Homeless Healthcare Submission

Inquiry into the financial administration of homelessness services in Western Australia

Introduction

Homeless Healthcare welcomes the Inquiry into the financial administration of homelessness services in Western Australia and the opportunities it brings to improve the way we address the needs of one of our most vulnerable groups of people. Thank you for the invitation to make a submission. In keeping with the priority of Western Australia's 10-Year Strategy on Homelessness, this Submission focuses particularly on people who are sleeping rough but acknowledges that there are many other people experiencing homelessness, and that prevention of homelessness in all its forms is fundamental.

This submission particularly focuses on the following Inquiry Terms of Reference:

1. *Current funding and service delivery*; with a particular focus on limitations and gaps that relate to the enormous health disparities facing people experiencing homelessness, and the inter-twined relationship between homelessness and health
2. *the WA 10-year homelessness strategy*; our concerns about the scant reference to health or the role of collaborations with the health sector in this

And to a lesser extent but still important

3. *Existing data systems and how data informs service delivery* – in particular, learnings from our own small but critical investment in evaluation and robust research to demonstrate the homelessness, health, economic and wider government benefits of addressing the health and homelessness nexus.

Our submission is structured as follows:

Contents

1 An overview of Homeless Healthcare

Established in 2008, Homeless Healthcare (HHC) is Perth's largest provider of dedicated primary healthcare services for people experiencing homelessness and the only organisation in Western Australia providing homelessness-specific healthcare across hospital and community settings, with specialised expertise in trauma-informed care, AOD, and mental health.

HHC's wide range of homelessness services includes:

- The **Street Health** team providing outreach GP service in the streets for people sleeping rough in Perth CBD and Fremantle.
- **Mobile services** delivered in settings familiar to people experiencing homelessness (especially people sleeping rough) including mobile clinics at drop-in centres, shelters and transitional accommodation facilities, women's refuges, and alcohol and other drug services.
- **In-home After-Hours Support Service** for people housed through the 50 Lives 50 Homes Housing First program, typically people who were previously sleeping rough.
- **The Transitions Clinic** providing accessible, welcoming, and comprehensive GP services dedicated to people experiencing homelessness, including after being housed.
- **Inreach GP services for Royal Perth Hospital** patients who are experiencing homelessness.
- Western Australia's first **Medical Respite Centre** providing pre- and post-hospital care for people experiencing homelessness, typically people sleeping rough with no place to prepare for, or recover from, hospital treatment.

HHC's model of care is trauma informed, person-centred, inclusive, culturally appropriate and based on building ongoing, respectful relationships and trust.

While addressing the health needs of patients is a priority, HHC enables holistic and wide-ranging psychosocial support and has strong collaborative partnerships with homelessness, housing and social sector organisations. Connecting patients to stable housing is prioritised as an essential part of healthcare and HHC recognises the importance "Housing First" solutions.

HHC's collaboration with a wide range of homelessness services is reflected also in the diversity of geographic locations and services within which it provides clinics and outreach healthcare, including the Ruah and UnitingWA Tranby drop in centres in Perth CBD, Ruah Fremantle, The Shopfront in Maylands, Passages Youth Engagement Hub, St Barts, The Beacon, The Salvation Army Bridge Program and Harry Hunter residential, St Pats transitional accommodation in Fremantle and temporary accommodation refuges/services for people experiencing family and domestic violence.

Notwithstanding this breadth of services, it is important to emphasise that there is a need to extend HHC's model of service to further parts of the metropolitan area as well as regional centres, to address the increasing spread of people sleeping rough beyond Perth and Fremantle.

The HHC team includes nine General Practitioners, two Nurse Practitioners, 36 Registered Nurses, four administration staff, two Case Workers and one Peer Support Worker. In 2021 HHC provided 29,063 occasions of service, 13,023 involved General Practitioners or Nurse Practitioners. The service is funded through Medicare bulk billing (20.76%), state government grants (71.5%) and private philanthropy (7.61%).

The impact and reach of HHC and its services has had independent university evaluation since 2017 and is captured in a growing number of published papers and reports including patient case studies and feedback. [2,3] Homeless Healthcare and its RPH Homeless Team have further been included as exemplars as case studies in two recent Productivity Commission reports[21,22] and cited in the WA Sustainable Health Review.[23]

2 The WA 10-Year Homelessness Strategy – urgent need for a stronger health focus

Locally, nationally, and internationally there is a strong evidence-base which confirms that health issues are a cause of homelessness, and that deteriorating health is a major factor which keeps people trapped in long-term street homelessness. Yet **health has been worryingly largely overlooked in Western Australia's 10-Year Strategy on Homelessness and the associated Action Plan.** This fails to recognise:

I. the strong bi-directional relationship between homelessness and poor health; which at worst, is seen in the revolving hospital door experienced by many people who are homeless
II. the enormous and largely preventable cost to the health system of homelessness (which is particularly salient to this Inquiry and to escalating pressures on the WA Health system)
III. the critical role of health-related support (mental health, physical health, disability etc) in enabling people to sustain tenancies once they are housed
IV. the significant role that dedicated homeless health services in WA (such as Homeless Healthcare) have played in proactively and collaboratively responding to homelessness in this state

This omission has serious knock-on implications for the achievement of the outcomes of the 10-Year Strategy and the associated financial administration of homelessness services in WA.

