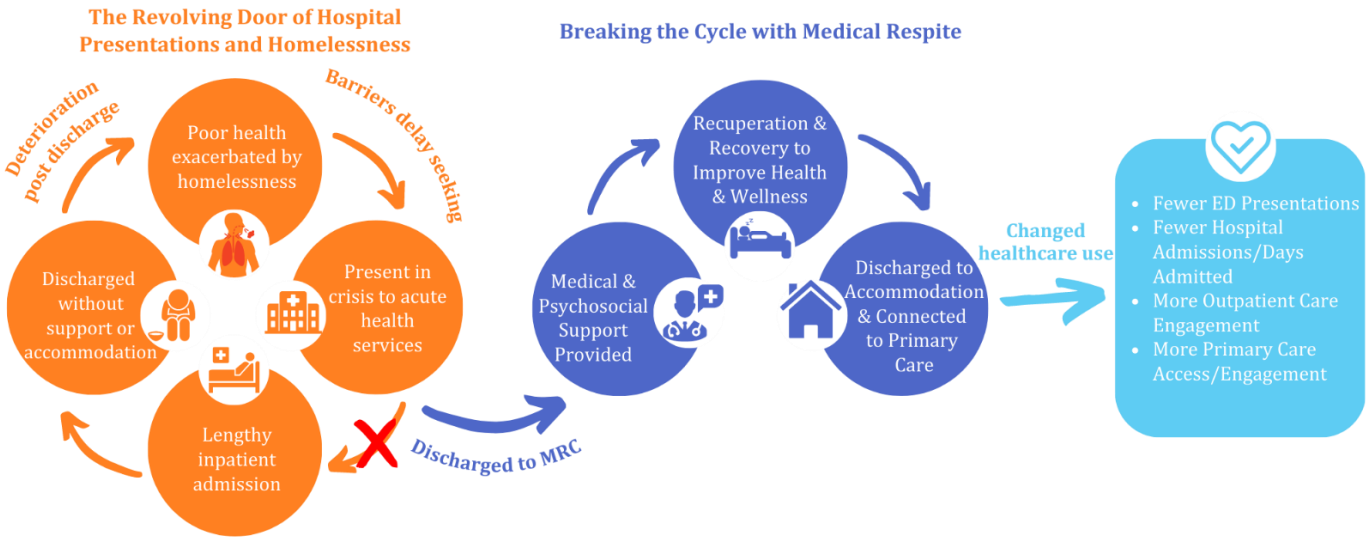

Figure 33: MRC Breaking the Cycle of Homeless Hospital Use

Photo 21: Patient Experiencing Homeless Being Supported by the RPH Homeless Team

7.3.3 Health System Cost Implications of Avoided Hospital Use

As shown in the recent report of the WA Office of the Auditor General (OAG)[74] on long-stay patients in public hospitals, a significant number of WA hospital beds are occupied by people who would not need to be in an acute hospital bed if a lower cost/day option was available, or if patients were able to be safely discharged to the community. The OAG report[74] puts a cost value on this, noting that there is in effect a daily cost to the health system of a long stay patient remaining in hospital when they are medically ready for discharge. The OAG report also notes that there are bed blocking consequences and reduced availability of beds for other patients, where these un-necessary long stays occur.

Conversely, the MRC in its first year has demonstrated that is has contributed both to more rapid hospital discharges, and provided a lower cost setting for medical care. In Figure 34, we summarise visually the number of hospital inpatient days and ED presentations avoided among residents with MRC admissions >14 days.

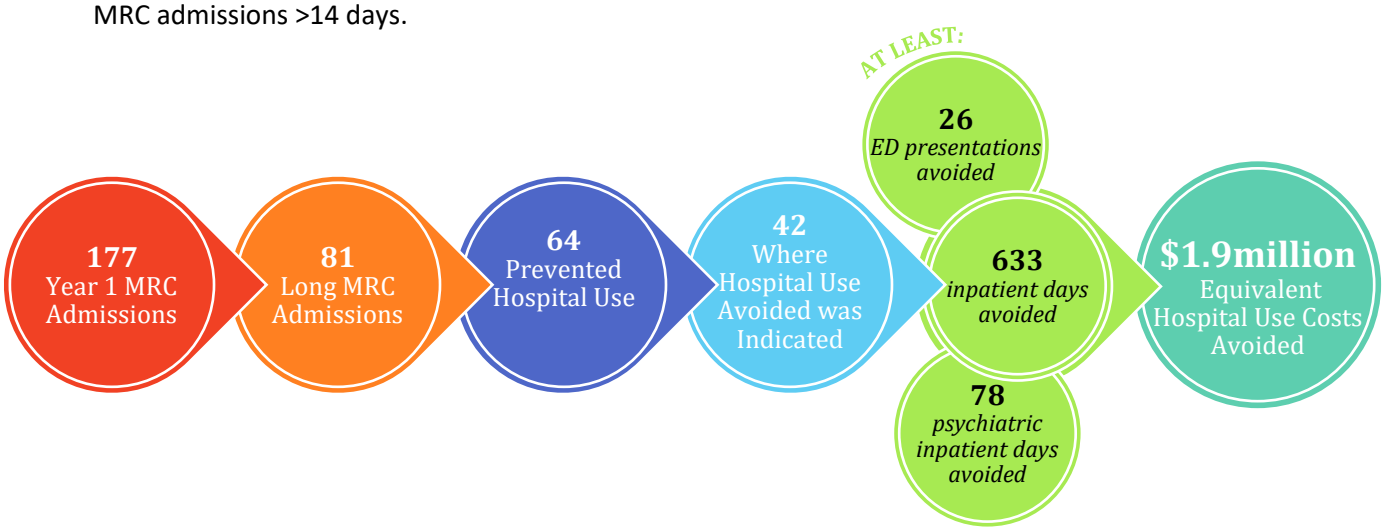

Figure 34: Estimated Hospital Utilisation Prevented by the MRC in Year 1

Note: Costs based on average ED cost to a WA Public Hospital of $922 per presentation and average cost of Inpatient admission of $2,787 per day[25] and average cost of psychiatric inpatient admission of $1,675 per day.[26] Please note, this estimate is very conservative and is only based on 24% of year 1 admissions in which we had data available.

Note, this $1.9 million is an extremely conservative estimate of avoided hospital utilisation relating to only 42 (of 177; 24%) MRC admissions in the first year of operation. If you consider that the total operational budget for the two-year MRC Pilot was approximately $4.72 million, the potential of avoided hospital use is astronomical if **24% of admissions in year-one alone were equivalent to a minimum of $1.9 million avoided** (i.e., in effect 78% of the Year 1 MRC budget)**.**

7.3.4 Hospital Staff Feedback on the Impact of the MRC on the Health System

Whilst the preceding two sections have focused on the quantitative outcome data relating to the role of the MRC in reducing hospital use, we report here on hospital staff feedback from the stakeholder survey about the potential benefits of the MRC in terms of hospital use and the health system. Survey respondents working in hospital settings were asked about their agreement or disagreement with eight statements about possible benefits of the MRC to hospitals or health system. The majority of survey responders agreed that the MRC improved discharge planning (82%), helped to reduce the number of homeless patients being discharged back to homelessness (80%) and reduced the length of inpatient stays (80%, Figure 35).

There was only one statement relating to the MRC reducing ED presentations that less than half of respondents (44%) agreed was a benefit.

