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24 March 2022

Attn: Standing Committee on Estimate and Financial Operations
Parliament House
4 Harvest Tce
West Perth WA 6005

Dear Committee of the Legislative Council,

Re: Inquiry into the financial administration of homelessness services in Western Australia

Thank you for the invitation to make a submission to the Council. In keeping with the priority of Western Australia's 10-Year Strategy on Homelessness, this Submission focuses of 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 highlights three particular gaps we have identified in the current provision of homelessness services, each of which relates also to people who should be recognised as important priority sub-groups if WA is to curb rising homelessness and its consequences. These three gap areas relate to:

1) Pregnant women experiencing homelessness, and the impact of homelessness on child removals into State Care and access to antenatal and postnatal care
2) People with dual mental health and alcohol/drug issues who are or have experienced homelessness
3) Housing and tenancy support for Aboriginal people experiencing homelessness in WA

This submission pertains particularly to Inquiry Terms of Reference 2: *All Paths Lead to a Home 10 Year Strategy,* and to particularly areas of the 2020-2025 Action Plan, including:

1) Priority Action 1 (Improving Aboriginal wellbeing). Relating to the need to strengthen Aboriginal organisation involvement, improve government policy and practice, ensuring culturally responsive approaches to ending homelessness and increasing culturally appropriate housing options.
2) Priority Action 2 (Providing safe, secure and stable homes). Relating particularly to point 2.2 and 2.4, ensuring rough sleepers have access to shelter, and driving innovative responses to homelessness.
3) Priority Action 3 (Preventing homelessness), 3.1 is of relevance to this submission ensuring tailored responses to vulnerable cohorts (in this instance, those with dual diagnosis and those who are pregnant)
4) Priority Action 4 (Strengthening and coordinating our responses and impact), 4.2 is of relevance in regards to prevent and end homelessness across the systems (particularly health, mental health and child protection).

We provide an evidence rationale for these three gap areas we have identified in the Strategy and its current Action plan in the sections that follow, with recommendations in Section 4.

1. Improving Antenatal Care Access and Reducing Child Removals for Homeless Pregnant People

Pregnancy, and antenatal and postnatal care for women experiencing homelessness and their babies presents enormously complex challenges for the Department of Communities and the WA Government more broadly. From our extensive research in homelessness and discussions with service providers and people with women with a lived experience of homelessness and pregnancy/ motherhood, challenges we have identified include:

- Prevalence of **risk factors for "higher risk" pregnancy** among homeless women, including poor nutrition, high rates of smoking and drug use, stress, safety issues living on the street
- **Access barriers to antenatal care**, including day to day focus on immediate survival, lack of transport, not having a regular GP, wariness of health services due to trauma or past negative experiences, and through to fear of infant removal as a barrier to engagement.
- **Co-occurring issues** common during pregnancy among homeless women, including experiencing family and **domestic violence, poverty, mental health and AOD issues, lack of social supports**
- Widespread **fear of among many pregnant homeless women of their baby being removed into state care.** The likelihood of a having had a previous baby or child taken into care is not uncommon among women who are rough sleeping, and as noted by several homelessness services, there is anxiety about this 'happening again' if they go to hospital.
- **Responsibility of The Department of Communities to assess potential risks to the welfare of newborn**, including whether safe accommodation and sufficient supports are available. If a woman is still rough sleeping close to the time of birth, this increases the risk of a newborn entering state care. In 2019/20, for around half of the newborns entering care from KEMH; parents experiencing "unstable accommodation" was one of the risk factors potentially impacting on safe care of the baby.
- The **dearth of safe accommodation options for pregnant women** in WA. This applies both to short-term and crisis accommodation (pregnant women often seen as higher risk), and longer term supported options where women can stay for the duration of their pregnancy and when the baby is born. Social workers in WA maternity settings struggle to find appropriate accommodation for pregnant women without a home (or whose current home is not safe to return to). *In 2021 alone, Indi Place (Indigo Junction), told us that they turned away 6,400 requests for their five onsite family units from young pregnant people and/or families*.
- **Barriers to postnatal care and support**. Even for young women experiencing homelessness who manage to get accommodation in time to be able to keep their baby, there remain barriers around access to postnatal care, child health services and support for parenting, all of which can impact on child development and longer-term outcomes.