Although the 10-year strategy notes alignment to the Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy[4], this is only one minor aspect of Health, and of far greater weight of impact to this State, is the substantial over-representation of people experiencing homelessness in frequent ED presentations, recurrent hospital admissions with lengthier stays, and topically, high rates of ambulance arrivals to hospitals.[15] We do note there are two brief mentions in the service profile section of the 10-year strategy, of the Homeless Healthcare approach and the HHC in-reach RPH service, namely that:

> *In its first two and a half years of service delivery, the RPH Homeless Team provided support to 1,014 patients, many with multiple complex health issues exacerbated by surviving on the streets.*[2]

And that:

> *The Homeless Healthcare approach recognises that the causes of homelessness and associated poor health are complex and that innovative and people-centred solutions are necessary.*[1]

However, the 10-year strategy then fails to recognise the integral role that health does and should play in what is purported to be a comprehensive 10-year strategy to end homelessness in this state. This is not merely the opinion of Homeless Healthcare. A review of other comprehensive homelessness strategies (other jurisdictions and internationally) generally reflects greater recognition of the homelessness-health nexus. Of recent note, the Centre for Social Impact recently released report entitled "*Ending Homelessness in Australia: An evidence and policy deep dive*"[6] emphasises the importance of health as a key component of homelessness strategies.

Below we summarise key imperatives for the Inquiry to recognise and urge rectification of the scant inclusion of health in the 10-year WA homelessness strategy.

2.1 The Humanitarian Imperative

Recent research from the University of Western Australia (UWA) has identified significant inequities in life expectancy amongst people experiencing homelessness compared to the wider WA population. Between 2016 to 2021, the Home2Health team have recorded 294 known deaths of people who have experienced homelessness in Perth, with an overall average age of death of 48 years. [13]

In 2021 alone, data collected by HHC and our research partners, the Home2Health research team led by Professor Lisa Wood, reported 58 deaths in this 12-month period among people who are or have very recently experienced homelessness in Perth, and we know this to be a conservative figure[3]. The average age of death observed in this Perth data is more than 30 years younger than the average age of death for the general Australian population. Studies in the United Kingdom (UK) and USA also show an approximate life expectancy gap of 30 years between people who are experiencing homelessness and those who have not.[6] People experiencing homelessness have a mortality rate ten times that of the general population, generally compounded by the presentation of multiple morbidities simultaneously.[6] Additionally, evidence from the UK suggests that a third of deaths among people experiencing homelessness were preventable.[6]

2.1.1 Health and homelessness Intertwined

There is extensive evidence that homelessness and poor health outcomes are strongly associated, as homelessness can both lead to and exacerbate poor health outcomes. The strong relationship means that health cannot be viewed in isolation (see Figure 3); both the causal pathways and the barriers to improved health for this vulnerable population group lie vested in socially determined factors ranging from trauma, housing, social isolation, early life experiences and addiction.[7]

Recent research undertaken by HHC in collaboration with the Home2Health team provides further evidence that people experiencing homelessness have multiple morbidities and chronic poor health. However, their access to primary care and preventative health services is much lower than the general population. For example, for a cohort of 2068 active HHC patients, 67.8% had at least one chronic physical health condition, 67.5% had at least one mental health condition, and 61.6% had at least one AOD issue. Nearly half of these patients (47.8%) had a dual diagnosis of AOD and mental health conditions, and 38.1% had a tri-morbidity, which includes mental health, AOD and physical health conditions.[14] See Figure 1.

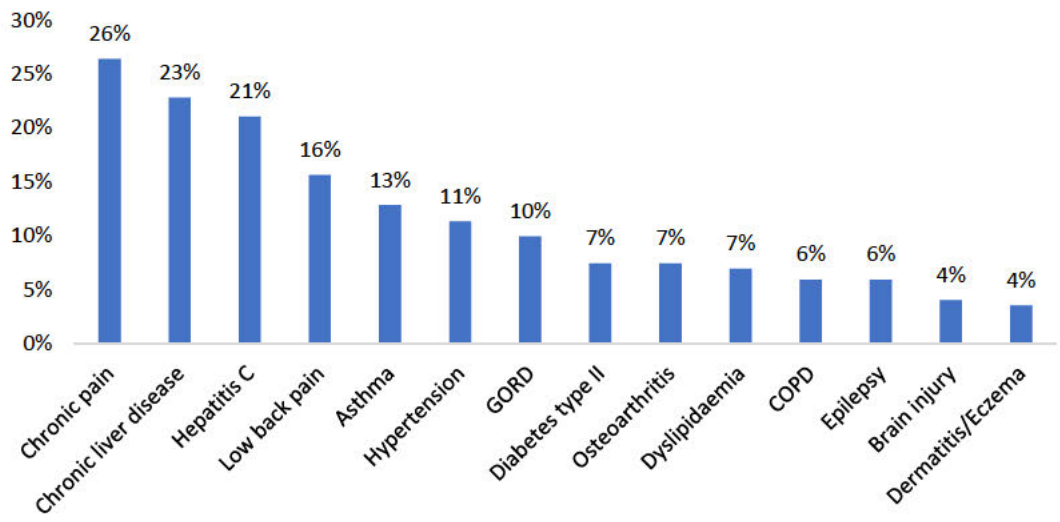

Figure 1: Percentage of Active HHC Patients with Physical Health Conditions

As shown below, people experiencing homelessness often cycle between homelessness, poor health and hospital admissions, with deterioration after discharge leading to frequent readmissions and a further decline in health status (as illustrated in Figure 2 below).[3]

Figure 2: Cycle of Homelessness, poor health, and hospital admissions.

As the WA Government announced its Sustainable Health Review[23] findings and recommendations at a similar time to the 10-year Homelessness Strategy, there is a dual imperative for the WA government to reduce the burden of homelessness on the health system and address the health needs of this vulnerable group.