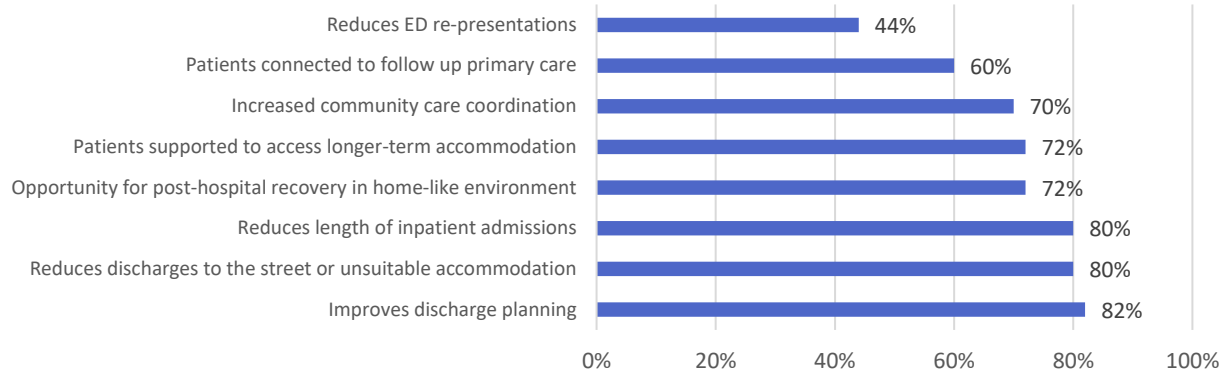

Figure 35: Hospital Stakeholder Perceived Benefits of MRC

Some of the key open-ended response themes that arose from the Stakeholder Survey in the survey are provided in Table 32.

Table 32: Stakeholder Feedback on the Impact of the MRC on Hospital Use

Theme	Quote / Example
Reducing hospital discharge back to homelessness	*This service has been very beneficial in helping discharge patients from the hospital to ongoing health & accommodation support.* – **Stakeholder Survey**
Post hospital care enabling an earlier discharge	*We liaised with Homeless Healthcare to discharge a patient to the Medical Respite Centre so that he could continue to receive medical support after leaving hospital. This in turn promotes better health outcomes for the patient plus access to community services and support.* **- Social Worker, Tertiary Hospital** *I am so supportive of the MRC in its entirety - I think it is absolutely fantastic and the impact this program is having on the homelessness space is invaluable. It is such a wonderful resource for discharge planning and ensuring people can leave hospital ASAP whilst also ensuring they get the ongoing care, treatment and supports they need.* – **Stakeholder Survey**
Reducing repeat ED presentations	*Fantastic program that has been very useful for homeless patients presenting to ED and reducing unnecessary admission times for vulnerable patients*. –**Stakeholder Survey**
Reducing Unnecessary Admissions	*Sometimes in ED we admit homeless patients to a ward because discharging them to the street would compromise their health outcomes, for example if medications get stolen or they are vulnerable to assault due to mobility issues. The MRC has provided a way to reduce some of these admissions*. - **RPH Staff Member** See Box 19 for another example of avoidable hospitalisations.
Freeing up acute beds	*Well [the MRC] frees up the beds, that's for sure. Yeah, like a lot of the people when you look at doing their case management you see that they're just continuously moving through the hospital system… like one person can just keep going through and through. So even just knocking the few on the head is beneficial.* **– MRC Key Worker**

Box 19: Stakeholder Vignette – Safe Discharge Location

I referred a 20yo Aboriginal patient who was experiencing chronic homelessness to the MRC – he had an abscess drained under care of the surgical team. Typically, this procedure is discharge same day or maximum 1 night LOS. This patient had to stay in hospital until a suitable discharge plan could be ascertained due to needing daily wound dressings.

Without a suitable address, he was not eligible for community supports. If the wound was not tended to appropriately, the risk of him representing with infection was astronomically high. The MRC became a very helpful avenue of discharge planning and was the perfect plan to ensure his needs could be met. He ended up finding local accommodation.

In instances like this, the MRC is the absolute perfect solution to ensure people's healthcare needs can be met and avoidable hospitalisations are prevented.

Note: Vignette taken from Stakeholder Survey and thus has been written from the perspective of the referrer

8 Conclusions, Learnings, and Recommendations

This final chapter summarises overall key findings from the first year of the Perth MRC Pilot program, discusses some of the key challenges and learnings that have been identified, and provides recommendations for both the second year of the MRC Pilot and the continuation the MRC beyond the end of the two-year pilot.

8.1 Key Findings

Overall, this independent evaluation for Year One of the MRC indicates that the combination of medical and psychosocial support provided in a trauma-informed MRC setting has to date achieved its two overarching aims, which were to:

1. **Improve physical and mental health outcomes for people experiencing homelessness; and**
2. **Improve social outcomes by facilitating the transition out of homelessness.**

Evidence to support that the MRC has made substantial progress against these aims has been presented in detail throughout this report, and key measures of this are summarised below.

8.1.1 Who has Been Supported by the MRC?

In its first year of operation the MRC:

- 280 referrals were received, 86% from hospitals, 8% from community organisations and 6% from another HHC site;
- There has been a steady increase in the number of inquiries and referrals as awareness of the MRC has grown, with a waitlist put in place in November 2022;
- 152 people were admitted, with a total of 177 admissions to the MRC; and
- One third of residents identified as Aboriginal and/or Torres Strait Islander, and 72% as male.

The MRC demonstrated reach to its intended target group:

- All residents were experiencing homelessness, or at high risk of returning to homelessness. More than half (54%) had been homeless for more than a year prior to MRC admission, and over a quarter (27%) for more than four years.
- Hospital use prior to MRC admission was collectively high, with ED presentations, ambulance arrivals and inpatient days equating to an estimated cost of more than $17 million.
- Hospital use among this cohort had escalated in the three years leading up to MRC admissions, doubling between the two and one year periods prior to admission.
- Multiple health issues and co-morbidity were common, with three out of five residents having 5+ co-occurring health conditions. Almost half (46%) had dual mental health and AOD conditions.
- All residents had experienced some form of trauma during their lives, including experiences of childhood adversity, family and domestic violence, poverty, emotional or sexual abuse, contact with the justice or child protection systems and/or relationship breakdown.

8.1.2 Progress Against Key MRC Aims

The MRC has two overarching aims, and in its first year of operation demonstrated significant activity and outcomes associated with both these aims. Key outcomes reflecting attainment of Aim 1 are shown in Table 33.

Table 33: Progress Against Aim 1: Improving Physical and Mental Health Outcomes

Key Metric	Key Year 1 Outcomes
Reducing hospital utilisation	For the cohort of residents (n=152) with at least one month of follow up hospital data following their **date** of first MRC admission: • 46% reduction in the number of ED presentations • 64% reduction in number of inpatient admissions • 44% reduction in inpatient days • 27% reduction in the number of individuals with a least one re-presentation to ED within 7 days of their previous presentation, and a 32% reduction in the proportion of 7-day ED re-presentations that led to inpatient admissions • Total estimated associated hospital cost reduction of over $2.31 million, or over $15,216 per person, over the 1-month period post MRC admission date Additionally, other ways in which MRC has contributed to reduced hospital use overall, as presented in case studies, quotes and other quantitative data from the Year 1 evaluation shows that the following were all seen by majority of referring hospitals/organisations as key benefits of the MRC: • Reducing length of stay/ facilitating more rapid hospital discharge • preventing unnecessary admissions • reducing hospital re-presentations
Improving physical and mental health and wellbeing	• Health assessments and primary care support provided for all 152 residents • 1 in 6 had a new GP care plan (chronic disease or mental health) put in place • Two-thirds of the Year 1 residents have continued to see HHC in the community since MRC discharge, and others have been connected to GPs near to where they are living • More than one quarter of residents were connected or referred to an AOD or mental health or other community • Self-reported improvements in physical and mental health were recorded for the vast majority of residents who completed patient reported experience questions (at admission and at discharge)

Key outcomes reflecting attainment Aim 2 are shown in Table 34:

Table 34: Progress Against Aim 2: Improving Social Outcomes by Facilitating Transition Out of Homelessness

Key Metric	Key Year 1 Outcomes
Identify psychosocial and wellbeing needs and link residents to community and support services	• Intake assessments for all residents included the identification of housing, social, legal, financial or other issues, and goals and support needs relating to these • 78% of residents were referred or connected by MRC staff to one or more services, most commonly government services, housing and homelessness services and AOD services • 84% of residents had some form of engagement with or support received from key workers and/or peer workers while at the MRC
Facilitate MRC residents to access suitable housing and/ or long-term accommodation and associated support.	• One quarter of MRC residents were discharged directly to some form of housing, accommodation or residential treatment setting. A further 15% were stepped down to StayWitch's beds awaiting accommodation availability. • 41% of people not on the priority public housing waitlist were supported onto it • Support provided to people choosing to get into a private rental (such as applying for bond assistance, rental applications) • One third supported to access ID or other documents impacting on housing access

As the data and findings presented in this evaluation report relate to the Year 1 evaluation, and the period of follow up data was limited, it is pertinent to note that many of the outcomes presented in Table 33 and Table 34 will have additional metrics and longer term follow up measures in the Year 2 evaluation report.