The recent Western Australian Sustainable Health Review highlighted the importance of the first 1,000 days of life to child development and future health,

> *"…the first 1,000 days of life, from conception until the end of the second year of life, are critical to developing the foundations of a person's future health, growth, and neurodevelopment. Both positive and negative experiences during these critical first 1,000 days of life have a significant influence on a child's future." (SHR, page 68)*

Homelessness, however, poses enormous challenges for pregnant mothers and their babies in these first 1,000 days. Moreover, there is a tragic overlap in WA between inter-generational homelessness and inter-generational experiences of child removal, and many of the street present women in Perth

in the last two years have shared with Homeless Healthcare that they have had previous children removed into care, as reflected in the following case study:

Case Study 1: Pregnancy and Homelessness

Background: "Melanie" is an Aboriginal women in her [redacted] with a history of PTSD, anxiety, depression, suicidal ideation who was living in "tent city" at the time she was engaged with Homeless Healthcare's Street Health service. Melanie has been rough sleeping for at least four years, after she was evicted from her Pubic Housing property. She was raised in foster care.

Situation: Melanie is currently 28 weeks pregnant, with three children already in foster care. She is determined to keep this baby in her care. She had not received any antenatal care at this point as she was afraid of her child being removed if they knew she was homeless.

Support Provided: The Street Health came across Melanie during routine outreach, where she appeared very unwell at the drop-in centre. She refused an ambulance, so team transported her to KEMH where she was triaged by the Foetal Assessment Unit and stayed a week to recover from sepsis. During her hospital stay her other acute health needs were met, which would have been difficult to manage in the community.

Outcome: Melanie continued to engage with the Street Health team throughout the reminder of her pregnancy and attended follow up appointments at KEMH. She has since gained transitional accommodation and case management with Uniting WA, Melanie now has the support she needs to gain access to stable, long term housing.

2. Supporting people with Dual Diagnosis (mental health and AOD issues)

The presence of concurrent mental health and alcohol or other drug (AOD) use disorders, or 'dual diagnosis', is extremely common among individuals experiencing homelessness.[1-3] Among a cohort of 2,068 active patients of Homeless Health for example, around half had one or more co-occurring mental health and AOD conditions, and 75% had multi-morbidity (mental health, AOD and chronic physical health condition).[2] With underlying trauma and adversity often present in people with a dual diagnosis:

> *'Dual diagnosis in people who are homeless is often rooted in childhood trauma; alcohol and drugs are frequently used to regulate mood and emotions associated with trauma and the severe adversity of homelessness. Practical issues can also perpetuate AOD use – for example women who use meth to keep awake on the streets at night when it is most dangerous'.* **— Dr Amanda Stafford, March 2020**

Co-occurring mental health and AOD issues are also commonly observed by WA homelessness services, and this can have direct impacts on housing and accommodation access and retention. Many accommodation services have exclusion criteria for people with current AOD use, or this becomes a reason for people being exited. Homelessness accommodation services are not funded or equipped to support people with mental health and/or AOD issues, but this can impact on behaviour, tenancy sustainment and returns to homelessness.

