



Government of **Western Australia**
Department of **Health**

Homelessness – No fixed address –
Can we still deliver care?

Clinical Senate Meeting

Final Report

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Introduction

The role of the Clinical Senate of Western Australia (WA) is to provide a forum where collective clinical knowledge is used to debate strategic health issues. Recommendations are made in the best interest of the health of all Western Australians and are subsequently provided to the Director General (DG), the Health Service Boards (HSBs) and through the DG to the Minister for Health.

The final meeting of the Clinical Senate of Western Australia for 2016 was held on 11 November at the University Club of WA.

The topic for debate was “Homelessness – No fixed address – Can we still delivery care?”

According to Homelessness Australia, and based on data from the Australian Bureau of Statistics and the Australian Institute of Health and Welfare Specialist Homelessness Services (AIHW SHS)¹ 2012-13, there were 9,595 people experiencing homelessness in Western Australia. This equated to 42.8 per 10,000 people in WA, compared to the national average of 48.9. The WA population consisted of 5,356 males and 4,326 females, of which 2,045 men and 2,107 women sought specialist homeless services. The main reasons for homelessness include domestic violence, relationship issues, financial difficulties and accommodation issues. More recent data suggests that on any given night up to 13,000 people are homeless in WA.

The growing number of homeless people in Western Australia and current changes across the WA health system and services proved a timely opportunity to address this important issue.

The focus for debate was to consider the clinical interface and disconnect of care associated with our homeless population. Senators discussed the economic and health impact of homelessness and developed recommendations designed to improve co-ordination of healthcare within WA Health facilities and community health services for people with no fixed address.

The sponsor for the debate was Professor Gary Geelhoed, Assistant Director General, Clinical Services and Research, Chief Medical Officer.

A broad range of multiagency, cross jurisdictional experts with knowledge of health economics, research, housing, social and community services attended the Senate debate. Several community organisations were represented as well as Aboriginal Medical Services, WA Police, Department of Corrective Services and Housing and the Mental Health Commission.

Professor Julie Quinlivan, Chair of the Clinical Senate opened the debate by calling on senators to consider how to ensure access to, and co-ordinated care for, people of no fixed address. She offered the following definition of homelessness:

Homelessness includes people who are sleeping rough, as well as people staying in temporary, unstable or substandard accommodation.

She emphasized that many people who are homeless cycle between homelessness and marginal housing. People are also staying in crisis accommodation for longer because they have nowhere else to go.

¹ Australian Bureau of Statistics, Census of Population and Housing: Estimating Homelessness, 2012 Australian Institute of Health and Welfare, Specialist Homelessness Services 2012-13, 2013. Homelessness Australia, Homelessness in Western Australia (2014) (accessed 10 November 2016)

http://www.homelessnessaustralia.org.au/images/publications/Infographics/WA - updated_Jan_2014.pdf

In setting the scene for debate, Professor Paul Flatau, Chair in Social Investment and Impact and Director of the Centre for Social Impact, The University of Western Australia and Professor Elizabeth Geelhoed, Professor in Health Economics, School of Population Health at The University of Western Australia, provided the social determinants and economic impact of homelessness.

Dr Michael Wright, Professor, Division of Health Sciences, Curtin University and Curtin University National Drug Research Institute offered a perspective on Aboriginal people and homelessness whilst Dr Amanda Stafford, Emergency Medicine Consultant at Royal Perth Hospital shared a WA Health initiative at Royal Perth Hospital (RPH) established set up specifically to address the health care needs of homeless people.

Ms Bernadette Harrison provided a courageous consumer perspective sharing her lived experience.

Eight poster presentations from academics, clinicians and community organisations showcased programs and research in the delivery of healthcare to people with no fixed address.

1. Process

The Clinical Senate in Western Australia was established in 2003. Debates follow an agreed standard. The process ensures senators have a clear understanding of process and receive sufficient information to discuss the topic and develop recommendations for the Director General of Health (DG) as System Manager and Health Service Boards (HSBs) as operational managers (Appendix 1).

Prior to the debate, attendees received pre-reading/viewing containing information in preparation for the debate. Speakers and additional expert witnesses provided additional information on the day (Appendix 2).

The full day Senate debate traditionally commences with a Welcome to Country, which for this debate was offered by Mr Brett Collard, Yelakitj Moort Nyungar Association Inc.

Clinical Senate Chair, Professor Julie Quinlivan welcomed attendees and provided an update on senate activities. She introduced the topic for debate calling on senators and other experts in the room to consider how best we can ensure access to, and coordinated care for, people of no fixed address. The aim she stated is to develop policy recommendations designed to improve access to care and co-ordination of care within and between WA Health facilities and community services.

She provided the following definition of homelessness:

Homelessness includes people who are sleeping rough, as well as people staying in temporary, unstable or substandard accommodation.

Many people who are homeless cycle between homelessness and marginal housing.

People are staying in crisis accommodation for longer because they have nowhere else to go.

Professor Quinlivan stated that homelessness has many drivers and causes, including the shortage of affordable housing, long term unemployment, mental health issues, substance abuse and family and relationship breakdown. Among women, domestic and family violence is the main reason for seeking help from specialist homelessness services.

Dr Russell-Weisz acknowledged the work by two groups honoured at the recent 2016 WA Health Excellence Awards. He stated that the Homeless Health Project was a finalist in the category of Overcoming Inequities and Ngatti House won the award for Improving Service Delivery.

The Director General also reported on the recommendations from the previous debate on Clinician Engagement. He noted the opportunity and importance of the debate in bringing together the System Manager and HSBs in order to consider and ensure clinician engagement.

He advised senators that he would be working closely with the HSBs and Chief Executives to ensure implementation of their recommendations.

The next stage of the Clinical Senate process for this debate was a series of presentations to set the scene for debate, offer an aboriginal perspective and showcase a local initiative impacting treatment and care for homeless people.

A series of poster presentations showcased programs and research in delivering healthcare to people with no fixed address.

The plenary session was opened with a talk by Ms Bernadette Harrison who shared her lived experience. This was followed by plenary discussion and debate on the barriers and solutions for improving care for people with no fixed address.

The afternoon workshops were focussed on developing recommendations:

1. to improve access to health services for people with no fixed address
2. to ensure coordinated, continued care for homeless people once they have left our hospitals.

Recommendations from the workshops were presented in the final session of the day and ranked in order of importance by the Senate. The Clinical Senate Executive issued a request for a response by the Director General of Health to each recommendation at the next debate.

Responses could be:

- a) endorsed,
- b) endorsed in principle,
- c) not endorsed, or
- d) refer to health service boards.

2. Presentations

Adjunct Associate Professor Kim Gibson, facilitator for the day, opened proceedings by welcoming participants, acknowledging the traditional owners both past and present, and introducing Mr Brett Collard who offered the Welcome to Country.