8.1.3 Who has Benefited from the MRC?

The growing body of literature supporting medical respite care for people experiencing homelessness, recognises a number of beneficiary groups, and this Year 1 evaluation of the Perth MRC has shown as demonstrated in Figure 36 that benefits have accrued to:

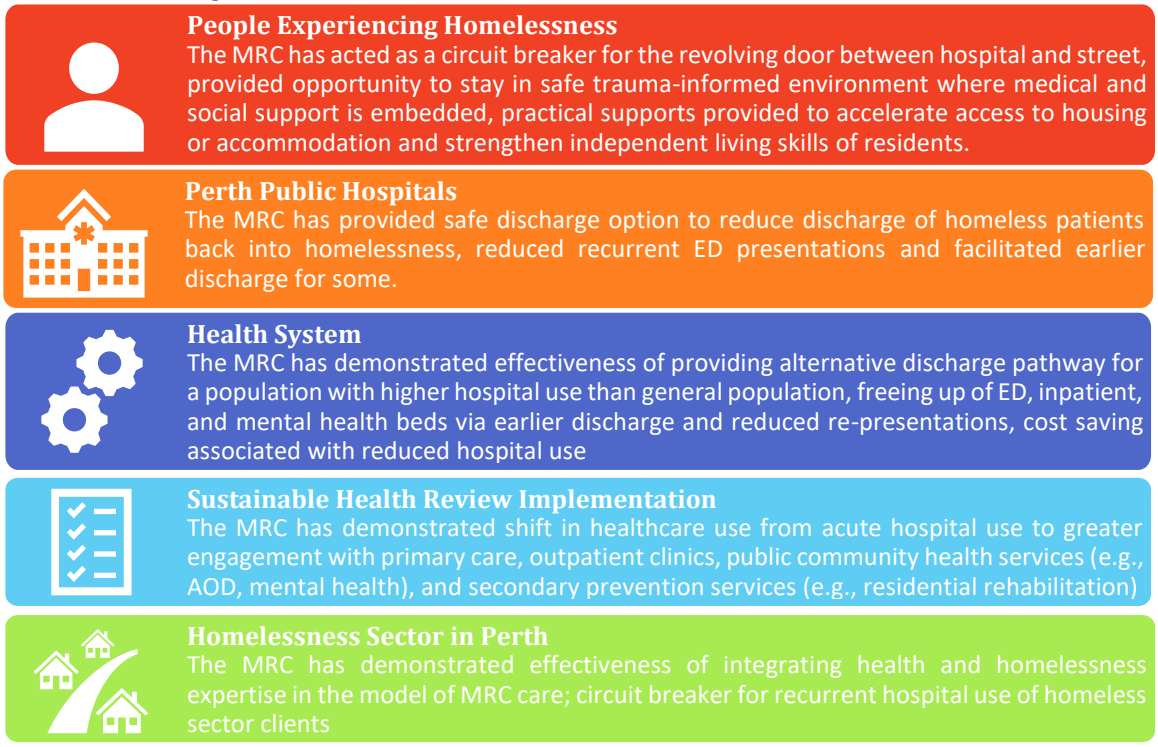

Figure 36: Summary of Year 1 MRC Benefits

8.1.4 How is the MRC 'measuring up' Against International Best Practice?

This MRC is the first medical respite service of its kind in Australia, with the only other Australian examples much smaller in bed capacity and not having onsite medical staff, limiting acuity of patients who can be admitted.[3, 15, 16] In fact, the respite facilities affiliated with St Vincent's Health Australia (in Melbourne and Sydney) have been strong proponents of the need for fully medical respite care options for hospital patients experiencing homelessness, and their feedback has helped inform the MRC model developed and now being implemented by the collaboration between HHC and Uniting WA.

There is **thus no Australian benchmark against which to compare the progress and effectiveness to date of the Perth MRC**. Nonetheless, given the importance of evidence-based healthcare espoused in the SHR, we feel it is important for this independent evaluation to monitor how the MRC fares in relation to key relevant guidance's and evidence from elsewhere. In this Year 1 evaluation, we are of the view that, the core tenets, model of care and operational service delivery of the MRC to date, align well to the eight **Standards for Homeless Medical Respite Care Programs** put out by the National Institute for Medical Respite Care in the US in late 2021 (Figure 37).[32] This alignment will be assessed in greater detail in the Year 2 evaluation.

Standards for Medical Respite Care Programs

- ✓ provide safe and quality accommodation
- ✓ provide quality environmental services (i.e. ensuring that there is a high standard of infection control, risk management and hygiene)
- ✓ manage timely and safe care transitions to medical respite from acute care, specialty care, and community settings
- ✓ administer high quality post-acute clinical care
- ✓ assist in health care coordination, provide wrap-around services, and facilitate access to comprehensive supports
- ✓ facilitate safe and appropriate care transitions out of medical respite care
- ✓ personnel are equipped to address the needs of people experiencing homelessness are driven by quality improvement

Figure 37: NIMRC Standards for Medical Care Programs

The Perth MRC has additionally in its first year demonstrated substantial reductions in hospital use among the cohort of people supported, of a magnitude that is impressive in the context of findings from published evaluations of more established respite services elsewhere. For example:

- An evaluation of a medical respite centre in the US (Illinois) observed a 49% reduction in inpatient admissions, a 58% reduction in the number of inpatient days, but no significant differences in ED presentations[10]
- Another evaluation of a medical respite centre in the US (North Carolina) similarly observed a 37% reduction in inpatient admissions, 70% fewer inpatient days, but no significant changes to ED presentations[5]
- An evaluation of a small respite centre affiliated with St Vincent's hospital in Melbourne reported an 18% reduction in the proportion of clients having inpatient admissions and a 7% reduction in unplanned inpatient admission days, but observed a 17% increase in ED presentations in the 12-months following respite support[3]
- A cost-utility analysis of a medical respite centre in Denmark observed an average three-month cost-reduction of €4,761 (~$7,400AUD) in hospital use amongst respite residents compared to an intervention group with no respite care[4]

8.1.5 How is the MRC 'measuring up' Against the WA Sustainable Health Review?

The MRC was established as a recommendation of the SHR (Strategy 4, Recommendation 13), which recognised the importance of improving pathways and models of care for *"groups of people with complex conditions who are frequent presenters to hospital".*[17] The SHR also notes that there are 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.[17] This is particularly salient for homeless populations, with numerous studies documenting the reliance on EDs for healthcare and barrier to GP and preventive health access.[75]

More specifically in relation to people experiencing homelessness, the SHR refers to:[17 p17]

- The disproportionately high rate of chronic health conditions, which can often go undiagnosed or untreated for long periods of time; and
- The consequential reliance on acute health services.

This aptly describes some of the key characteristics of the people referred to and supported at the MRC in its first year of operation, indicating that it is hitting the mark in terms of engaging with people experiencing homelessness who have high rates of undiagnosed or untreated chronic health conditions and frequent reliance on acute health services.

The MRC service itself, and the increased engagement by many of the Year 1 MRC cohort in primary care since their MRC admission, aligns well to SHR calls encouraging people to access lower-cost healthcare options beyond the ED, as this frees up available resources (staff and beds) to meet the needs of other patients. The contributions of the MRC in this regard are positive, given the continuing pressures on the WA hospital system, particularly EDs, ambulance services and mental health beds.