Not being stably housed is an enormous barrier also to treatment options (mental health and/or AOD), as there is often a reluctance to let people enter detox or rehabilitation services without accommodation to be discharged to. Moreover, people are in day to day survival **mode,** and it is **hard to effectively engage in counselling or access other support if worrying about where you can sleep safely each night.**

"it sets people up for relapse and failure if they do detox but then they have nowhere to live – their substance tolerance has been reduced and then they end up back on the streets to fend for themselves" – **homelessness sector stakeholder, 2021**

Not addressing dual diagnosis among people experiencing homelessness has a significant economic impact also, including:

Health sector: literature has reported that people who have AOD use disorders in conjunction with psychiatric comorbidities have more emergency admissions and higher prevalence of suicide, co-morbid conditions and psychosocial problems than those who have only substance use disorders or other psychiatric diagnoses.[4] Given there is a high over-representation of people with a dual diagnosis in the Perth homeless population, this has significant fiscal impacts on the health system, with people often bounced between mental health and AOD services for years.

Homelessness/housing: While there are often challenges in sustaining housing after experiencing homelessness, this can be particularly challenging for those with a dual diagnosis if people are not being supported in their mental health/AOD recovery.

Justice sector: People experiencing homelessness far more likely than the general population to have been victims of crime, to have committed offences, and to have been imprisoned.[5] Ascertaining causality for this relationship is complex, with the origins often lying in early life circumstances, trauma, mental illness and addiction issues.[6] Mounting evidence on the effects of trauma on brain and emotional development highlights the detrimental effect of trauma on people's capacity to feel safe, to assess danger, and to regulate physical and emotional responses to stressors.[7,8] Childhood abuse and pervasive trauma are acutely evident in the lives of numerous of the people supported through 50 Lives, with high levels of both offending and victimisation, and while every journey into homelessness is different, turning to drugs as a way of numbing emotional pain and coping with trauma and mental health issues is common. In turn drug use contributes to a vicious cycle of both offending and victimisation, as sadly illustrated in the case study below. Additionally, many of the intersections with the justice system are directly related to drug use/possession, with our evaluation of the 50 Lives program finding that the most common offence was drug-related offences (25%).[9]

Case Study 2: Dual Diagnosis and Offending

Background: "Hannah" is a female in her [redacted], who has been homeless since she ran away from home at 17. She has a childhood history of extreme and significant trauma. Consequently, Hannah has multiple of mental health issues including depression, PTSD and borderline personality disorder, which are compounded by drug-induced psychosis.

Justice Contacts: Hannah has an extensive history of contact with the justice system over the last decade, both in offending and as a victim of crime. When she first came into contact with the Choices Post-Discharge Service,[10] she had been in custody for breaching a move on order while rough sleeping. Most of Hannah's offending is related to possessing and using illicit substances, however she has breached numerous restraining orders and has been arrested for stealing. She has been a victim of numerous crimes (dating back to her early teens) with multiple assaults and threats of violence, and with many possenssions stolen.

Hannah has said to the After Hours Support Service (AHSS)[11] team that she *"is trying to abstain from drugs but it's nearly impossible while homeless, without stable accommodation and a routine."* She has concerns that the longer she remains homeless the more entrenched her drug use is likely to become. Hannah moved into private accommodation in late 2018, but then was in hospital with an infection (relating to injecting drug use) for several weeks, and not long after, the AHSS reported that her property appeared to be abandoned.

For people with dual diagnosis, support is more effective when mental health and AOD issues are addressed together.[12] Yet the health system response remains largely "siloed" – **interventions or**

services that simultaneously address both issues are rare, and people with dual diagnoses are commonly "bounced" back and forth between mental health and AOD services, without the coordinated approach that is needed to improve patient outcomes.[13] Mental health and AOD services have different funding streams and separate recording systems – resulting in services not being able to access patients' health records across systems.