Mr Brett Collard opened the session and offered a Welcome to Country. He shared that homeless is not just homelessness and people don't always consider the other issues. People who are homeless experience depression, thoughts of suicide, mental health issues and suffer ill health. They are separated from family, partners, siblings and others and often feel as if no one loves them which is hard to comprehend when you are on your own. Often, the doors shut when you are on your own – but many believe they created it themselves. He called on senators to consider that the best option is not always right but the right option is best.

Professor Julie Quinlivan followed and opened the debate firstly, by providing an update on Clinical Senate activity since the last meeting. She reported on:

- (1) New Terms of Reference including the establishment of the Clinical Senate Alumni
- (2) Clinical Senate publications
- (3) Survey for hot topics for 2017
- (4) Clinical Senate's role in the Victorian quality and safety review.

Prof Quinlivan reported that the new Terms of Reference (TOR) had been adopted and encouraged senators to review them in order to understand the structure of the Clinical Senate going forward as well as how the recommendations would be progressed to the Director General (DG) for system issues and the Health Service Boards (HSBs) for operational issues. Secondly, she stated as per 7.2 of the TOR and our Change Day pledge for 2016, the executive would be establishing a Clinical Senate Alumni which would help to strengthen the Senate's engagement networks.

With regard to the second item, she reported on two articles arising from work conducted by the Clinical Senate executive had been published. The manuscripts relate to the Senate survey on clinical engagement and on the Clinical Senate as a model to achieve policy input from clinicians.

The publications are as follows:

Quinlivan Julie A., Miller Mary, Hutton Marani (2016) Can a clinical senate enhance state-wide clinician engagement? A survey study. Australian Health Review Available at: <http://www.publish.csiro.au/ah/AH16110>

Quinlivan JA, Basile T, Gibson K, Xu D, Crocker N (2016) The Western Australian Clinical Senate as a Model for State-Wide Clinical Engagement. Health Care: Current Reviews 4: 172. Available at: https://www.researchgate.net/publication/310453164_The_Western_Australian_Clinical_Senate_as_a_Model_for_State-Wide_Clinical_Engagement

Prof Quinlivan reported on the survey for hot topics advising that in order to prioritise Senate debate topics for 2017 a survey had been sent to senators, Board members and senior staff in WA Health. The results of the survey would inform topic selection for 2017.

Finally, Professor Quinlivan advised that following input by the Clinical Senate executive into the Victorian Quality and Safety Review, a recommendation was made to implement a clinical senate-like structure in Victoria.

In turning her attention to the topic for debate Professor Quinlivan called on participants to consider how to ensure access to, and coordinated care for, people of no fixed address. Our

aim is to develop policy recommendations designed to improve access to care and co-ordination of care within and between WA Health facilities and community services.

She provided the following definition of homelessness:

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Professor Quinlivan stated that homelessness has many drivers and causes, including the shortage of affordable housing, long term unemployment, mental health issues, substance abuse and family and relationship breakdown. Among women, domestic and family violence is the main reason for seeking help from Specialist Homelessness Services (SHS).

Professor Quinlivan shared two personal stories of her interactions with homelessness as a both clinician and tribunal member. In Mary's story, participants learned of why a homeless patient failed to attend surgery to treat a high-grade precancerous lesion on the cervix. Given the choice of missing surgery or leaving her trolley containing lifelong possessions unguarded, Mary chose her trolley.

In Mike's story, we heard of a 56 year old schizophrenic who lived with and was cared for by his mother until she died of a stroke. His mental health deteriorated and he was referred for psychiatric review. Mike was triaged to attend health services based on his postcode. However, by the time he presented had been evicted from his home and was living on a friend's couch in another suburb. This meant he no longer fell into the postcodes of health service 1 and his care was redirected to health service 2. By the time he received an appointment he had been kicked out of the friend's home and was living in a homeless shelter, but unfortunately this was in a suburb in yet another health service. When Mike eventually saw a psychiatrist, he had assaulted another resident at the shelter and was facing court. Upon review by the tribunal all three health services advised that Mike was not a current patient of their service. Mike's story challenges us to consider if the system let Mike down and how to handle referrals from the central referral service when people are transient.

Prof Quinlivan called on participants to consider how best we can ensure homeless Western Australians can access our health services, and how we can ensure they complete their care. She asked them to consider practical solutions that could be implemented by WA Health or HSBs.

She stated to further stimulate discussion and inform the debate there would be presentations by Professor Elizabeth Geelhoed and Professor Paul Flatau on the economics of homelessness and Dr Michael Wright would provide a perspective on aboriginal people and homelessness. Dr Amanda Stafford would then provide insight into a current WA Health initiative at Royal Perth Hospital targeted at homelessness.

Professor Quinlivan advised during an extended morning tea eight presenters would offer rapid fire poster presentations from people across our health services, universities and other organisations to showcase current research or programs on homelessness.

She informed the plenary session would be opened by Ms Bernadette Harrison who would share her journey through homelessness. This would be followed by a free flowing debate allowing for clinicians and a broad range of experts to debate the key issues. Experts were invited to inform the session.

Prof Quinlivan welcomed senators and member representatives and formally reminded participants of how the Clinical Senate of WA operates stating we seek to:

- work collaboratively, setting aside individual and organisational agenda.
- state your opinions freely, drawing on your clinical experience and expertise.
- empower you to influence others in all your professional spheres with the new perspectives gained through the debate.
- play a leadership role in health reform, developing strong, valid, priority recommendations in the best interests of the health of all Western Australians.

Prof Quinlivan reported that the recommendations from the debate on Clinician Engagement had been presented to the Director General and Health Service Board Chairs. She thanked the Director General for sponsoring the debate and introduced him to officially open the meeting, report back on the recommendations from the previous debate and offer his thoughts on the topic.

The Director General thanked Brett Collard and acknowledged senators and invited guests including former Director General Kim Snowball and members of the HSBs.

In reporting back on the recommendations from the previous debate Dr Russell-Weisz stated that the debate on clinician engagement was timely and created an opportunity for the newly appointed Health Service Board Chairs, Chief Executives and Senators to consider clinician engagement into the future. He stated the debate provided the start of an important conversation between the System Manager, Health Service Providers and Boards, Health Service executives and clinicians. He reminded that senators were charged with the task of developing suggestions for each HSB for development of clinical engagement strategies. They also developed three recommendations for the System Manager on state-wide clinician engagement. The Director General reported that all three recommendations were endorsed. They reinforce the need for WA health to have the right strategies in place. He stated the debate promoted some terrific discussion around for example how we ensure our clinicians have access to the right learning tools at the right time, regardless of whether they work in a remote hospital in the State's north, or in one of our busy tertiary hospitals in the metro area.