8.2 Key Learnings and Challenges

In addition to the MRC evaluation objectives relating to the service delivery outcomes of the MRC, as a pilot program, the evaluation framework also encompassed:

- Assessing the collaboration and care pathways between hospitals and the MRC; and
- Documenting the implementation of the model of care, adaptations over time, and key learnings

An action research approach was incorporated into the evaluation framework and methodology, ensuring that evaluation team observations and learnings identified during the course of Year 1, were

relayed to MRC and HHC management in a timely manner. This led emergent learnings being relayed and addressed well before the conclusion of Year 1 of the pilot. The MRC team itself has exhibited a strong commitment to action learning and quality improvement, and has made adjustments to the model of care and operational service delivery during Year 1, in consultation as required with the EMHS post commissioning steering group. We have touched upon many of the iterative learnings and adaptions made in the body of this report, but provide a concluding summary here.

Overall, learnings from Year 1 of the MRC pilot that have been identified and addressed over the last year can be grouped into four key themes, encompassing learnings relating to:

- **Day to day operations, policies and service delivery.** As a new and unique service with no equivalent medical respite precedent in Australia, many operational policies, protocols, job role descriptions and referral processes had to be designed by the MRC team prior to service commencement on the 25th of October 2021, and as would be expected for any pilot service, there have been adaptions and quality improvements made along the way;
- **Adjustments to the model of care or operations responsive to the needs of people referred to the MRC.** This has included modifications made to staffing, room configurations, security, availability of therapeutic activities, and the way in which AOD support is provided onsite;
- **Flexibility around length of stay and discharge pathways** due to the Perth shortage of housing and accommodation options and wait times for residential rehabilitation and supported mental health accommodation; and
- **Data capture and systems** to support streamlined referral and admission processes, care coordination, EMHS reporting and evaluation.

Many of these learnings correspond to challenges that have been encountered in the first year of MRC operation. As with MRC learnings, challenges have been referred to in various places in the body of this report, as this anchors them in context, and where applicable we have provided commentary or case studies to illustrate ways in which the MRC has sought to address or 'work around' some of the challenges experienced. In this concluding chapter, we have synthesised what we assess to be the four main types of challenges encountered by the MRC, and these are depicted in Figure 38.

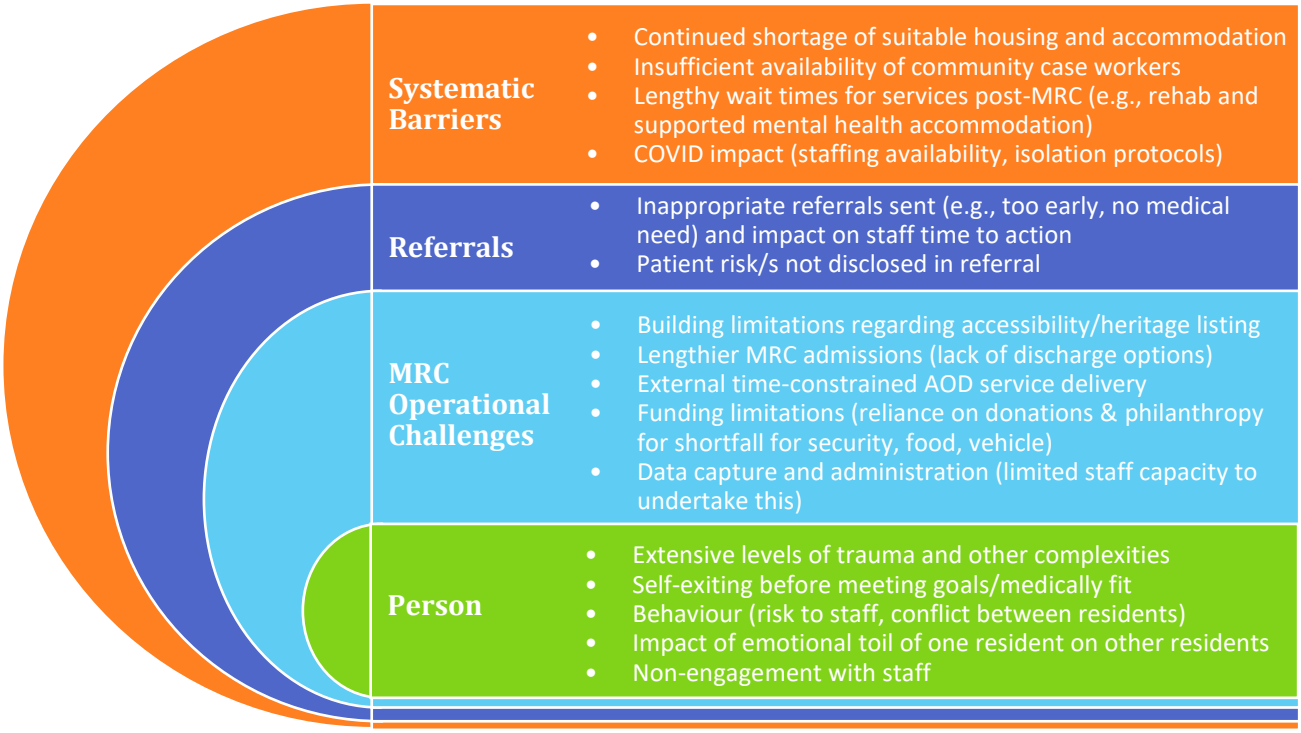

Figure 38: Overview of Year 1 MRC Challenges

Whilst the MRC has made inroads in addressing some of these challenges, many are beyond the realm of immediate MRC influence, particularly where challenges relate to wider systemic barriers and gaps beyond the influence of the MRC (and indeed HHC), or are challenges relating to external organisations (e.g., hospitals and others referring people to the MRC), limitations of the current MRC facility (such as capacity to accept referrals for people with high mobility constraints or people who do not feel safe in mixed gender settings), or the complexity of the population cohort.

Photo 22: MRC Staff

8.3 Future Considerations

The following considerations and suggestions have been triangulated from interviews with staff, stakeholders, and residents, responses from the Stakeholder Survey, observational data from the research team during site visits, overall sector knowledge, and draw on learnings from national and international respite models.

The suggestions for consideration are grouped into two areas:

- Specific suggestions to consider for the second year of the MRC Pilot; and
- Considerations for the MRC model of care and funding beyond Year 2.

8.3.1 Specific Suggestions for Year 2 of the MRC Pilot Service

The following suggestions are based on learnings from Year 1 of the MRC pilot, and are put forth for consideration by EMHS and the MRC contracting steering group (as summarised in Table 35).