2.1.2 Economic benefits of a greater health focus in the 10-Year homelessness strategy

An extraordinary amount of money is spent on hospital healthcare for people experiencing homelessness around the world. The health burden attributable to homelessness in WA is colossal. A few examples follow:

- In 2021, people of no fixed address (which we know to under-report homelessness) comprised half (50%) of the top ten most frequent ED presenters at RPH and two out of three (65%) of the top 20 most frequent presenters.[24] Each ED presentation in a WA public hospital costs $838[26] and where ED presentations lead to a hospital admission, the cost is far higher, at $2,909/day[26] in a WA public hospital.
- In the longitudinal evaluation of 50 Lives 50 Homes led by Vallesi and Wood[16], linked Perth hospital data shows clearly how hospital use escalates the longer people remain homeless. Over a three-year period, there was a doubling in the number of ED presentations and inpatient admissions prior to 50 Lives support among the cohort of 327 rough sleepers who are part of 50 Lives for whom there was matched hospital data (compared to their hospital use 3 years prior). The cost to the WA health system in terms of ED presentations, inpatient admissions and ambulance use for this group of 327 rough sleepers over this 3-year period prior to support was a staggering $19.5 million, or $59,671 per person.

Conversely, proactively responding to homelessness via healthcare settings and services can not only significantly reduce the cost burden on the State[2,3,15] in terms of reduced hospital use, but importantly

for the intent of this Inquiry and the intent of the 10-year strategy, health-led interventions (such as the work of the RPH Homeless Team, Homeless Healthcare, and the Mental Health Homelessness Pathways project at Bentley Mental Health), have been shown to help facilitate rough sleeper access to housing, and to improve the likelihood of them not returning to homelessness.[16,17]

For a sample of 97 previous rough sleepers who had been housed for at least one year through the 50 Lives 50 Homes program, there was a 47% reduction in ED presentations, 46% reduction in inpatient admissions for a total of $10.1k per person reduction of service year when comparing the year before, to the year after housing.[1]

We encourage the Inquiry Committee to review also evidence of the economic impacts of homelessness on the WA Health and Justice Systems in published reports on the RPH Homeless Team, the 50 Lives evaluation and the Choices program evaluation,[2,16] all of which draw on administrative government service use data.

2.1.3 Breadth of health-related services and settings integral to a comprehensive response to homelessness in WA

As the intent of the WA strategy is to be a whole of government and community response to homelessness in WA, the sparse references to health has unfortunately missed the opportunity to recognise the breadth of healthcare services and settings in WA that:

- Already come into regular contact with people experiencing homelessness
- Are directly responding to health issues that not only contribute to pathways into homelessness but affect people's capacity to navigate the system to get out of homelessness (such as post-traumatic stress, mental health conditions, alcohol and drug use, cognitive impairment due to injury and so on)
- Have specialist expertise and experience that complements that of social sector homelessness services
- Are already collaborating on the ground with the homelessness sector. Examples include the active involvement of Homeless Healthcare and the RPH Homeless Team in the 50 Lives Steering Group, the Perth zero project and the By Name List, and critically, our organisations proactive role since March 2020 in working with the WA homeless sector and WA government to respond to the risks COVID-19 poses to people experiencing homelessness.[25]

The diagram below depicts the breadth of ways in which health services and health professionals are, or should be, integrally involved in any whole of WA response to homelessness:

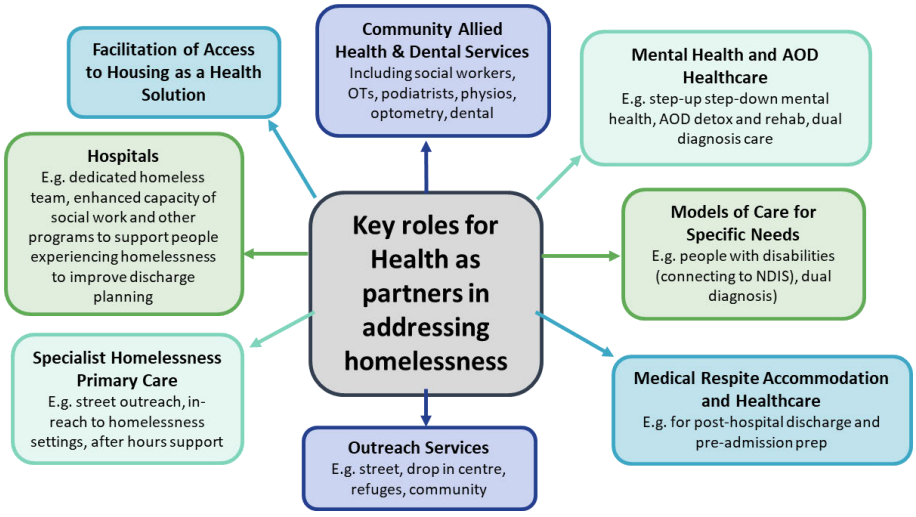

Figure 3: Key roles for health services to address homelessness

3 Implementation Issues of WA's 10-Year Strategy on Homelessness

It is positive that WA's 10-Year Strategy on Homelessness 2020-2030 and associated Action Plan 2020-2025 gives priority to people sleeping rough and to the Housing First approach and this is highly congruent with international best practice and the learnings and evidence from Homeless Healthcare since establishment in 2008.