One example of a dual-diagnosis service that supported people experiencing homelessness is the one year HODDS pilot that ran from March 2019 to March 2020, funded by a Department of Health RTP grant awarded to Homeless Healthcare. The HODDS team comprised a mental health- and AOD-trained doctor (dual diagnosis doctor) and nurse, who worked alongside Homeless Healthcare GPs and nurses.[14] Prior to the HODDS pilot, HHC estimated that only around 15% of its patients with severe mental health illnesses were receiving any form of specialist mental health care, and this is compounded when people have dual diagnosis. In addition to specialist mental health care the HODDS team provided directly to patients during the pilot, having a psychiatrist working within HHC helped to facilitate improved access for patients to specialist mental health care. In total, 122 people were supported by the pilot program. Support included trust and rapport building, clinical assessments, developing care/ treatment plans, advocacy to access housing, linkage with other community and health services and, for some patients where needed, facilitating access to mental health inpatient care or AOD detoxification or rehabilitation. In our team's evaluation of the HODDS pilot, a 27% reduction in emergency department presentations and 7% reduction in inpatient admissions was observed when hospital use was compared in the year before HODDS engagement compared to the year after HODDS support.[15]

Case Study 3: Reduction in Hospital Use after HODDS

Background: [redacted] is a young lady in her [redacted] who has been homeless since she was 14 years old. She was housed in mid-2018 through the 50 Lives 50 Homes program and is well engaged with HHC through its GP clinics and the After-Hours service. [redacted] has an extensive mental and AOD history with numerous diagnoses on record, including: EUPD, PTSD, depression, anxiety, conduct disorder, amphetamine use disorder and alcohol use disorder, among others.

HODDS Support: Having a psychiatric registrar with dual diagnosis expertise embedded in HHC via HODDS enabled a comprehensive review of [redacted] medications and crisis plan, and she was connected to the Assessment and Treatment Team at City East.

Hospital Utilisation: In the year before her first HODDS visit, [redacted] had numerous ED presentations and inpatient admissions (including multiple involuntary psychiatric admissions), equating to a cost of approximately $324,000 (average cost of ED presentations, inpatient bed days and psychiatric inpatient bed days of: $857,[16] $2,697[16] and $1,514,[17] respectively). While she still had multiple ED presentations and admissions in the year following support with HODDS, her hospital use reduced by about 40%, meaning in the year after HODDS support she had a $128,000 reduction in service use.

Unfortunately, this pilot dual diagnosis outreach service only had one year funding, and Homeless Healthcare has not been able to secure funding to continue it, despite frequent requests from the homelessness sector for it to resume. As noted by Dr Amanda Stafford, Clinical Lead of the RPH Homeless Team:

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

Prior to the HODDS pilot, HHC estimated that only around 15% of its patients with severe mental health illnesses were receiving any form of specialist mental health care, and this is compounded when people have dual diagnosis. In addition to specialist mental health care the HODDS team provided directly to patients during the pilot, having a psychiatrist working within HHC **helped to facilitate improved access for patients to specialist mental health care**.

3. Aboriginal Controlled Accommodation Options

A whole dedicated submission could have been prepared on Aboriginal homelessness across WA alone, however in the time permitting, we focus here on what we see to be a particular gap; the urgent need for more Aboriginal controlled housing (including housing stock and tenancy management). While the national rate of homelessness for Aboriginal and or Torres Strait Islander sits at 28%,[18] currently our street-present Aboriginal population is abysmal, sitting at 40% of Perth's street-present population.[19] While there are many factors contributing to the disproportionate rates of Aboriginal homelessness[20-22] the sense of "not belonging", shame and exclusion relating to mainstream housing policies are all contributing factors.

From our evaluation of the 50 Lives 50 Homes Housing First project, we know that on average Aboriginal people reported spending longer periods of time experiencing homelessness prior to completing the VI-SPDAT (11 months longer than Non-Aboriginal people), and that generally it was harder to access and sustain housing.[23] Specifically, our evaluation found that:[23]

- Fewer Aboriginal people were permanently housed compared to non-Aboriginal people (40% compared to 51%)
- Aboriginal people were less likely to sustain their home for one year compared to non-Aboriginal people (75% vs 83%)
- It took nearly two months longer to house an Aboriginal person supported by 50 Lives (186 days compared to 134 days).
- While it took approximately the same amount of time to complete someone's priority listing paperwork, it took ***nearly double the time for an Aboriginal person to be housed after being priority listed compared to a non-Aboriginal person*** (308 days compared to 170 days); this pattern was observed for both public and community housing.