Table 35: Suggested Considerations for Year 2 of the MRC Pilot

Suggestion	Rationale
Revise KPI (KPI 9) for average LOS at MRC to be up to 3 weeks.	14 days is much shorter than the average respite care LOS reported across 105 respite care facilities in the US, of which only 13% had a LOS 14 days or shorter.[36] This average LOS has proven unrealistic for the MRC (average 18 days Year 1) due to the complexity of medical and other needs, and in light of the shortage of step-down or supported mental health accommodation and residential rehab places.
Incorporate into MRC quarterly reporting to EMHS, the utilisation and added benefits of StayWitch's beds as a step-down option for some residents.	As shown in this Year 1 evaluation, many MRC residents reach the point of being able to be medically cleared for discharge, but there are no suitable accommodation options, and discharging those residents back to homelessness would not only go against the ethos of the MRC, but also substantially undoes the improvements in health achieved during their MRC admission. The MRC has been fortunate to have philanthropic funding that has enabled them to keep open some additional non-medical beds within the same facility (known as StayWitch's). During Year 1, 26 (1 in 6) residents were discharged from the MRC to StayWitch's, and were able to stay here for an additional 1- 7 weeks, until suitable housing or accommodation or a residential rehabilitation space or NDIS support became available. Preliminary results suggest that MRC residents who stepped down to the StayWitch's non-medical beds prior to discharge had greater reductions in hospital use. Given the daily 'cost' of these non-medical step-down beds is cheaper than a medical MRC bed, and about 10x cheaper than the cost per day of an inpatient bed day in WA public hospitals, it is clear in our view that this has added value to the MRC model of care and to 'cost savings' to the health system, and we recommend that this be incorporated more explicitly into the MRC reporting to EMHS, and incorporated into the Year 2 evaluation. *… if we didn't have StayWitch's we wouldn't be able to clear MRC beds as it is against our fundamental ethos to discharge people back to the streets… having StayWitch's beds is a substantial supporting factor of the MRC… it supports better health, housing and psychosocial outcomes*. **– Zoe Thebaud, Director of Residential Service, HHC**
Investigate scope for MRC to have an earmarked allocation of prioritised pathways for public housing and supported mental health accommodation	Whilst the MRC team has supported residents to get onto the priority housing list, or onto waitlists for supported mental health accommodation, it is very rare for any accommodation to be available (even transitional) within a 6 week period. As the MRC has a commitment to not discharging people back into homelessness, this places pressure on its LOS KPI **(KPI 9)** and reduces the availability of beds for new referrals (hence there is now a constant waitlist for MRC beds). Given there is a whole of WA government commitment to support Housing First (i.e. house people rapidly, without pre-condition), it is recommended that discussions be held with the Office of Homelessness (Department of Communities) and Mental Health Commission to explore potential for prioritised housing pathways for at least some MRC residents, particularly those with health needs that require urgent housing. This could include more direct and prioritised access for MRC residents to community caseworkers via the Street to Home or HEART programs (existing programs via Department of Communities to support vulnerable rough sleepers to access and maintain housing).
Resource greater administrative capacity and data collection at MRC	The current MRC budget only covers the manager role, clinical health staff, and community service trained key workers. The medical and support needs of residents to date has been even higher than was anticipated when the MRC commenced, and at the same time, there has been a significant upswing in the number of hospital inquiries and referrals, and waitlisting for MRC beds. Some of the most effective respite care services in the US have dedicated personnel to field inquiries, triage and process referrals, manage waitlists, undertake data entry, manage data systems and so on. With the new AOD service onsite, inquiries and referrals have increased and the volume of data entry and management has expanded.

8.3.2 Considerations for the MRC Model of Care and Funding Beyond Year 2

The following are recommendations proposed by the evaluation team to be taken into consideration for the future of the MRC model and service delivery:

- Explore scope for a second affiliated facility that can serve as a **step-down residential service** from the MRC
- Expand capacity to **accept more referrals for people requiring AOD detox** (which is currently contributing to the escalating demand and waitlist)
- Consider a more **fit-for-purpose building** for MRC continuation, including one that can accommodate people with mobility challenges, allow for separate communal areas for men and women, and ideally a closer proximity to RPH (including more fit-for-purpose for detox)
- **Investigate optimal future MRC capacity** to meet hospital demand – the number of inquiries, referrals and waitlist for the continues to grow, but funded capacity is capped at 20 beds. There are mixed views in the literature regarding ideal MRC size, but the general tenure is that the benefits of a home-like environment can be diluted if a respite facility has large bed capacity. Pending Year 2 evaluation outcomes, it may be that two MRCs are required in Perth (this is the approach being considered by St Vincent's Hospital Melbourne to expand respite capacity for people experiencing homelessness)
- **Expand government funding for the core MRC staffing model** to include (see Table 45 Appendix 5 for specific details and costings):
    - Peer support workers (currently funded by one-off Lotterywest grant and philanthropy)
    - Establish a Clinical Care Coordinator role
    - Onsite security (not included in original MRC budget, has had to be funded through HHC cost-cutting elsewhere)
    - Dedicated allocation of funding for professional supervision, trauma training and support, reflective practice
    - Funding for awake-shift night nurse (currently met via HHC cost cutting elsewhere and philanthropy) as essential due to acuity of patients and move to onsite AOD detox.

8.4 Summary

Even in its first year, the MRC has already demonstrated how it addresses a critically important gap in the overall system of service delivery to people experiencing homelessness. Overall, this independent evaluation indicates that the combination of medical and psychosocial support, provided in a trauma-informed MRC setting has met its two aims; to improve physical and mental health, and improve social outcomes for people experiencing homelessness and facilitate their transition out of homelessness.

Congruent with a pivotal rationale for the SHR recommendation for the establishment of the MRC, there is concrete evidence to indicate that in Year 1, the MRC has overall contributed to significant reductions in hospital use, that equate to a freeing up of hospital beds and cost savings that exceeds the operational cost of the MRC service.

The MRC in Year 1 has demonstrated the merits of its unique combination of medical, homeless sector, and peer-led lived experience staff at the MRC, and enabled delivery of cost effective high quality care and residential accommodation in a warm non-clinical trauma sensitive setting. Overall, significant progress has been made with many residents to facilitate transitions out of homelessness, but this has been hampered by the continuing acute shortage in Perth of public housing and other accommodation options for people who are rough sleeping.

Finally, we conclude by noting that perhaps some of the most profound achievements of the MRC in its first year cannot be captured in data, or numbers or reports. As an evaluation team we have watched and seen firsthand how the MRC has played a substantial role in restoring trust in health services and a sense of self-worth and hope among almost 200 people (at the time of concluding this report) who have endured extensive trauma and adversity during and preceding their homelessness. For many, they have left the MRC, not only with improved health and wellbeing, but hope and pathways towards a life beyond homelessness.

> *… I think my confidence comes from the staff… it's kind like of somebody finally cares. Somebody's finally supporting me. Somebody finally cares about me and my situation and I think that brings you back to there are good people in the world. They're not all bad.* – **MRC Resident**

Photo 23: Some of the Many Year 1 MRC Residents Participating in Activities

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Appendix 1: International and Australian Medical Respite

Table 36: Examples of International and Australian Medical Respite Facilities

Medical Respite Centre	Location	Bed Capacity	Average LOS	Additional Support and Resident Criteria
Australian Examples				
The Cottage[3, 19]	Melbourne	6	9 days	-
Sumner House	Melbourne	43	3-6 mo	COVID+ patients from Apr '20 to Jun '21 and Aug to Sept '21 only
Tierney House[16]	Sydney	12	11 days	-
Homelessness Respite Facility[15]	Adelaide	10	14 days	-
International Examples				
Barbara McInnis House	Boston, US	104	1-14 days	Supports veterans, people over 55 years. Provides 24-hour nursing supervision.
Bradford Respite Intermediate Care Support Service	Bradford, England	14	3+ mo	-
Interfaith House	Cook County, Chicago, US	64	42 days	Only available for people with low medical acuity.
Red Cross Care Center for Homeless	Copenhagen, Denmark	8	14 days	-

Appendix 2: Sources of Data Used for MRC Evaluation

Table 37: MRC Resident Details Collected During Intake and Admission

Form	Key Information Collected	

Referral to the MRC (hospitals)	• **Information for Referrers** (overview of the MRC – what is and what is not provided)
	• **Referral process**
	• **Demographics** (incl. healthcare details)
	• **Medical Section** – completed by a member of the medical treating team:
	  ◦ Primary reason for hosp. admission
	  ◦ Medical Reason for MRC admission
	  ◦ MRC anticipated needs
	  ◦ Chronic health issues
	  ◦ Scheduled outpatient appointments
	  ◦ Referrer details and contact
		• **General section** – completed by a member of the social work team:
		  ◦ Referrals made in hosp.
		  ◦ Income status
		  ◦ Risk assessment
		• **Requirements post-successful referral**
		• **Patient consent**