Dr Russell-Weisz emphasised the need to further reflect on the progress of these recommendations during 2017 particularly given how the environment has changed post reform. WA Health is now one system. HSBs are more ready for the 'new world' than the Department. These need to be considered and addressed to ensure recommendations are being met in the Department. In order to facilitate this he announced an audit of the recommendations.

The full list of endorsed recommendations were as follows:

Recommendation 1:

Clinical Senate recommends that the System Manager develops (within 12months) a policy framework on clinician engagement that incorporates

- KPI (as part of Health Service Performance Reporting)
- Expectation that Area Health Boards will have a clinical engagement strategy (and report on that)

Elements of policy/framework:

- Measuring clinical engagement
- Share values across system
- Common principles
- Transparency
- Investment e.g. IHL programs (state-wide approach)

Recommendation 2:

Adopt a 'measurable KPI' (using an identical tool across all HSBs) for clinical engagement and put it into safety and quality outputs within HSB agreements and link the score to a performance bonus/penalty. Results (after an introduction phase of 1-2 years) must be transparent and published so all internal and external stakeholders can see and compare outcomes across WA Health.

Recommendation 3:

That the System Manager when considering or developing a direction or policy that has operational impacts, a broad range of clinicians from all Area Health Services are consulted, engaged and recorded.

Develop a clinician engagement framework with agreed outcomes for implementation by the Boards.

Dr Russell-Weisz next spoke on the topic of the day and commended the Clinical Senate for addressing the issue of homelessness. Dr Russell-Weisz shared a snapshot of homelessness in Western Australia. According to Homelessness Australia² 9,595 people are currently experiencing homelessness in WA.

Dr Russell-Weisz cited the Australian Government Australian Institute of Health and Welfare: Profile of Specialist Homeless Services (SHS) in Australia 2011-12 to 2014-15³ and reported on comparisons between 2011-2012 and 2014-15. A total of 441,992 clients (aged 15+) approached SHS agencies for assistance and that 6 in 10 (61%) were female; more than 1 in 2 (54%) were aged 15-34; 1 in 6 (16%) were Indigenous, and almost 2 in 3 (64%) were in major cities. with the highest need for help (64%) coming from those who lived in major cities. Accommodation provision was the highest need for all cohorts and in the case of rough sleepers 78% sought accommodation, yet only 62% received it.

Dr Russell-Weisz acknowledged the work of two groups who were honoured at the recent 2016 WA Health Excellence Awards. He stated that the Homeless Health Project was a finalist in the category of Overcoming Inequities and Ngatti House were winners of the award for Improving Service Delivery, this award was accepted by homeless people. Both groups were in attendance.

He identified the need for more research and awareness of the health care needs of the homeless populations. He emphasised the need to consider that the health care issues faced by homeless people are complex as is the challenge of delivering services. He asked senators to consider whether or not they are receiving appropriate care. Finally, how do ensure appropriate care post discharge and importantly, who is responsible?

Dr Russell-Weisz called on senators to consider practical solutions that both the system manager and health service providers could implement over time. He cautioned one size does

² Australian Bureau of Statistics, Census of Population and Housing: Estimating Homelessness, 2012 Australian Institute of Health and Welfare, Specialist Homelessness Services 2012-13, 2013. Homelessness Australia, Homelessness in Western Australia (2014) (accessed 10 November 2016).

http://www.homelessnessaustralia.org.au/images/publications/Infographics/WA_-_updated_Jan_2014.pdf

³ Australian Government. Australian Institute of Health and Welfare: Profile of Specialist Homeless Services (SHS) in Australia 2011-12 to 2014-15. (accessed 10 November 2016) <http://aihw.gov.au/homelessness/shsc/profiles-of-homeless-clients/>

not fit all and there is the need for strategies that can be adopted to each areas needs i.e. North metro, South metro etc. with consideration given to the different demographics/needs.

Adjunct Associate Professor Gibson thanked Dr David Russell-Weisz for his comprehensive response to the recommendations from the previous debate and for sharing his perspectives on homelessness. She then introduced the first speakers for the day, Professor Elizabeth Geelhoed, Health Economist, School of Population Health, UWA and Professor Paul Flatau, Centre for Social Impact, UWA to set the scene for debate through their presentation on the economics of homelessness. This was provided from both a social and public health perspective.

Prof Flatau began by defining the three 'cultural' definitions of homelessness according to Chamberlain & MacKenzie (1992):

Primary homelessness includes those who sleep roughly on the streets, under bridges, in parks, cars, deserted buildings or impoverished dwellings... secondary homelessness includes individuals in need of emergency or supported accommodation as well as those who live in, shelters/refuges, caravan parks or reside in the home of friends or family members ... and tertiary homelessness classifies individuals who dwell in boarding houses or hostels.

Those whose conditions have classified them as falling into the category of primary homelessness are often referred to as 'rough sleepers' because of their poor living conditions on the street. In addition, those who can be classified under the category of secondary homelessness are called 'couch surfers' because of their frequent nomadic living spaces.

Prof Flatau cited the Australian Homeless Census in 2011 which reported that 105,200 Australians were homeless in 2011, with 6% falling under the category of primary homelessness, 38% secondary homelessness and the other 56% tertiary homelessness.

He next shared the statistical definition of homelessness (ABS 2012 information paper) as when a person does not have suitable accommodation alternatives they are considered homeless if there current living arrangement:

- Is in a dwelling that is inadequate;
- Has not tenure, or if their initial tenure is short of not extendable;
- Does not allow them to have control of, and access to space for social relations.

He emphasised the point that those in overcrowded dwellings are defined as homeless in the ABS definition but not in the cultural definition. Prof Flatau stated there is also a disconnect between the definition of homelessness and hospital definition of 'no fixed address'.

Homelessness can be episodic, first entry and chronic and there are strong links between chronic homelessness and poor health outcomes.

In adapting Nooe, Patterson & Whitaker's (2010) ecological model of homelessness he demonstrated that the two biopsychological risk factors of homelessness individual and structural circumstances can impact on one's health and wellbeing. These authors determined that homelessness can be episodic in nature and that there are strong links between chronic (long term) homelessness, health outcomes and health costs.

Prof Flatau demonstrated the influences and impact on intergenerational homelessness and the strong prevalence within Indigenous populations. He shared the many drivers for intergenerational homelessness. In comparing indigenous and non-indigenous factors he concluded: for indigenous populations, 49% of the sample group presented a time when the father was homeless on at least one occasion compared to 22.8% of the sample presented for the same criteria for non-indigenous populations. For the mother, the results displayed a 59.8% rate for indigenous families (mothers being homeless on at least one occasion) and a 33.6%

rate for the non-indigenous families. These results display a direct correlation in the sense that in instances where both parents were homeless on at least one occasion, 69% indigenous compared to 43% non-indigenous⁴.