Our over-riding concern however is with the blockages preventing this from being more than rhetoric. Since the launch of the 10-year strategy in August 2020, several key indicators and data points have tracked in the totally wrong direction:

- *the public housing and priority waitlist continues to grow*, with more than 17, 000 people on the waitlist in the last available figures. The announcement in September 2021 to deliver 3,300 new social housing dwellings over the next four years is of course welcomed, but this barely makes a dent in the current waitlist let alone reflects capacity to rapidly house people by Housing First principles.
- *the high number of people new to homelessness each month as reported on the By Name List dashboard* (that the Department of Communities has helped to establish) far exceeds the number of people who get housed (i.e., exit homelessness each month), in some recent months by a factor of 14 people new to homelessness for every person housed.
- The RPH Homeless Team has seen a*n increase in the number of people rough sleeping presenting to its hospital*, and soberingly, around 45% of the people homeless seen by the team in the last 6 months, identify as Aboriginal people. A startling figure given that Aboriginal people comprise around 3% of the WA population overall.
- There continues to be *high hospital use and bed occupancy by people who are homeless who have nowhere to be discharged to*. Given WA government and wider parliamentary and community concern about the unsustainable pressure on WA hospital staff and beds, it is economically costly and inhumane that people are enduring extended stays in mental health wards due to a dire shortage of appropriate accommodation.

What remains lacking in the implementation of the 10-year strategy is a comprehensive and coordinated funding and service delivery strategy with outcomes measurement to achieve the 10-year strategy commitment to Housing First.

Maintaining and actively achieving the integrity of <u>housing rough sleepers rapidly</u> is essential for the 10-year strategy to be effective. Central to this is a much larger investment in social housing (new stock, not budget for repairs to existing public housing stock), incentives for private sector and public-private partnerships to develop and implement innovative solutions (such as the My Homes project), and more tangible whole of government action on drivers of homelessness that are amenable to intervention (such as the high rates of people exiting WA prisons into homelessness, or the fact that 4 out of 5 people on the By Name List do not yet have a case worker who can assist them with housing applications and other supports).

It is undeniable that WA has a significant "backlog" of street homelessness to address, stretching back many years, and grimly, this has worsened in the last few years. In our resource-rich state with budget surpluses, it is unacceptable that 1000+ West Australians sleep rough in our streets every night with very little hope of being housed. Homeless Healthcare sees this firsthand at the Medical Respite Centre that opened in October 2021. Homeless patients discharged to the MRC with multiple health issues made worse by living in survival mode on the streets. To get people into transitional accommodation or detox has long wait lists at present, with the MRC finding it can take 6-8 weeks for a bed to become available in transitional accommodation such as The Beacon run by Salvation Army. And this is the wait for transitional housing, the wait for Housing First is currently an impossible dream.

It is also unacceptable that with the resources available to WA we have not made any meaningful reduction in rough sleeping, or overall homelessness, while numerous cities in the world are doing better than WA in addressing chronic homelessness. For example, as of November 2021:

- 14 communities in the United States have achieved functional zero for a homeless population in their community. Functional zero is when there are fewer people actively experiencing homelessness than are successfully exiting homelessness (i.e. being housed) at any given time.
- 12 communities have ended veterans' homelessness, 5 communities have ended chronic homelessness, and 3 communities have ended both in the United States.
- 16 communities across Canada and the United States have made homelessness rare, brief, and non-recurring for a population of people experiencing homelessness.[6]

In contrast, in WA the prevalence of people sleeping rough and the plight of those involved has not improved since the release of WA's 10-year Strategy on Homelessness in 2020, despite the Strategy indicating that major progress will be made with regard to people sleeping rough within the first 5 Year Action Plan, stating:

> *We will initially target rough sleeping, as the most vulnerable cohort, with the intention that future action plans across the ten years will have an increased focus on prevention and embedding system changes to improve and sustain our efforts to end homelessness.*

The extent of the current housing crisis in Western Australia, the lack of available social housing, and the time required to build new social housing stock means that the number of people experiencing homelessness and especially the number sleeping rough is likely to increase unless an overall strategic context and more urgent implementation is achieved for WA's 10-Year Strategy on Homelessness.

3.1 10-Year Homelessness Strategy – Implementation Gaps

There are several major implementation gaps in the financial administration of homelessness services in WA, including that:

- There is a need for measurement of key outcomes or indicators to demonstrate progress on reducing rough sleeping, reducing waitlist and waitlist times. This would provide tangible measures to support the strategy and funding to deliver **Housing First** with a priority for people sleeping rough, including the required person-centred, wrap-around support including health (and in-home support where required), with no time limit.
- There is no evidence of an overall WA State Government **funding strategy** for homelessness, with a priority for people sleeping rough and the current system provides limited capacity for **innovation** and associated timely response.
- There is no comprehensive and reliable **homelessness data** to provide the evidence-base for policy, strategy, funding, coordinated service delivery and outcomes evaluation.

Each of these key implementation gaps is explained below. While it is recognised that 2022 is only year 3 of the 10-Year Strategy and 5-Year Action Plan, it would be expected that these fundamental implementation gaps would have been addressed (or progress made in addressing them) as the basis to pursue the Strategy's stated outcomes and priorities.

3.1.1 Implementation Gap – Housing First

Housing First is a priority of WA's 10-Year Strategy on Homelessness and the Strategy's Outcomes include under **Outcome 2:**

- Providing safe, secure and stable homes
- Chronic homelessness is ended.

- Diverse and appropriate housing options are available and accessible.
- Access to safe and permanent housing as first priority for people experiencing homelessness.
- Individualised support services are available to help people maintain long term housing and achieve their goals.

In the 10-Year Strategy the Housing First priority is expressed as:

> *The first and primary goal is to provide people access to safe and stable housing without preconditions or judgement. Once housing is secured, individual supports can then be provided as required, to address other needs. To enable this approach, the system must be supported by low-barrier and low-threshold accommodation and housing options as well as flexible and appropriate services that are tailored to individual needs, acknowledging that for some people these may be needed long-term.*

However, there are significant implementation issues and system blockages for each of the two key elements of Housing First – providing a permanent home and delivering the required individual support, as reflected in the following key issues

3.1.2 Providing a Permanent Home remains elusive in WA

The WA State Government has announced increased investment in social housing with common ground seemingly being seen as the sole option for people experiencing homelessness. This ignores the fact that this group has diverse needs and congregate living is inappropriate for many of them. Importantly, there appears to be no policy, strategy, dedicated funding, targets or outcome measures focused on housing people who are rough sleeping as a priority.