Referral to the MRC (community)	• **Information for Referrers** (overview of the MRC – what is and not provided)
	• **Referral process**
	• **Demographics** (incl. healthcare details)
	• **Medical Section**
	  ◦ Medical Reason for MRC admission
	  ◦ MRC anticipated needs
	  ◦ Chronic health issues
	  ◦ Scheduled upcoming health appointments
	  ◦ Referrer contact details
		• **General section** – completed by a member of the social work team:
		  ◦ Services client has been referred to
		  ◦ Income status
		  ◦ Risk assessment
		• **Requirements post-successful referral**
		• **Patient consent**

MRC intake form	• **Demographics**
	• **General Support Needs**
	• **Upcoming Appointments**
	• **Resident Goals** for the time at the MRC/ StayWitch's
		Need for support in relation to:
		  ◦ Housing/accommodation
		  ◦ Legal
		  ◦ Finances
		  ◦ AOD
		  ◦ Mental Health

Individual care plan	• **Reason for admission** to the MRC • **Observations**/charts • **Chronic health conditions** and related goals • **Mental Health** details and related goals • **AOD details** (incl. smoking cessation) • **Identified risks** (and mitigation strategies)	• Monitoring • **Planned interventions** (tests/surgery preparation, etc.) • **Screening and preventive health** • **Outpatient attendance** • **Discharge planning**
Discharge Plan	• **Demographics** • **Admission and discharge date** • **Discharge destination** • **Medical treatment received** at the MRC	• **Primary GP/Healthcare provider** • **Support received** at the MRC • **Services connected to**/referrals made • **Upcoming appointments**

Resident Feedback Form	• **Experiences of care received in relation to:**
	  ◦ dignity and respect
	  ◦ safety and security
	  ◦ required care and support provided
	  ◦ staff explanation
	  ◦ staff listening
		• **Self-rated:**
		  ◦ Overall health
		  ◦ Mental health
		  ◦ Achievement of goals
		• **Gaps in support**
		• **Improvements for future**

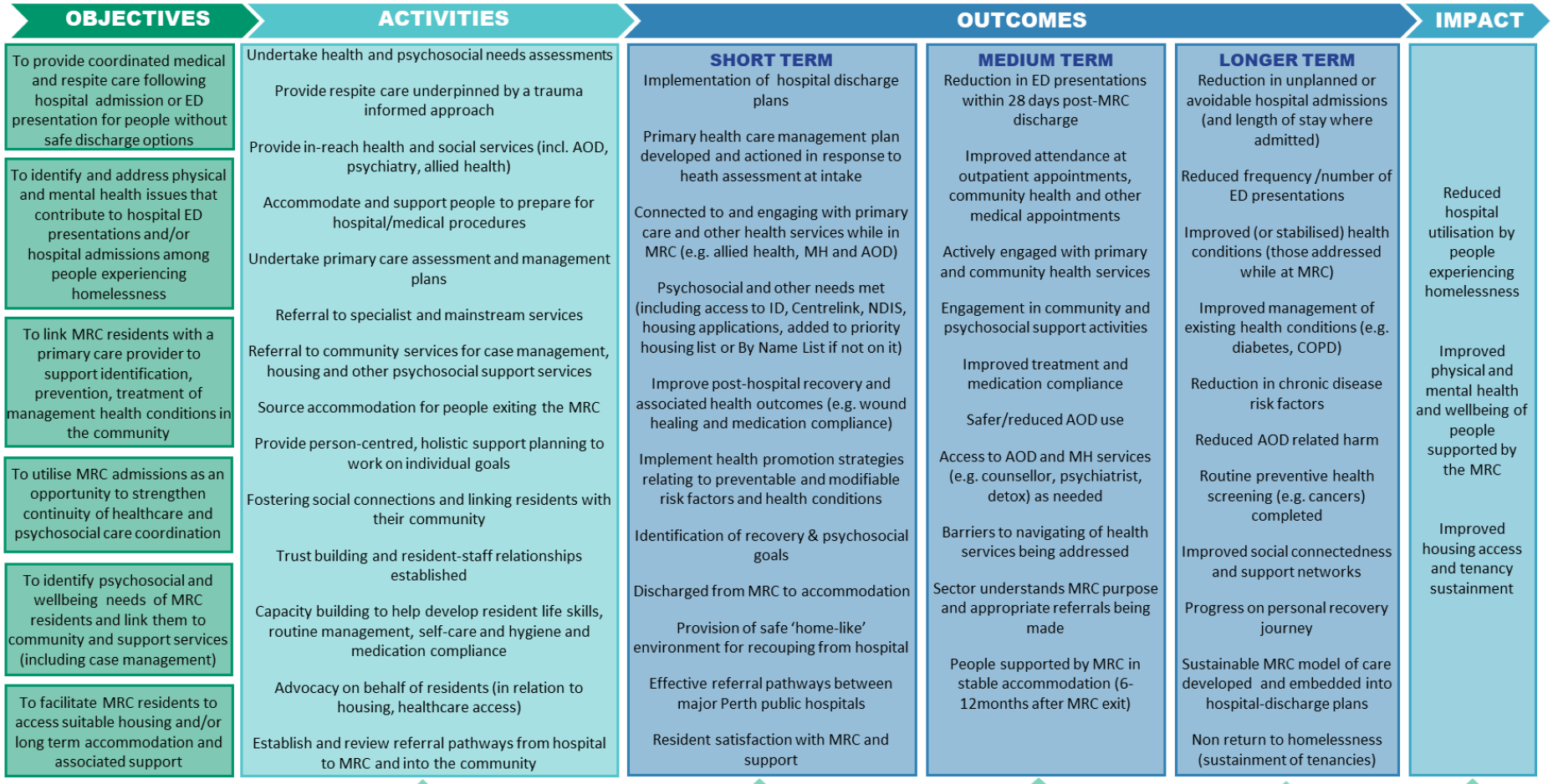
Table 38: Evaluation Objectives, Key Performance Indicators (KPIs), and Targets

Research Objective	Associated KPIs	Target	Did the MRC Meet the Target in Year 1?	Chapter
Measure the impact of the MRC on health service use	**KPI 12:** Unplanned presentation to the ED and/or hospital readmissions of former residents within 28 days of discharge from the MRC.	Number of unplanned representations to ED and/or readmissions	53 people with 151 presentations *(54 resulted in readmission)*	7.2.1.2 & Appendix 5
Assess the impact of the MRC on health and wellbeing of people supported by the MRC	**KPI 1:** Percentage of comprehensive health assessments commenced within 24 hours of residents arrival, encompassing physical, mental, psychosocial and AOD issues.	100% of residents with health assessment commenced within 24 hours	✓ **100%**	6.1.1.3
	KPI 8: Percentage and number of residents with Medicare number on discharge.	Percentage and number based on total admissions to the MRC	**99%**	0
	KPI 11: Percentage of residents with medical discharge plans/summary completed.	100% of residents	✓ **100%**	6.1.1.3
	KPI 13: Percentage of residents reporting improved physical and mental health at discharge from the MRC.	Percentage reported via exit survey (Patient Reported Outcome Measure)	**67% physical health** **62% mental health**	6.1.3.1
Assess psychosocial factors that impact on health and homelessness	**KPI 5:** Percentage of residents engaging with one or more external/in-reach community and/or social support providers during their stay at the MRC as a client of those services.	100% of residents	**78% external** **>84% inreach**	6.2
	KPI 14: Percentage and number of residents with access to Centrelink or other benefits progressed on discharge from the MRC.	Percentage and number based on total admissions to the MRC	**97%**	0
Measure the impact of the MRC on facilitating a pathway out of homelessness	**KPI 6:** Percentage of residents with a person-centred plan relating to options for stable accommodation, as part of their discharge plan.	100% of residents	**99%**	6.2.3.3
	KPI 7: Percentage and number of residents discharged into a) immediate short-term accommodation, b) transitional accommodation or c) longer-term accommodation on discharge from the MRC.	Percentage and number based on total discharges from the MRC	30% short term or transitional 13% long term	0
Assess the collaboration and care pathways between hospitals and the MRC	**KPI 2:** Acceptance or decline of a patient referral for the MRC within 4 business hours of the referral being received.	90% within 4 hours* of MRC receipt of referral	✓ **100%**	4.1.1.1
	KPI 3: Readiness to admit patients to the MRC within 24 hours following acceptance of the referral, where suitable bed is available.	90% within 24 hours of referral acceptance	✓ **99%**	4.1.1.1
Document the implementation of the MRC model of care, adaptations made to this model over time and the impact on patient satisfaction	**KPI 4:** Availability of 20 beds in the MRC at all times.	100%. Within 1 business day of failure to be rectified	✓ **100%**	4.2.2
	KPI 9: Average length of stay at the MRC.	14 days.	**Average = 20 days** Median = 14 days	4.2.3
	KPI 10: Bed utilisation.	Equal to or greater than 85%	**Max 74%**	4.2.2
	KPI 16a: Number of complaints received. **KPI 16b:** number of compliments received.	Number of complaints received Number of compliments received	6 Compliment 1 Complaints	Not reported