Speaking specifically about homelessness for children and young people, Prof Flatau shared the following evidence: two thirds of young homeless have been in and out of home care; more than half (56%) of homeless youth had run away from home due to domestic violence between parents or guardians on at least one occasion. Of those who ran away for this reason the median age of their first experience leaving home was only 10. Furthermore, one in five (20%) homeless young women had attempted suicide in the past six months compared with one in ten (12%) young men. More than one in four (28%) young homeless women engaged in non-suicidal self injury behaviours compared with 17% of young men. Finally, just over half (55%) of homeless youth who had attempted suicide in the past six months had not received any counselling or professional support.

In a study of high school students from the Yarra Ranges, which Prof Flatau called 'normal suburbia' he demonstrated the high links with suicide attempts and homelessness particularly amongst young females with 20% attempting suicide in the past 6 months, equating to 1 in 4 females.

Prof Flatau provided strong evidence to support the health profile of the homeless population as one which involves frequent multiple conditions which may be diverse and complex. These include but are not limited to chronic physical illness, mental illness i.e. abuse, premature mortality and comorbidities. He stated each on their own could be addressed however, there is often delayed intervention, severe outcomes and frequently multiple conditions compounded by a lack of access to services.

Prof Flatau reported each problem is well documented with 'easy treatment' however as these populations do not fit the typical health profile leading to difficulties to address with traditional models of care. They are frequent users of emergency departments (ED), have a greater likelihood of needing intensive care, experience longer stays in hospital resulting in greater healthcare costs. Therefore there is the need for an individual approach tailored to the needs of the homeless person. WA Health must modify 'traditional' episodic care and shift to a collaborative approach towards continued care that included primary care and outreach. He stated there is opportunity for high cost saving for health systems to improve interventions through the creation of efficient models of care for these populations.

The significance of data linkage was evidenced when reporting on the impact of the National Partnerships Agreement on Homelessness (NPAH) programs on health costs. Prof Flatau outlined the significant cost saving to government associated with reduced health service use. He reported: Reductions in health service use after entering a public housing tenancy (for the 3383 people in the study) was calculated as \$16,394,449 in one year or \$4,846 per person per year. Costs on average \$6462 per person/year to provide support via NPAH program, For NPAH clients' health system cost savings were \$13,273 per person/year and for NPAH clients

⁴ Flatau, P., Conroy, E., Spooner, C., Eardley, T. and Forbes, C. (2013) Lifetime and intergenerational experiences of homelessness in Australia, AHURI Final Report No. 200, Australian Housing and Urban Research Institute Limited, Melbourne.

receiving support upon exiting a mental health unit the cost savings equalled \$84,135 per person/year. Therefore, the greatest health savings when housing is coupled with support.

Professor Elizabeth Geelhoed spoke of the economic challenges in the area of homelessness. She stated we should spend money in areas where we can make the most difference and it is quite possible to achieve much better outcomes. She stated in considering this it was important to drill down into the health issues.

Prof Elizabeth Geelhoed reported on work undertaken in the United Kingdom on the causes of death and mortality rates for the general population versus the homeless population⁵. The mean age of death for the general population (males) was 74 compared to 48 for homeless men. The mean age of death for general population (females) was 80 compared to 43 for homeless women.

She spoke of the need for an individual approach and reflected on a recent talk by Dr James J O'Connell from the Boston Homeless Program where he shared that of the homeless aged 30-45 in their area, only half would be alive one year on. He conveyed that part of his training/induction was to wash the feet of the homeless before taking up his position. This highlighted the importance and impact of training on healthcare professionals and the important aspect of providing compassionate care.

Professor Elizabeth Geelhoed identified the strong need for evidence-based health interventions that include integrated care from a multidisciplinary healthcare team with an outreach focus, and involvement of local and state agencies led by primary care physicians. Components of the ideal model should include: primary care, outreach and the capacity to deal with psychosocial issues. All of this she stated should be done within the context of stable housing. There is also a need to address episodic care, limited access and inadequate treatment capability, particularly in terms of psychosocial demands.

Prof Elizabeth Geelhoed cited health economic data from the NHS which indicates that homeless individuals were 5 times more likely to visit emergency departments, 4-8 times more likely to be hospitalised and the total hospital cost 4 times more than the non-homeless patient. There is also a need to systematically collect and monitor data for this group in order to estimate cost effectiveness of interventions and address high rates of potentially preventable hospitalisations as these are indicators for system failure and reflect unacceptable inequity. There is opportunity to deliver savings in the hospital sector.

She described economic evaluation that measures both costs and health outcomes to assess the net cost of delivering improvements in health. Quality Adjusted Life Years (QALY) is typically the metric for policy in the health sector. Homelessness spans into additional sectors, particularly housing and is a key component of evidence based care and recognised as necessary for sustainability of health outcomes. This has imperative implications not only for estimation of cost-effectiveness of health interventions, but also for coordination of health services.

Prof Elizabeth Geelhoed spoke of the costs of homelessness in relation to 'lived history'. To consider this we look at mental health and wellbeing, physical health, substance use, social isolation, education, employment and the potential effect on mainstream health and corrective services, child protection, loss of output, taxes and welfare payments. She highlighted the real costs which are separated into personal and social and economic categories. Personal and

⁵ Thomas, B. (2011). Homelessness: A silent killer. A research briefing on mortality amongst homeless people, Report commissioned by Crisis.

social costs include educational and employment outcomes, poor physical health, the impact on mental health and wellbeing, substance abuse issues, crime and justice consequences, problems with social connectivity, and alienation, boredom and effects on social relationships. The real economic costs are related to mainstream service and system costs, higher income support payments and lower taxes and long term impacts such as productivity, workforce and economic growth.

In closing, Prof Elizabeth Geelhoed reiterated the need to consider in broad context complex care and the need to incorporate this into cost effectiveness.

Dr Michael Wright, Professor, Division of Health Sciences, Curtin University and Curtin University National Drug Research Institute spoke next presenting on Aboriginal people and homelessness. His presentation included a definition of homelessness, current strategies for addressing Aboriginal homelessness, negative perceptions, and a profile of homelessness for Aboriginal people and principles for working with Aboriginal Elders.

Dr Wright stated that leaders in the healthcare sector must address social policies and structural factors that result in Aboriginal homelessness. This requires directly working with Aboriginal Elders to bring people together and work collaboratively to address the lack of trust by aboriginal people of the healthcare system. He called for a holistic approach.