The Housing First strategy on which the WA 10-year strategy is premised, is at substantial reputational and outcome attainment risk if WA does not develop a specific social housing policy that gives priority to people sleeping rough and provides these people with a permanent home with no time limits on occupancy. Key drivers and issues include:

3.1.2.1 Massive shortfall between social housing demand and supply

Despite the WA Government's two Common Ground projects and increased funding commitment for social housing, there will still be a significant shortfall in availability of social housing for some years to come and, given the number of people on the social housing list, everyone needing social housing will not be able to be housed. As of 2020 the wait period on the priority waitlist for a one-bedroom property was 69 weeks.[16] The WA government's rental subsidies, while a valid concept, has little relevance when there are so few rental properties available.

3.1.2.2 Lack of Housing Priority for People Sleeping Rough

Given the ongoing shortfall in social housing, the WA Government's targets to deliver additional social housing could be technically met without any impact on reducing the number of people sleeping rough. Rather without clear policy, targets and outcome measures specific to people who are rough sleeping or experiencing chronic homelessness, social housing could be provided to people on the State Housing Priority List with less complex needs - an easier option.

3.1.2.3 Barriers to Accessing Social Housing

Even if there was an intent to house people sleeping rough as a priority of WA's social housing strategy, it is important to be aware that not all people sleeping rough have a case worker and may not have any means of being included on the social housing priority list. It is recognised that as part of the coordination role of the Zero Project, where possible homeless people listed on the By Name List are also referred for inclusion on the social housing priority list. But while the By Name List is a good start,

as of December 2021 just over 500 people sleeping rough were included on the By Name List for Perth, Fremantle and surrounds (about 50% of the cohort) and only 1 in 5 people on the By Name List has a case worker.

If a person sleeping rough is one of the few to be allocated social housing, because people sleeping rough have no street address and frequently move locations, it can be the case that the person allocated a house cannot be located, or if located, it can be too late to accept the housing within the designated time limit for response, after which the offered housing is allocated elsewhere and the person is removed from the social housing list.

Case Study 1: Value of prioritizing rough sleepers for housing

Background

[redacted] is a young male in his early twenties who has been cycling in and out of homeless for at least four years. He has multiple co-morbidities including diabetes, depression, asthma, mobility and learning difficulties and possible schizophrenia. His diabetes is not clearly Type 1 or 2, and poor management of it has led to recurring hospital presentations. His medical records indicate that he has been advised to use insulin four times a day and to store it in a fridge – an impossibility when living on the street.

Health Service utilisation and cost

Between 2016 and 2020, [redacted] presented to a Perth public ED 33 times, and spent 31 nights as an inpatient. His frequent hospital use increased due to deterioration of his health, particularly related to his diabetes. By the nature of ED, it is usually only the presenting and immediate issue that is addressed before discharge. His hospital use over this four year period equates to $115, 940, based on the average cost of an ED presentation in a WA public hospital of $838, and an inpatient bed day cost of $2,909.[26]

3.2 Critical need for funding of evidence based Individual Support Once Housed

The 10-Year Strategy makes a clear commitment to providing ongoing individualised support services for people once housed and there is also commitment to support at-risk tenancies (p41) which would include vulnerable people who have been rough sleepers. The in-home After-Hours Support Service delivered by Ruah caseworkers and Homeless Healthcare nurses as part of the 50 Lives 50 Homes (now called the Zero Project) provides the evidence-base for what is required.

It is important to emphasise that the Zero Project in-home support is only available after hours and does not have a secure funding base being reliant on ad hoc philanthropy (Sisters of St John of God) and unreliable Federal funding (WAPHA).

While the Zero Project has the role to "provide place-based coordination to help local service systems to work collaboratively so they can more effectively allocate housing and support resources",[18] funding provided is limited. Beyond the Zero Project, the current system does not provide individualised support for homeless people once housed, or support provided is very limited in scope and continuity because of lack of funding.

What is needed is appropriate and reliable funding to develop and deliver a comprehensive service model for housing allocation for people sleeping rough based on an effective triage system, together with availability of 24 x 7 person-centred support, including in-home support where required, for as long as needed.

The service model, funding and outcome measures for Housing First support services need to incorporate the role of Community Housing Providers as social landlords enabling previously homeless tenants to maintain their tenancies and linking tenants to case workers to coordinate access to all required personal support needs, including health needs.

The *Inquiry into the Financial Administration of Homelessness Services* provides the opportunity to guide implementation of Housing First with a priority for people sleeping rough.

3.2.1 Implementation Gap – Funding Strategy and Innovation

Western Australia's 10-Year Strategy on Homelessness[1] emphasis that significant change is required in the funding strategy for homelessness and the interrelationship of funding and innovation and states:

"To drive innovation and increase housing and support options, innovative funding options will be explored. To effect real change, alliances, partnerships and pooled funding are critical".[1]

One option could include exploring social impact investing, where investor capital would be used to design and fund solutions to complex social problems, with a return based on agreed social outcomes. This model promotes new partnerships, innovation and cross-sector collaboration.

The community services sector has a strong role in driving innovation and in identifying new funding sources, including engaging philanthropy.

It is acknowledged that services are currently doing a significant amount with often limited resources and ongoing uncertainty has made it more difficult for services to meet the needs of vulnerable members of the community. Working genuinely with service providers and users (as opposed to token efforts) will be a priority to ensure the needs of people experiencing homelessness are met.