We acknowledge that the State's Action Plan has a section on improving Aboriginal wellbeing, and within this some specific actions that mention the role of Aboriginal organisations in design and delivery (priority action 1.1, 1.3, 1.4), we argue strongly that this needs to go beyond simply having co-design input into accommodation and delivery of services. There needs in WA to be:

- A substantial increase in the capacity of ACCO's to become registered Community Housing Providers under the Regulatory Framework – it is currently cost prohibitive and complex to register for this.
- An increase in the quantity of housing stock managed by ACCOs – this is essential if we are to actually address Indigenous homelessness.
- Greater funding support for ACCOs to provide tenancy management, including Aboriginal employees to provide direct tenancy support to clients.

From our work in the homelessness space over the past six or so years, we have interviewed dozens and dozens of Aboriginal workers and services, and Aboriginal people and Elder's experiencing or at risk of homelessness. One thing comes up time and time again, the current policies and procedures are not culturally appropriate and go against many elements of Aboriginal culture:

> *"I can tell you without a doubt that our people live in over-crowded conditions because it goes against Aboriginal culture to turn away your family. What we have, we share. That is our cultural norm"*- **Noongar Cultural Framework, 2021**[24 p.16]

In our 50 Lives evaluation, feelings of judgement where often noted by Aboriginal people about when non-Aboriginal landlords came into their homes for property inspections.[23] Per recommendation 4 of the joint Shelter WA and WA Alliance submission to the Federal Parliamentary Inquiry on Homelessness "*services for Aboriginal and Torres Strait Islander people must be culturally informed and culturally led… This includes the provision of housing supply and services managed by Aboriginal Community Controlled Organisations."*[25]

Additionally, Shelter SA recommends mandatory cultural training for all property managers to ensure they understand cultural differences and how to challenge negative cultural stereotypes.[26]

> *"You have to be empathetic in a lot of cases, and you have to be able to make decisions that are not about a policy or document that says it can only be – you can't say if someone calls up "well my policy says this and because of this you have a strike and you're out" – its almost like the policies and procedures cause them to treat people as numbers and not as individuals and that's where we are a little bit different … the way the tenancies are managed are totally different… its more culturally appropriate*" **– Aboriginal Property Manager**

This does not mean re-inventing the wheel as there are some initiatives that are working well or could be adapted or scaled up. These include:

Housing Standards: One specific example of an organisation working differently to mainstream providers is Noongar Mia Mia, which developed their own Tenant Housing Standards. These Standards were developed by Noongar Mia Mia and approved by a council of 100 Elders through the ***Ngulluk Koolunga Ngulluk Koort (Our Children, Our Heart) Project***[27] and each tenant signs off on them before moving into their property. This helps to ensure that tenants are aware of their Elders' expectations of them and how they are to manage and behave in their home.

Housing First: To date, there have been few Indigenous-specific examples of Housing First Initiatives, with the only published examples coming from Canada and New Zealand.[28-30] Conventional Housing First approaches focus primarily on the individual or at best the family unit, whilst for Indigenous models there is more focus on kinship, culture and connection to community and land. In late 2021, Noongar Mia Mia released the Noongar Housing First Principles,[24] the first of its kind in Australia. This builds the framework for other Aboriginal nations across the country to develop their own culturally appropriate Principles in local language.

Type of housing stock: Family size and obligations and cultural considerations and preferences mean that the type of housing often assigned to Aboriginal people is inappropriate. There have been some good examples elsewhere however of housing designed specifically with and for Aboriginal people, and WA needs much more of this.