Citing data from Homelessness Australia Dr Wright reported there are currently 105,237 people in Australia who are homeless and 25% (or 26,744) are Aboriginal and Torres Strait Islander Australians. In WA there are currently 9,595 people who are homeless⁶. The likely reasons for homelessness are: racism/discrimination in relation to access to housing be it private or public-unwilling to rent to Aboriginal people. Aboriginal women experience family violence and are 35 times more likely to become homeless; and there is a lack of cultural education leading to poorly designed housing that is unable to accommodate extended families. Dr Wright stated there is a lack of understanding of how aboriginal people live-kin based societies. Housing for aboriginals is made up of generations living together and poorly designed public housing leads to overcrowding. Other contributing factors include poverty, mental health, substance abuse and economic barriers in relation to cost. Policies enable homelessness to happen due to this lack of understanding.

Dr Wright spoke of homelessness and discrimination and the negative perceptions impacting policy. He cited several studies to support this and that indicate: the public and media portrayal of homelessness people as unemployed, beggars and drunks (Memmott); the most visible Indigenous 'homeless' people are small groups who live in public places, socialising, sheltering, drinking, arguing and fighting in public: and in the instance of a homeless woman refusing support (Hopper (2007) in which Hopper calls 'not justice at last-but injustice, consistently applied'.

Offering a profile of Aboriginal homelessness Dr Wright shared information from two separate studies.

The study by Memmott et al (2003)⁷ defined three different categories that define Aboriginal homelessness:

⁶ Homelessness Australia

<http://www.homelessnessaustralia.org.au/index.php/about-homelessness/homeless-statistics>
(accessed 10 November 2016)

⁷ Memmott, P., Long, S., Chambers, C., Spring, F. (2003) Categories of Indigenous 'homeless' people and good practice responses to their needs, AHURI Final Report No. 49, Australian Housing and Urban Research Institute Limited, Melbourne.

Public place dwellers;
Those at risk of homelessness; and
Spiritual homeless people.

To be homeless in this latter context, means to be without country. This is a form of spiritual and psychological homelessness. Importantly, he states that many individuals and families who have been removed from their traditional countries and wider circle of family kin by government agencies.

In the second study by Barker J et al ⁸ concluded there has been little attention given to the plight of Aboriginal people who are homeless despite the disproportionate number who are homeless. The main themes from the study indicated the existence of relationships are central to any meaningful engagement between service users and workers; services should be tailored to the individual needs and when flexible, have less restrictive rules. Importantly, all of these and the need for them to not require disclosure of personal information was critical to engagement. Finally, greater consumer choice and control will more likely produce positive outcomes for clients.

He spoke of issues of compliance, homeless populations/mentally ill are often not compliant. The system is not flexible to accommodate the lack of compliance so these populations are excluded from long term care. Dr Wright stated the need to think beyond the physical definition of the presentation and explore the underlying issues that need to be addressed.

Dr Wright emphasised the need for true engagement which is reliant upon trusting relationships. In describing the key principles for engaging he quoted Canadian philosopher, Charles Taylor

“To treat me equally you will need to treat me differently”.

The key principles for working with Aboriginal people are: recognition of cultural protocols; establishing and building trust; co-production and inclusion; services must be flexible and responsive; investing and committing to capacity building of staff and implementing strategies to ensure sustainability.

For aboriginal people there is a spiritual connection to land, those in Perth for treatment- what are the options for accommodation ‘short term’ accommodation often results in homelessness ‘limbo’ between care i.e. sleeping in the park

He spoke of the skillset required to engage with the community as partners in order to develop solutions. Dr Wright stated that humility was the key and called on participants to give up “being the expert”. He asked them to be non-judgemental and open to the ideas of others. He quoted Harry S Truman “We can get an awful lot done if we don’t care who takes the credit”.

Dr Wright closed emphasising the need to set targets in order to address homelessness and monitor progress. He reiterated Aboriginal Elders are the portal to working with aboriginal people. Leaders in healthcare must address social policies and this requires directly working with Aboriginal Elders to bring people together and work collaboratively to address the lack of trust by Aboriginal people of the healthcare system.

Dr Amanda Stafford, Emergency Medicine Consultant, Clinical Lead, Royal Perth Hospital (RPH) Homeless Team provided insight into the RPH Program addressing the healthcare needs of homeless people.

⁸ Barker, J., Humphries, P., McArthur, M., & Thomson, L. (2012). Literature Review: Effective interventions for young people who are homeless or at risk of homelessness. Canberra: Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

She stated the program is based on the successful UK Pathway Program to provide specialist homeless General Practitioners (GPs) in hospital to meet and care for homeless people. At RPH it was in response to the many homeless people who frequently present to emergency department (ED). Dr Stafford stated the reason for the program is that hospitals provide acute care for injury and illness but do not deal with or fix the underlying causes for the homeless. In hospital she stated, we do not manage their chronic disease or do health promotion and there is the need for primary care and prevention.

The RPH Homeless Team along with Homeless Healthcare (HHC) work together to focus on the patients' real problem providing links to community services. This includes the exchange of information which is vital to their ongoing care. The nurses and GPs provide follow up appointments aiding in building trust. There is improved discharge planning and follow up; and they provide advocacy and support. At RPH there is a Clinical Lead working with the team and they round on homeless patients in the ED, observation ward and inpatients wards especially psychiatry.

Dr Stafford reported it includes the hospital, community services and Homeless Health GPs being equal partners and the community making the difference for homeless people.

In describing the hierarchy of needs for homeless populations she stated the first is survival/safety; second comfort-warmth and food; and the third is health. They require 24/7 access to care (safety) as they often sleep during the day and are awake at night. Dr Stafford stated the best healthcare for homeless people is housing.

Dr Stafford described that in Perth, the number of chronic high acuity street homeless is approximately 300; many are trimorbid having physical, mental health and alcohol and drug issues. She stated there are huge costs to healthcare, justice, welfare benefits and child protection. Using an example of 94 people from the Mobile Clinical Outreach Team (MCOT) – Street Homeless Psychiatric patients she stated there is an average of 47 days per year in hospital (90% psych). A simple bed cost is \$58,750 per person/per year. This cohort cost is \$5.5 million on 94 people = \$1130/week or \$4150 per month. Another example shared in a subgroup of schizophrenic patients >90 inpatient days per year – 14 patients had 177 bed days per year. The bed costs equal \$3.3 million with per patient costs \$236,250 per year /\$4500 per week or \$18,173 per month.

Dr Stafford challenged senators with these questions: Why are we wasting so much money? Why don't we just treat the problem? Finally, if we are doing the same thing every day how can we expect change?

Presentations from the day can be found on the Clinical Senate website:

<http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia/Clinical-Senate-debates-and-publications>

During the morning tea break participants heard from a number of presenters in a rapid fire session that showcased current research and programs related to homelessness and health care. Included was a range of programs and initiatives from across WA Health and the community. Many of these involve collaborative partnership programs and innovative approaches to working with, and for homeless people.