3.3 Implementation Gap – Current Funding System for Homelessness.

The following examples highlight dysfunctional aspects of the current funding system for homelessness and related services:

3.3.1 Whole of government response is needed in relation to institutional discharges to homelessness in WA

HHC frequently supports patients who have become homeless upon discharge from government institutions, including hospitals, mental health facilities and prisons. The severe shortage of appropriate social housing options and lack of adequately detailed discharge planning underpins institutional discharge into homelessness.[8,9] Discharge from prisons into homelessness disproportionately impacts Aboriginal people and people with more complex support needs.[9,10] Whilst HHC outreach services attempt to support this patient group, discharge from institutional settings into homelessness further compounds overwhelming poor health status, and is a lost opportunity to provide appropriate housing and necessary wrap-around support.[11] International and Australian evidence has found that discharge from prison into homelessness is associated with increased health-related costs and recividism,[11,12] compared to the substantial cost savings if people are appropriately supported into housing.

3.3.2 Sustainable funding for essential primary care specialist homeless health services

As previously highlighted, HHC's services are aligned with, and integral to, the priorities of WA's 10-Year Strategy for people who are rough sleeping, with a comprehensive, culturally competent and trauma informed model of care providing psychosocial support and pathways to housing. HHC's services support people sleeping rough from outreach on the streets to in reach into the home once housed.

HHC's services have clear outcome measures and have been independently evaluated[3], including analysis of the financial savings delivered to the WA government through reduction in ambulance use, emergency department presentations and hospital inpatients; savings that far outweighing the cost of service delivery by HHC. Yet HHC's services are impacted by fragmentation and uncertainty of funding. For example:

HHC Health Department Contract

HHC had a 5-year contract from 2013-2018. The original contract was for 10 clinics and 5000 visits and was increased to 14 clinics and 7000 visits, with the addition of four case workers. This has been varied on many occasions and since 2018 has been extended for a period of anything from 5 months to 13 months. With the expiry of each extension HHC must liaise with the Department and lobby the Minister, and just at the point of needing to cut services to homeless people, funding is renewed for another short period of time. Significantly, it has been emphasised by the Health Department's contract managers that this is an issue of budget and internal processes, and that the Health Department is very pleased with the services delivered by HHC recently illustrated by additional short-term funding provided to increase our COVID vaccination effort.

Reliance on philanthropy for street outreach

HHC's Street Health is a nurse-led street outreach service that provides nursing care and support to people sleeping rough, with the HHC nurse accompanied by a community case worker where possible (but hindered by lack of funding). The aim is to address lack of access to medical care for people sleeping rough by engaging them where they are, rather than expecting them to present to medical facilities; and to build trust and rapport with clients and link them with health, housing and other support services to break the cycle of homelessness.

Assertive outreach is increasingly recognised as being critical for this population, as many of the most vulnerable rough are wary of attending homeless services, or as quite often seen by our street health nurses, have trauma and other adversities that require weeks and months of patient rapport building. To date Street Health has relied nearly entirely on philanthropic funding in both the Perth CBD and Fremantle area. A recent Impact 100 grant in Fremantle enabled Street Health to be expanded in Fremantle for 3 days a week for a one-year period).

Medicare unfortunately only provides rebates for primary care services delivered at a GP clinic, in the patient home/hostel or an aged care facility, yet some of those most vulnerable will not or are not able to attend a structured set time clinic. In late 2020 Homeless Healthcare trialled having a GP accompany the nurse on street outreach (with some one-off funding from the Chief Allied Health Office). This was extremely beneficial but not sustainable without funding. Earlier engagement of rough sleepers in primary care has been shown in our evaluations of HHC and the RPH Homeless Team to significantly curb escalating hospital presentations,[7,19] which increase the longer people are homeless.

Case Study 2: Value of Assertive Primary Care Street Outreach

Background

[redacted] is in his mid-thirties and has been homeless for six years. He has schizophrenia that has only been sporadically treated in the past. A Homeless Healthcare street outreach nurse came across [redacted] huddled in a doorway in the Perth CBD. He was very disordered in his speech and was reluctant to acknowledge any mental health issues. He was regularly using meth and had psychosis which was potentially drug induced. In mid-2020 he had a two-month mental health admission then returned to the street. This admission alone equates to a cost of $93,868 to the WA Health system.

Support Provided

Homeless Healthcare street outreach nurse has built trust and rapport with [redacted] over the past year, looking out for him when they do their walking rounds in the CBD. They have informed [redacted] of food and accommodation options, and gently broached moderating the frequency of his drug use. When it was clear

his mental health was deteriorating, the street health nurse and GP explained that they can find him and provide his monthly antipsychotic depot, and he has been very happy for this to occur. Being able to remove all barriers to health care access and take it to [redacted] in his familiar surrounds has been pivotal. His schizophrenia is now stabilised, and he now has a case worker, who together with the HHC nurse, have assisted [redacted] to submit an application for transitional accommodation, and to get onto the priority public housing list. Checking in with him regularly on street rounds continues several times a week.

After Hours support for people who are housed

As previously emphasised, the provision of appropriate wrap around support through a Housing First lens is a priority of the 10-Year Strategy. Yet in Year 3 of the 10-Year Strategy the funding for these services is still based entirely on year-by-year philanthropic funding from the Sisters of St John of God and uncertain funding from WAPHA.

Zero Project and By Name List

As a further example of funding problems of the current homelessness system, the Zero Project in its coordination role of Housing First is central to WA's 10-Year Strategy on Homelessness and yet, as already highlighted, there is no dedicated, coordinated funding provision for individual support services for people once housed, and the By Name List relies on a Lotterywest grant with no certainty future funding strategy.