Other housing considerations: Our evaluation of the 50 Lives program found that Aboriginal people supported reported statistically significantly more health conditions than their non-Aboriginal counterparts.[9] Poor health outcomes may have implications for housing location and type (i.e. needing 24 hour support, or a ground floor home, close to transport), which can contribute to further delays to be housed. Additionally it may mean individuals require longer ongoing support to ensure treatment compliance and well-health.

4. Implications and Recommendations

The following implications and recommendations are not exhaustive but pick up on some of the issues raised above:

4.1 Improving Antenatal Care Access and Reducing Child Removals for Homeless Pregnant People

- **Prioritise accommodation for pregnant women and homeless mothers with newborns to reduce child removals**, as this relates both to the Department's dual priority areas of homelessness and child protection, and the Sustainable Health Review priority emphasis on 'the first 1,000 days'. One specific recommendation is **expanding or duplicating "Indi Place" operated by Indigo Junction in Midland.** To maximise engagement and minimise some of the barriers associated with vulnerable Aboriginal women accessing mainstream organisations, it is critical that an ACCO play a key role or lead the initiative. The Department of Communities has indicated support for this recommendation, noting that *"increased supported accommodation for pregnant women and homeless mothers will also help support the National Agreement on Closing the Gap initiative and may assist in addressing Target 12 of the National Agreement - reducing the number of Aboriginal children entering care and Target 13 - a reduction in violence and abuse against Aboriginal women and children".*
- **Fund antenatal outreach services and follow through support for pregnant women who are homeless.** This has been trialled informally by Homeless Healthcare, and the value has been recognised by KEMH maternal health social workers, but it needs dedicated funding.
- **Ensure lived experience input into any initiatives relating to pregnancy among homeless women.**

4.2 Supporting People with Dual Diagnosis

- **Increase the number of low-threshold accommodation options (i.e. where people do not need to be sober, abstinent or in treatment for mental health issues or AOD use)** or provide staffing/resourcing of facilities that currently exclude MH or AOD to have the capacity to support these clients as described in the MHC's A Safe Place Strategy.[31] This is acknowledged in the Action plan (in section 3.1) but there needs to be concrete metrics relating to the number of accommodation options available, demand for these, and level of unmet need.
- **Encourage Mental Health Commission to fund a continuation of Homeless Healthcare's HODDS Dual Diagnosis Outreach service for people experiencing homelessness.** This was shown to be effective and was embraced by homeless sector as addressing a critical gap but only had funding for a one year pilot.
- **Support a more flexible service for AOD detox that is linked to discharge accommodation and GP support.** For example enabling Bridge House to have a nurse onsite to deal with withdrawal and a GP on call is one option.
- **Establish regional detox facilities** to provide local options for people outside of Perth, including a regional **detox service for young people** (similar to DAYS model) that enable people with mental health issues to access AOD support.

4.3 ACCO Accommodation Options

- **Increase the capacity of ACCO's to become registered Community Housing Providers** under the Regulatory Framework, and **directly manage housing stock, or transfer Department housing stock Aboriginal Housing Providers** to manage to ensure that culturally appropriate tenancy support is provided

- **Department of Communities to consider implementing Noongar Mia Mia/*Ngulluk Koolunga Ngulluk Koort* housing standards into Aboriginal tenancy management**
- **Implement compulsory cultural training of Housing Officers** and provide regular upskilling and training opportunities for improving cultural competency of workers.
- **Increase the number of Aboriginal Housing Officers working for the Department.**
- **Support other Aboriginal communities/nations to develop local Housing First principles that are locally specific and in language**, building on the Noongar Housing First principles by Noongar Mia Mia.

5. Submission Conclusion

We encourage this Inquiry to give due consideration to this submission and the issues raised as well as the recommendations made and importantly, the implications of no actions being taken.

We would welcome the opportunity to discuss this further with the Inquiry Committee, or to provide any other additional information or evidence you require.

Submission prepared by:

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