The poster presentations were as follows:

Poster presentations:

Development of a resource booklet for patients who present to Fiona Stanley Hospital who are experiencing or at risk of homelessness

Presented by: Ms Melissa Stirling, A/Senior Social Worker, ED FSH, Accommodation and support services – Fiona Stanley Hospital

Ngatti House

Presented by: Ms Polly McCann, Team Leader, YouthReach South, NMHS Youth Mental Health and Ms Natasha Campbell, Operations Manager, Life Without Barriers

YouthLink and YouthReach South provide specialist mental health services

Presented by: Ms Kerry Curtis, A/Co-Director, Consultant Clinical Psychologist, YouthLink, Youth Mental Health Services

An Evaluation of the St Patrick's Community Support Centre Health Clinic for the Homeless program

Presented by: Ms Traci Cascioli, Day Centre Manager, St Patrick's Community Support Centre and Adjunct Research Fellow Jacqueline Davis, Project Manager Health Systems & Health Economics, School of Public Health at Curtin University

Mental Health Assessment, Categorization, and Treatment - Innovating a Reduction in the Failure Rate of Homelessness Services

Presented by: Ms Beverley Wilson-Malcolm, General Manager, Homelessness Services, The Salvation Army (WA)

Audit of homeless people attending Sir Charles Gairdner Emergency department

Presented by: Ms Joanne Willox, Senior Social Worker, Sir Charles Gairdner Hospital

50 Lives 50 Homes

Presented by: Ms Ros Mulley, Executive Manager Operations, RUAH Community Services

Housing instability and exposure to domestic violence are risk factors for default from antenatal care

Presented by: Professor Julie Quinlivan, The University of Notre Dame Australia

The following additional posters were on display:

Street Connect, Anglicare WA

A street-based outreach program assisting homeless and at risk young people 15-25 years old in the Perth inner city area – Mr Esben Kaas-Sorensen, Street Connect Coordinator, AnglicareWA

Assessing the nature and magnitude of Health, Economics and Wellbeing Benefits of Homeless Healthcare (HHC) Services in Perth WA

Associate Professor Lisa Wood, School of Population Health, The University of Western Australia.

Following the morning break, Senators heard from a Consumer and engaged in a free flowing plenary debate.

3. Plenary debate

3.1 Caring for the homeless

- | | |
|--------------------|--|
| Facilitator | ➤ Adjunct Associate Professor Kim Gibson |
| Consumer presenter | ➤ Ms Bernadette Harrison |
| | ➤ Dr Aresh Anwar |
| | ➤ Dr Andrew Davies |
| | ➤ Ms Debra Zanella |
| | ➤ Ms Ros Mulley |
| | ➤ Mr Chris Twomey |
| | ➤ Superintendent Kim Massam |
| | ➤ Mr Paul Whyte |
| | ➤ Mr John Berger |
| Expert witnesses | ➤ Mr Todd Gogol |
| | ➤ Ms Sue Ash AO |
| | ➤ Ms Beverley Wilson-Malcolm |
| | ➤ Ms Adele Stewart |
| | ➤ Mr Esben Kaas-Sorensen |
| | ➤ Ms Adele Stewart |
| | ➤ Ms Clare Askew |
| | ➤ Dr Carmen Quadros |
| | ➤ Ms Traci Cascioli |
| | ➤ Mr Chris Hall |
| | ➤ Assoc Prof Lisa Wood |
| | ➤ Ms Trish Sullivan |
| | ➤ Mr David Axworthy |

Adjunct Associate Professor Gibson outlined the process for the session as one that would consist of a consumer presentation followed by free flowing discussion/debate.

The plenary session “Caring for the homeless” was opened with a presentation from Ms Bernadette Harrison who shared her lived experience.

In a brief introduction, Bernadette thanked the Clinical Senate for giving her the opportunity to share her story. “I have fought many battles over the years but one of the many struggles time and time again has been homelessness. Homelessness can be extremely debilitating for many people who do find themselves in this situation”.

Bernadette explained that she experienced homelessness for several years. She said:

I stand here today to tell you that these are some of the most heartbreaking and soul shattering days I faced – society treated me as rubbish. I was looked down on, treated cruelly and it was as if everyone thought I was a second class citizen, yet no one knew the horror I faced daily trying to find shelter. I was starving, my physical health was deteriorating, I was sick, scared and alone. Bernadette stated that it got to the point where she was so physically unwell that she presented to triage at Royal Perth Hospital (RPH). It all seemed to be going ok until a doctor found out she was homeless. She recalls: “He suddenly looked at me differently and his whole attitude changed. He spoke

down to me, I was so embarrassed and ashamed that I left without treatment". This was the first time it happened but sadly it was not the last.

They say doctors take an oath to do no harm- this doesn't just mean ensuring correct medical procedures and correct medical doses, it also the way you speak to a patient. Those words could have a negative impact that, in turn, may emotionally cause harm to a patient.

Bernadette recalled

"The longer I was homeless the more my physical and mental health deteriorated". I would do whatever it took to avoid the Emergency Department (ED). I started suffering physical health issues and was sent to hospital and the response I got was she is just a psych patient, give her some tablets and send her on her way. It was at that point I just wanted to scream I am person, my circumstances don't define me.

"Day after day I became more and more ashamed of my situation". This creates a perpetual problem for many homeless who face biases and prejudices. Sometimes it is easier to ignore the infection or illness than deal with the feelings of worthlessness – that illness or infection then becomes a bigger issue needing more time, more medical intervention and resources all due the stigma attached to 'getting help'.

This continued for years until I was fortunate enough to meet a doctor who took the time listen. I said to her "before you say anything, I do have mental health issues and struggle with homelessness." This doctor took the time look past this and after several tests discovered I was suffering from an autoimmune disease that required immediate treatment having taken several years to be diagnosed. I was grateful someone took the time to see beyond my circumstances and find the cause. All any person asks for is to be treated with dignity and respect.

I spent time in psychiatric care at RPH and I did find it quite difficult, I had no voice and it seemed no one wanted to listen. I was finally admitted to Perth Clinic where there was consistency and continuity of care. I had the same doctor who guided my treatment plan and there was consistency with the nursing staff. Consistency for me made all the difference, it helped quicken my recovery through ongoing therapy and support. Consistency meant I knew what was happening and why. My voice was heard, listened to and respected.

The results for Bernadette meant many amazing changes to her life. This included the team at Street Connect (Anglicare WA) where even after ageing out of the services she was still welcome. They assisted her by connecting her to a community team with access to Centrelink. They also introduced her to a social worker who in their very first meeting was able to start a process that connected her to a network of services and support.