Table 39: Data Available by Hospital Site

Hospital	Acronym	ED	Inpatient	Outpatient
Armadale-Kelmscott Health Service	AKHS	✓	✓	✓
Bentley Health Service	BHS	-	✓	✓
Fiona Stanley Hospital	FSH	✓	✓	✓
Fremantle Hospital Health Service	FHHS	-	✓	✓
Graylands Hospital	GH	-	✓	-
Kalamunda Health Service	KHS	-	-	✓
King Edward Memorial Hospital	KEMH	✓	✓	✓
Osborne Park Hospital	OPH	-	✓	✓
Rockingham-Kwinana Health Service	RKHS	✓	✓	✓
Royal Perth Hospital	RPH	✓	✓	✓
Sir Charles Gairdner Hospital	SCGH	✓	✓	✓

Appendix 3: MRC Program Logic



Appendix 4: EMHS MRC Flyer

Government of Western Australia
East Metropolitan Health Service

Medical Respite Centre

For patients experiencing homelessness

Are you caring for a patient experiencing homelessness:

- who would benefit from a period of post-acute care and recovery (up to 14 days) following a hospital presentation or admission?
- who is considered high-risk of representation if discharged without adequate support?
- who would benefit from advocacy and links with community and social supports that may lead to pathways out of homelessness?

East Metropolitan Health Service is working in partnership with a Consortium to pilot the 20-bed Medical Respite Centre (MRC):

- led by Homeless Healthcare, in conjunction with Uniting WA, who each have extensive experience in:
  - providing consumer centred, trauma-informed and culturally appropriate medical and psychosocial support through a range of innovative homelessness services
- the 7 days a week medical respite service is:
  - staffed by nurses, GP in-reach and key case workers providing short-term intensive support
  - with in-reach from the Royal Perth Bentley Group Consultation Liaison & Alcohol and Other Drug Service.

MRC objectives:

1. To support the individual to receive post-acute care during their recovery from illness or injury in a safe environment.
2. To link the person with community and social supports and where possible, discharge to stable accommodation.

The MRC operates from a beautifully restored federation-style building in Perth.

Referrers please contact the MRC on 6424 9730 to speak to a HCC staff member to discuss eligibility criteria and bed availability before completing the MRC Referral Form.

For more information, including the MRC Intake Criteria and Referral Form, visit the EMHS, Armadale Kalamunda Group or Royal Perth Bentley Group Medical Respite Centre Hub page.

HOMELESS HEALTHCARE

Appendix 5: Supplementary Data Tables and Figures

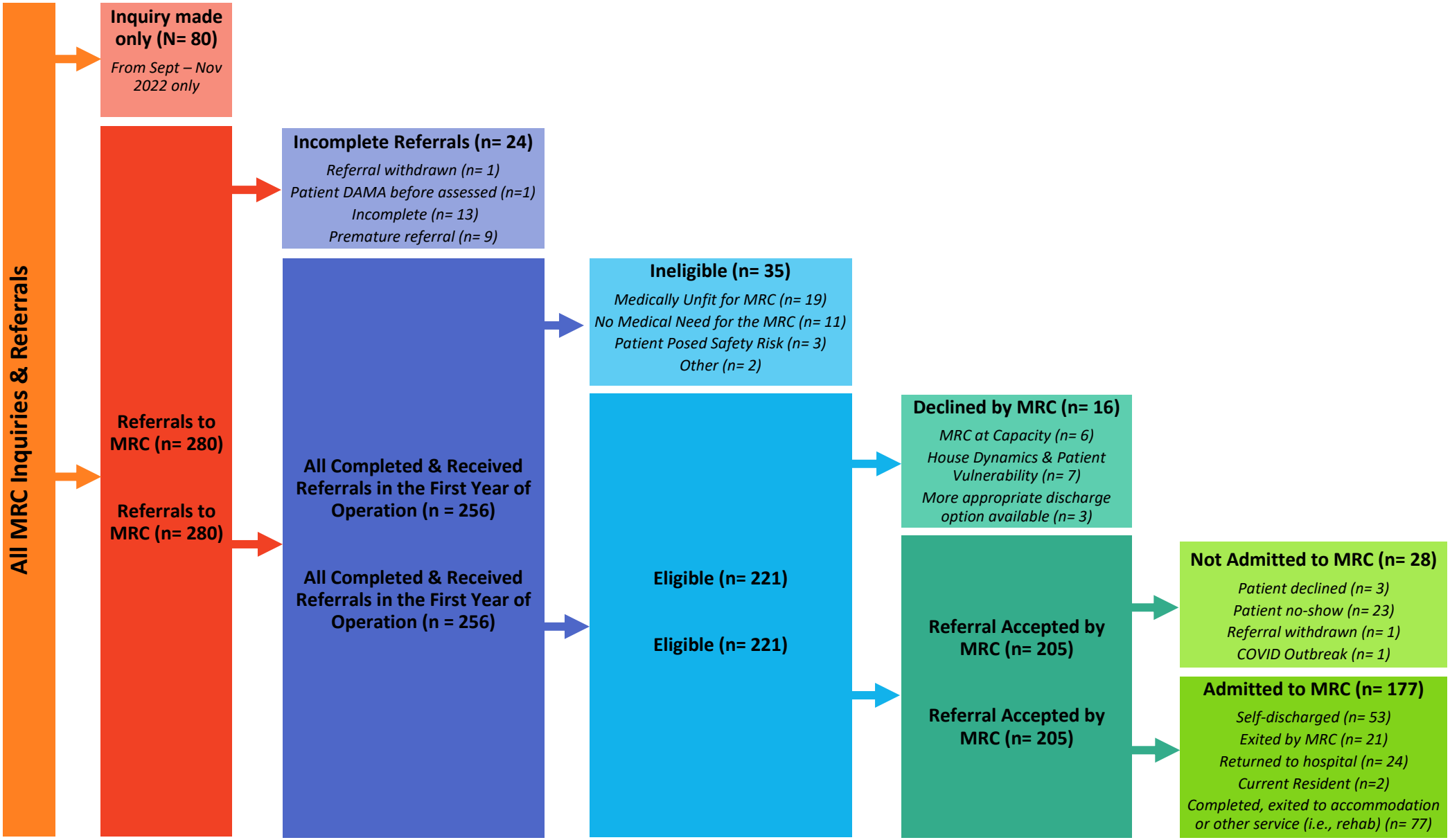


Figure 39: MRC Inquiries and Referrals Received by Eligibility, Acceptance and Admission Status