3.3.3 Need for New Funding

While in the longer term there is a need to reposition WA's homelessness services and associated funding from transitional accommodation to Housing First, there is an urgency to introduce significant new funding to address street homelessness given the number of West Australians who are living and dying on our streets.

Fortunately, WA is well positioned to introduce significant new funding, given the State budget surpluses and the opportunity to secure significant funding by engaging private business and philanthropy. Some realistic ways of fostering this are outlined below:

3.3.4 Engaging Private Business and Philanthropy

WA's 10-Year Strategy on Homelessness includes the role of private business and philanthropy in increasing the overall resources available and in leveraging investment opportunities (p20). The time is right to create strategies for such investment given the ESG responsibilities of major corporations and the (as yet small scale) interest from WA philanthropic organisations in funding for homelessness.

Acting now is imperative, given the urgency to address the housing shortage and the number and plight of people sleeping rough. **Yet no strategy has yet emerged in Year 3 of the implementation of WA's 10-Year Strategy on Homelessness to engage private business and philanthropy.** Rather the engagement of philanthropy is minor and based on a "begging bowl" approach from individual homelessness agencies in the community sector.

Social impact investment and similar strategies have been discussed for many years by successive WA governments with no progress, despite evidence of success of such approaches in tackling homelessness and other social issues in other jurisdictions.

3.3.5 Barriers to Innovation caused by the Current System

WA's 10-Year Strategy recognises the importance of innovation in order to address homelessness, especially given the challenges of our backlog of 1000+ people who are rough sleeping and WA's

housing crisis (both in terms of limited housing availability and delays in building new homes because of the impact of Covid on building materials and labour).

However, in Year 3 of the 10-Year Strategy, it is concerning that no mechanisms have emerged to encourage and support innovation.

The structure of the current funding system also significantly hampers innovation in addressing homelessness. Key issues are:

- Lack of coordination of Federal and State funding for Health, Housing and Homelessness strategies.
- Budget fragmentation across Health, Housing and Homelessness portfolios and agencies.
- Activity Based Funding of hospitals and primary health care, and associated KPIs, which inhibit innovation and promote maintenance of the current system
- No funding dedicated to innovative solutions aligned to strategic priorities.
- Engagement of individual homelessness agencies with philanthropy for individual projects and services (a "begging bowl" approach), but no strategic engagement between government and philanthropy to deliver significant outcomes, as noted above.

The current system hampers innovation to the extent that key strategic innovations, once agreed, take years to implement, for example:

Medical Respite Centre (MRC) The MRC provides pre and post hospital care for people sleeping rough, with links to a wide range of homelessness services and housing providers. Homeless Healthcare's detailed evidence-based business case for a medical respite centre was presented to the Minister for Health and East Metro Health Service in 2017. Homeless Healthcare was requested by the Minister for Health to make a submission about the MRC to the Sustainable Health Review and this was submitted in October 2017, in partnership with Royal Perth Hospital and St Bartholomew's House. Despite the MRC being identified by the Sustainable Health Review as a high priority it was not until 18th May 2021 that the tender for the MRC was awarded to HHC as lead contractor. It was an unfortunate delay to the implementation of an innovative, evidence-based solution to address rough sleeping.

***"My Home"* Project** The innovative, evidence based "My Home" project provides rapid build, high quality housing for people experiencing homelessness based on a Public Private Partnership model which brings together government and church land, private sector funding, and Community Housing Providers to create housing.

However, despite support from the WA Government in providing land, there was a significant delay in the signing of the first contract for land in North Fremantle. The impact has been that homeless people who could have been housed through this project were instead left to live on the street or in precarious accommodation.

3.3.6 Implementation Gap – Data Systems to Inform Homelessness Strategy and Services

Data is critical to create the evidence-base to inform homelessness policy, funding, service delivery and outcome measurement. In WA there is no common database with comprehensive data to achieve this.

The research of the Home2Health team led by our research partner Prof Lisa Wood has highlighted the value of independent robust academic research and real time data monitoring to address data gaps. However, we are aware that this research on homeless deaths has been entirely unfunded, with the research team undertaking all of it on an unfunded basis.

The lack of systematic data recording of deaths amongst people experiencing homelessness remains a key gap that needs to be addressed. Another current gap in existing data is the number of people who become homeless when released from prison in WA. As acknowledged in a Government response to a parliamentary question in latter 2021, Corrections in WA do not collect data on prison releases to homelessness, and this hiding behind 'no data' is of grave concern. Other states do have data on housing destination (or not) of people being released from prison, and it is inconceivable that with all the protocols and checks in place around releasing people from prison, that this data void could not be resolved. WA also seems to have far fewer earmarked supported accommodation options for people exiting prison. This is counter to rehabilitation and reducing recidivism.[11] Recent media reports of Albany prison providing people with a sleeping bag or swag when being released with no accommodation is a travesty.

WA also has no common system or process for triage, which is essential to ensure that homelessness services give priority to those people sleeping rough with the highest and most urgent needs. A start was made during the 50 Lives 50 Homes initiative by using the internationally developed VI-SPDAT[5] tool to measure vulnerability of people experiencing homelessness and introducing the By Name List to collect preliminary data on individuals. However, much more needs to be done to collect the comprehensive data required and it is important to note the limitations of the VI-SPDAT and By Name List. For example, Boston Healthcare, which developed the VI-SPDAT some years ago, no longer uses it and instead measures length of time homeless as their assessment of vulnerability. This is based on the knowledge that the longer someone experiences homelessness, the worse the health of people sleeping rough will be and the higher and more complex the person's needs. Other WA research led by Shannen Vallesi has highlighted the limitations of self-report health data and notes that if only done at a single point in time, a person's VI-SPDAT score may not reflect additional vulnerabilities and risks that have accumulated with prolonged homelessness. [6]

Given the reliance on the VI-SPDAT in WA's Zero Project and numerous homelessness services in WA, it is recommended that analysis is undertaken of the suitability of the tool using evidence-based research and liaising with Boston Health Service (where Homeless Healthcare has good relationships and can make introductions).