She credited Dr Andrew Davies and the Homeless Healthcare Team (HHC) calling them her saving grace. HHC is the largest provider for homeless and marginalized people in WA. Their aim is to improve the health and wellbeing of people who are homeless by providing ongoing support to allow people to break the cycle of homelessness.

Finally, as part of addressing her long term needs she was introduced to a social worker for external support with housing from the staff at 50 lives 50 homes who worked hard to find her housing.

She said: "I finally had something to look forward to... then I got a call I had waited years for. I had been allocated a unit and to say I was over the moon is an understatement. I finally had hope, hope for a better future. I didn't have to spend each day just trying to survive. I could start to aim high and thrive. They made sure I was connected to the afterhours support service who would visit me in the evenings. We would prepare meals, do dishes, takes walks along the river

which might not seem very exciting but after years of not having this option I finally had some normality. I was able to share my hopes and dreams, it was all about celebrating victories big or small. I am now able to be myself without fear of judgement. On the days I might struggle, they become a life line reminding me I'm special, I matter and they remind me of my achievements and support me to reach my goals.

Bernadette stated the bigger difference for her is that she now has a big support team who communicate and advocate on her behalf and with her permission information is shared in order for her to receive the best care possible. She reminded clinicians that early intervention is the key and that collaborative care can make all the difference.

They say some people are just six weeks away from homelessness – they lose their job, go through all of their savings and they can't pay their rent and they are left with no other option than to live on the streets.

Homelessness can happen to anyone, circumstances change, and it is important to understand that someone who is homeless deserves the same dignity and respect.

Bernadette closed

"I stand here today proudly saying I am no longer homeless and supported by a great team. I hope that after hearing my story, you will have a better understanding and as a community you must all become one to combat this issue".

This was followed by a plenary session "Caring for the homeless" where senators were reminded of the focus for debate which was on the delivery of healthcare to homeless West Australians.

The facilitator identified that there are many multiagency issues therefore many experts had been invited to attend. She acknowledged and thanked them stating they come with expertise in economics and research, housing, community services, hospital staff, aboriginal health and research, WA Police and corrective services. She also advised that members from the Health Service Boards were interested observers for the debate.

Senators were encouraged to share their experience and to draw on the expertise. They worked to identify the barriers at the coal face with all participants working together in determining solutions. They considered the multifactorial issues impacting both the ability to deliver care to homeless people as well as what is required to ensure they have continued long term care.

Additional emerging areas of homelessness were identified and included: youth, forced marriage, veterans and the aged. They also considered partnerships within health to connect with community services and emphasised the importance of housing. New trends included: the changing economic environment; increased population with disabilities and aged care.

Senators highlighted difficulties in relation to the use of our definition for no fixed address and that used in the hospital. This issue makes it difficult for information to be made available for the person. This is an issue for clinicians at the coal face, we need to make more information available.

Senators raised some issues around: the lack of specific resources; limited Social Work services (Kimberly) and lack of specific resources required for highly complicated/complex cases. Also highlighted was the lack of consideration for the homeless population when closing the Fremantle Hospital. Transportation for this group is an issue and there is a big impact as they are not close to other services.

Key messages were:

- The hospital system strives to assign an address for homeless people.
- There are issues with postcodes both in registration and follow up care.
- Need for partnering and cross agency collaboration.
- Need for social and affordable housing.
- Culture and attitudes are important. There should be no moral judgement about people in deciding whether they have services or not.
- In the acute setting clinicians are challenged every day about the length of stay and it is very distressing to discharge a patient with no fixed address and know there is no ability to coordinate their care.
- Aboriginality – risk of spiritual homelessness when people move out of country.
- For Aboriginal people... in order to treat me equally you will need to treat me differently.
- Issues with youth and chronic conditions- accommodation providers often send back to hospital as it can't deal with these conditions.
- Information sharing to and from hospitals to provide collaboration and coordination of continued care.
- Primary care- communication strategies for GPs to make sure patients attend specialist appointments.
- There is heavy reliance on the not for profit sector.
- Need models that meet the future needs. How do we identify homeless people and what is the suite of care required.
- Specific concerns were raised for children and teenagers.
- There is no education on homelessness- there is the need to build on teaching the social determinants of health.
- Risk factors – must be identified by clinicians up front.

Key summary points:

- Anyone can be homeless at any time.
- We must respect all patients and treat them with dignity and respect.
- Cross jurisdictional/cross sector coordination is required and services must be linked up with healthcare professionals aware of what is available.
- Macro level leadership with cross-sectoral leadership is required. Requires inter government cooperation.
- Health has a culture that has biases towards homeless people and they are not always welcome in the clinical setting.
- There is the opportunity for WA Health to lead.
- WA Health must advocate for programs that work.
- There are many opportunities to utilize existing services and redirect them.

- Need for a comprehensive approach that addresses all the issues, health, social, emotional and physical needs.
- Need for coordination - use resources more wisely, better outcomes for society.
- The solutions don't rest with one organization or sector we need to challenge ourselves to integrate our thinking and share our resources.
- Homeless people tell us that there are significant barriers to accessing GPs unless we are able to go where homeless are and where they feel comfortable, then we cannot provide care.
- Many homeless people have previously been refused service. Our health system is not designed for people to have a relationship. Waiting lists are long- the sooner the appointment the less likely for DNAs.

There was a strong sentiment that in order to address the health needs of homeless people there must be housing and that health and community services must work together to provide long term wrap around services.

There was a call for a change of attitude from the people and the system. It is time to listen and not judge.

At the conclusion of the plenary session Ms Gibson confirmed a clear call to action on this important issue. She advised that the key themes emerging from the full morning session had been captured using mind map software and would inform senators in the afternoon workshops.

All participants then broke for lunch.

Following the lunch break Senators participated in concurrent workshops to consider: improving access to health services for people with no fixed address and; ensuring coordinated, continued care for homeless people once they have left our hospitals.

What follows are the working group notes and final senate recommendations.

4. Workshop One

4.1 Workshop 1 – Improving Access

Facilitator	Adjunct Associate Professor Kim Gibson
Executive Committee Member(s)	Ms Tanya Basile Ms Mary Miller Dr Jeanette Ward Ms Pip Brennan
Expert Witnesses	Dr Andrew Davies
Support	Ms Barbara O'Neill Ms Paula Camer-Pesci

Ms Gibson opened the workshop stating the focus as to consider strategies for people with no fixed address who need to enter health care services and remain within it for a period of time.

In the first part of the workshop groups worked to consider the eight key issues drawn from the morning session and identified additional issues. The facilitator led discussion around the key themes. Once determined senators self-selected to the group of their choice where they developed recommendations. All groups were allocated 2 themes each.