Table 40: Examples of Organisations MRC Residents were Referred To

Type of Organisation	Example/s	
Health/Allied Health Services	• Dental Services (Australian Dental Health Foundation; Healing Smiles; TIMA Perth) • Derbarl Yerrigan Health Service • Hearing Australia	• Hospitals (incl. outpatient appointments) • SpecSavers • WA Aids Council
Mental Health Services	• Alma Street • City East Mental Health • Community Mental Health Services (incl. MCOT) • Consultation-Liaison AOD In-Reach Service	• MindSpot • Mental Illness Fellowship of WA (MIFWA) • Partners in Recovery • Richmond Wellbeing
Rehabilitation and AOD Services	• AOD Counselling • Bridge House • Cyrenian House • Drug and Alcohol Youth Services • Harry Hunters	• Next Step Drug and Alcohol Services • Palmerston • Solid Ground (Wungening) • Teen Challenge Foundation • Wungen Kartup
Housing Services	• Aboriginal short stay accommodation (e.g., Elizabeth Hansen Autumn Centre) • Boorloo Bidee Mia • Brooke Stone Real Estate • Connect Housing WA • Department of Housing • Ebenezer House • Emmaus House • Foundation Housing • Homeless Accommodation Support Service (HASS; Uniting WA) • Housing Choices	• Housing First Rapid Response Team (HEART; St Pat's, Wungening, Uniting WA) • Moorditj Mia (Noongar Mia Mia) • Perth Inner City Youth Services • Share Accom WA • St Bart's • Tate Street Lodge • The Beacon • The Foyer Oxford (Anglicare) • Tom Fisher House • Urban Fabric • 55 Central
Homelessness Services	• Centrecare • CHANGE (Shelter WA) • Passages Youth Engagement Hub (Vinnies) • Ruah Community Services	• Safe Night Space • St Pat's • Uniting WA • Wungening Aboriginal Corporation
Psychosocial Supports and Disability Services	• Alcohol & Narcotics Anonymous • Anglicare Men's group • CBUS Superannuation • Centrelink • City of Vincent Library • Financial Counselling (Uniting WA)	• Max Employment • MyAged Care • NDIS • Rise Network • Silver Chain
Justice/Legal Services	• Aboriginal Legal Service • AOD Diversion Program (Drug Court) • Daydawn • Fremantle Courthouse • Gosnells Legal Centre • Street Law Centre WA	• Legal Aid WA • Midlas • Public Trustee • ReSet (Wungening) • Strategic Offender Management System • Welfare Rights & Advocacy Service WA
Women's Services	• Kamberang Place (Ruah) • Woman and Newborn Drug and Alcohol Service (WANDAS, via King Eddies)	• Women's Health and Family Services • Zonta House
Other Services	• Freedom Centre • Multicultural Futures • Patient Assisted Travel Scheme (PATS)	• Pets in the Park • The Association for Services to Torture and Trauma Survivors (ASeTTS)

Table 41: Changes in ED Utilisation Amongst the Year 1 Admitted Cohort, 1-month, 3-months and 6-months Pre/Post First MRC Admission Period

	One Month (n=150)			Three Months (n=127)			Six Months (n=94)		
	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change
Total People (%)	128 (85%)	69 (46%)	-46%	117 (92%)	81 (64%)	-30%	90 (96%)	70 (74%)	-23%
Total ED Presentations	281	175	-38%	395	336	-15%	474	408	-14%
Mean^ (SD)	1.9 (1.8)	1.2 (2.1)		3.1 (3.6)	2.6 (4.3)		5 (7.1)	4.3 (7)	
Range	0 – 13	0 – 13		0 – 22	0 – 26		0 – 44	0 – 49	

Table 42: 7-, 28- and 90-day ED Re-Presentations in the 1-month Period Post-Date of MRC Admission Date

	One Month (n=152)		
	Pre MRC	Post MRC	% Change
# Individuals with 1+ ED Representations within 7 days^	50 (33%)	36 (24%)	-27%
Total number of 7-day ED re-presentations	108	85	
N (%) of 7-day re-presentations resulting in admission	48 (44%)	25 (30%)	-32%
# Individuals with 1+ ED Representations within 28 days^	72 (47%)	60 (39%)	-17%
Total number of 28-day ED re-presentations	177	137	
N (%) of 28-day re-presentations resulting in admission	91 (51%)	43 (32%)	-37%
# Individuals with 1+ ED Representations within 90 days^	90 (59%)	66 (43%)	-27%
Total number of 90-day ED re-presentations	217	145	
N (%) of 90-day re-presentations resulting in admission	118 (54%)	47 (33%)	-39%

^ Note: as a % of admitted cohort

Table 43: Changes in Inpatient Utilisation Amongst the Year 1 Admitted Cohort, 1-month, 3-months and 6-months Pre/Post First MRC Admission Period

	One Month (n=150)			Three Months (n=127)			Six Months (n=94)		
	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change
Admissions									
Total People (%)	119 (79%)	49 (33%)	-58%	111 (87%)	62 (49%)	-44%	84 (89%)	57 (61%)	-32%
Total Admissions	168	80	-52%	220	153	-31%	238	179	-25%
Mean^ (SD)	1.1 (0.9)	0.5 (1)		1.7 (1.7)	1.2 (2.1)		2.5 (3.1)	1.9 (2.8)	
Range	0 – 5	0 – 7		0 – 12	0 – 13		0 – 18	0 – 16	
Days Admitted									
Psychiatric bed days	79	178	+125%	343	296	-14%	351	342	-3%
Non-psychiatric bed days	818	240	-71%	1,181	552	-53%	1,282	747	-42%
Total Days	**897**	**418**	**-53%**	**1,524**	**848**	**-44%**	**1,633**	**1,089**	**-33%**
Mean Days (SD)	6 (7)	2.8 (8.5)		12 (18.7)	6.7 (13.5)		17.4 (30.8)	11.6 (20.8)	
Range	0 – 48	0 – 81		0 – 128	0 – 81		0 – 243	0 – 96	

^ Note: as a % of admitted cohort

Table 44: Changes in Outpatient Appointments Amongst the Year 1 Admitted Cohort, 1-month, 3-months and 6-months Pre/Post First MRC Admission Period

	One Month (n=150)			Three Months (n=127)			Six Months (n=94)		
	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change
Total People (%)	40 (27%)	74 (49%)	82%	56 (44%)	84 (66%)	50%	49 (52%)	70 (74%)	42%
Total Appointments	73	160	119	165	323	96	308	393	28
Mean^ (SD)	0.5 (1)	1.1 (1.4)		1.3 (2.4)	2.5 (3)		3.3 (6.1)	4.2 (5.4)	
Range	0 – 5	0 – 6		0 – 12	0 – 15		0 – 34	0 – 33	

^ Note: as a % of admitted cohort

Table 45: Budget Short-Falls

Budget Item	Cost met by HHC Year 1	Funder	Rationale
Security	$252,000	Philanthropy, HHC cost cuts elsewhere	Not covered by original budget, has required modifications to premise and night security due to complexity of residents and the inner-city neighbourhood the MRC is located in
Awake Night Nurse Shift	$197,340 shortfall	HHC cost cuts elsewhere	Originally costed as a sleep shift. Due to number of residents and complexity of needs, the sleep nurse was awakened multiple times per night and the decision was made to change this to an awake shift
Peer Support	$252,000 (2 FTE)	One-off Lottery West Grant Year 1	Important complement to clinical staff and integrally involved in resident engagement and support and referrals to support post MRC
Clinical care Coordinator	$131,000	New role requiring funding	Due to complexity and acuity of residents, and volume of workload associated with clinical care coordination and liaison with other staff and external health services, a dedicated clinical care coordinator role has been identified by HHC as a learning from Year 1. This would enable more effective coordinated management of resident treatment, care coordination, and optimisation of patient outcomes.
Ongoing training, staff development and reflective practice	Absorbed into workload of current MRC manager and HHC Medical Director	Currently unfunded, and needs expansion	Guidelines developed by The UK National Institute for Health and Care Excellence (NICE) and the Centre for Homelessness Impact for integrating health and social care for people experiencing homelessness[76] recommend that staff in homeless health services are provided regular, ongoing training and support, professional supervisions and reflective practice opportunities. Given the pervasiveness of trauma and complexity among MRC residents, additional funding for dedicated professional supervision and reflective practice is recommended.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