The Zero Project, led by Ruah Community Services, manages the WA By Name List (BNL) database. The BNL provides "live" data on who is currently homelessness in a community and can be used to see how the service system is working, to drive evidence-based improvements that help reduce rough sleeping and chronic homelessness. The BNL enables organisations across the sector to collaboratively track and quantify homelessness.[2] However, while a useful tool, the By Name List has limitations:[3]

- Data will vary from day to day because the BNL is a 'live' database, and users are constantly updating information.
- Up to 70% of the people on the BNL do not have a lead organisation/worker and thus there may not be a worker able to provide regular updates on the majority of people.
- It's not research quality data, i.e., extracted snapshots are only an indication of what participating organisations have added to the BNL at the time.
- It's not a mandatory database for participating organisations. Contribution is solely based on the goodwill for a collaborative approach to ending homelessness.
- The dashboard is not a snapshot of all homelessness and focuses only on those who are experiencing rough sleeping and chronic homelessness.
- The data captured is not state-wide, it is limited to where the Housing First support services are located, and outreach is conducted.

Further, it is important to note the funding for the By Name List is insecure and reliant on a Lotterywest grant.

Conclusion

- Addressing health as an integral part of homelessness strategy is an important and strategic consideration for the inquiry into the financial administration of homelessness services in Western Australia. We have the local, national and international evidence-base and proven HHC service model to successfully integrate health into the WA's 10-Year Strategy on Homelessness and associated Action Plan. Failure to address health has the potential to impact negatively on achievement of the objectives of the 10-Year Strategy as well as on WA healthcare costs.

- The current system is not working in terms of housing people who are sleeping rough, based on Housing First Principles and does not deliver required individualised support in order to keep people housed and prevent a return to homelessness. Future WA Government investment in social housing is not yet focused on priority for people sleeping rough. WA is unlikely to meet the vision of the 10-Year Strategy that, "Everyone has a safe place to call home and is supported to achieve stable and independent lives".[1] The *Inquiry into the Financial Administration of Homelessness Services* provides the opportunity to guide implementation of Housing First with a priority for people sleeping rough.

- Implementation of WA's 10-Year Strategy on Homelessness is dependent on reliable data to create the evidence-base for policy, strategy, funding, service delivery and evaluation of outcomes. It is therefore urgent that funding is provided, and work undertaken to analyse information needs and develop and implement a common information system, the use of which is mandated if receiving State Government funding. The analysis needs to include the role of the By Name List and its capacity to be extended to meet overall information needs, together with evaluation of the VI-SPDAT and associated data collection.

- Delivery of WA's 10-Year Strategy on Homelessness urgently requires an overall funding strategy with increased investment of funds from the WA Government, private business and philanthropy together with opportunities for innovation in order to:
    - Achieve the priorities for Housing First and people sleeping rough in a meaningful way.
    - Address inconsistent, inadequate and uncertain funding of current homelessness services aligned to the 10-Year Strategy.

4 The Way Forward -Recommendations

The recommendations below are suggested to overcome some of the barriers to the effective implementation of WA's 10-Year Strategy on Homelessness and improve outcomes for people experiencing homelessness.

1. **Integrate greater inclusion of health into the WA's 10-Year Strategy on Homelessness** and associated Action Plan. Homelessness and Health are inextricably intertwined, explicitly integrating a health focus will support the achievement of the 10-year strategy objectives and help overcome existing implementation gaps. Addressing health as an integral part of homelessness strategy therefore is an important and strategic consideration for the inquiry into the financial administration of homelessness services in Western Australia.
2. **Develop a more detailed and comprehensive implementation plan to support the 10-Year Strategy and Housing First Principles;** including consideration of the barriers people sleeping

rough face in accessing social housing, prioritisation of people sleeping rough to access appropriate permanent housing, and the provision of integrated wrap-around support service (e.g. AHSS) once housed. Consolidate links between state-wide rollout of Housing First to identify people in need of rapid housing.

3. **Address institutional discharges to homelessness and improve the quality of discharge planning to support people who are exiting government institutions** including hospitals, mental health facilities and justice settings at-risk of homelessness to access appropriate secure housing and any necessary wrap-around supports. Develop strategies to address the over-representation of people with complex support needs, Aboriginal people and pregnant women amongst those discharged from government institutions into homelessness.
4. **Resolve dysfunctional aspects of the current funding system for homelessness services** that result in fragmentation and uncertainty. Increase funding periods for services to avoid frequent, costly and inefficient applications for contract renewals that limit the continuity of services delivered and limit opportunities for future planning. Allocate substantial new funding to reduce reliance of core-services on one-off grants. Develop strategic engagements between government and philanthropic organisations.
5. **Systematically collect data to create the evidence-base to inform homelessness policy, funding, service delivery and outcome measurement.** Develop a system for triaging people experiencing homelessness that includes a comprehensive approach to data collection. Address urgent existing gaps in data including the number of deaths amongst people experiencing homelessness and the number of people being discharged from government institutions into homelessness.
6. **Develop mechanisms to encourage and support innovation within the sector.**

Importantly, tangible outcomes from the Inquiry into financial administration of homelessness services is the opportunity to genuinely position Perth and Western Australia alongside leading cities in the world in addressing homelessness.

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