Participants worked in four groups with each group choosing two themes each to develop recommendations. The full list of themes was as follows:

- Leadership
- Postcodes
 - Central access point
 - Identification
- Policy
 - Design of facilities and services
- Approaches to clinical care
 - Workforce
 - Education
- Attitudes and culture
- Advocacy
- Consumer empowerment
- Evidence based best practice

A summary of the discussion from each group is provided below.

Group 1 – Themes: Consumer empowerment and Advocacy

Clinicians in group one discussed consumer engagement and empowerment through education. They identified some of the subgroups such as: youth, mental health, disability and aboriginal health. Senators discussed the tools required to assist consumers in navigating the system.

They proposed that health services partner with specialist homeless service to develop educational materials, approach and deliver methods to empower homeless people (and vulnerable to homelessness) in order to navigate the system.

Senators developed a recommendation aimed at reducing high costs related to prolonged length of stay admissions for homeless people. In order to address this they suggested the System Manager should determine the presenting diagnosis and proactively send specialist care into the community for services such as Dental and Podiatry.

Group 2- Themes: Evidence based practice and Leadership

Senators addressing evidence based practice called for the need to gather and analyse WA data to capture the health issues and needs of the WA homeless population. They agreed the need for specific models of care to improve their health and functional outcomes.

Also identified was best practice in terms of health and mental health with the call to identify leaders who will champion health outcomes for the homeless in each health service. These leaders should coordinate and lead policy and service development.

They identified the need for leadership on policy and recommended that both the Department of Health and the Mental Health Commission take a leadership role, addressing the health issues and social determinants across the homeless population of WA.

The final recommendation from this group highlighted the need for WA Health to adopt the principles outlined in the Boston Health Care for the homeless program that integrates self and health care. www.buchp.org

Groups 3 – Themes: Post codes and Policy

Clinicians addressed the issues related to post codes and policies.

They agreed the need to add an alert to referrals which identifies people who are homeless or at risk of being homeless. Critical to this was the need to: allow for referrals to choose appropriate facilities/ services for patients care outside of the Central Referral Service (CRS) postcode boundaries; one that notifies the patients GP of appointment details with patient referrals prioritised and that all homeless people be identified at triage.

In addressing policy senators discussed the design of both facilities and services. They recommended the System Manager sets a policy for all homeless people to have access to social work services prior to discharge and including after hours. They agreed telehealth where available should be used in rural/remote areas.

Group 4 – Themes: Workforce and Attitudes and culture

Clinicians discussed the importance of addressing attitudes and cultures including their own biases and prejudices. They identified the need for workforce preparedness and education.

They identified that health services must recognise the importance of “first point of contact” and vulnerable groups/people in the design of see and treat services.

The key recommendation called for the System Manager to invest in education packages related to the social determinants of health and linkages to homelessness. They agreed the

package must address four key areas that address: the relationship of mental health and its impact on homelessness; personal bias toward homeless people and how this can effect care; the knowledge to connect homeless people into community services and importantly, trauma informed care models.

A total of ten recommendations were developed by participants in workshop one with the top five taken to the final session.

5. Workshop Two

5.1 Workshop 2 – Coordinated, continued care

Facilitator	Ms Nerida Croker
Executive Committee Member(s)	Professor Julie Quinlivan Dr Jeanette Ward Ms Marani Hutton Ms Pip Brennan
Expert Witnesses	Dr Amanda Stafford
Support	Ms Kimberly Olson Ms Zoe Ashby-Deering

Ms Croker opened the workshop stating the workshop focus as to consider strategies for homeless people once they have left our system. Senators considered how to ensure coordinated, continued care from the hospital setting into the community for people with no fixed address.

In the first part of the workshop groups worked to consider the key issues firstly reviewing the Mindmap from the morning session and discussing other issues. The facilitator led discussion around the key themes with the full group. Senators then self-selected to a theme of their choice where they developed recommendations.

Participants worked in five groups with each group choosing either one or two themes each to develop recommendations. The full list of themes is listed here with the bolded themes progressed to the recommendation forming stage.

- **Policy**
- Education
- Access (outside in – integration with community) * parked for the other workshop
- **Homeless specific expertise**
- Service delivery – reduce the number of do not attends (DNA)
- **Discharge planning** – connecting to care: awareness of resources/services – coordinated care out into the community
- **Partnerships** – investment in approach; integrated
- **Stats collection** – data (capturing group, area health service)
- **Outcome measures**
- **Compassionate care**

A summary of the discussion from each group is provided below.

Group 1 – Themes: Discharge planning and Expertise

Clinicians considered key issues of community networks, after hours support, coordination of care and client centred care as related to discharge planning. They also discussed the expertise required to assist homeless people in gaining access to community services.

They determined a definition for at risk patients – those requiring immediate referral to social work/or referral as soon as practicable to in-patient support services via a Homeless Hub. This Hub would hold expertise of available community services including access to allied health, dental, podiatry etc. and importantly at full subsidy.

Their recommendation called for the System Manager to develop the concept of a Central Homeless Hub including a team of experts who would hold the knowledge, expertise and resources. They agreed this would assist in decreasing DNAs and repeat hospitalisations and increase community care planning.

Group 2- Themes: Policy and Partnerships

Senators developed recommendations that called for the Department of Health to take a leadership role in developing statewide homeless health policy. This requires consumer involvement and a focus on cross-sector engagement and referral pathways with agreed target to reduce homeless on an annual basis.

They also called for the Department of Health to take a lead in developing a goal of housing a certain number of people (300) within 18 months.

In addressing health economics and leadership their final recommendation (merged with another group) identified the need for WA Health to take a more active role in developing a social return on investment tool in integrated homelessness services via their membership on the Partnership Forum.

Groups 3 – Themes: Compassionate Care (Patient centred)

Senators highlighted the importance of compassionate care. They discussed the need to consider their own interaction both at point of presentation and duration of care.

They reviewed current models of care and agreed their needed to be a systemwide contemporary standard of care that included professional practice standards, code of ethics and code of conduct. The standard of care would also consider culturally safe care and safe practice, existing safety and quality frameworks and the patient experience/evaluation of care.

Group 4 – Themes: Outcomes – Stats & Data collection

Senators considered the use of data to inform the many agencies that are involved in caring for the homeless. Annual data must be provided to all HSBs and Chief Executives of Health Services.

WA Health must develop a standardised classification and definition of homelessness and this must be incorporated into the demographic information that is collected at all hospital presentations. It must also be included in the referral notices into hospitals from primary care. Where homelessness is identified it should be listed as a co-diagnosis in outpatient letters, discharge summaries and other clinical correspondence.

They discussed the need for admission criteria to code and identify homelessness. They agreed this should lead to a standardised classification within info-markers of a patient within WA Health. This should be identified by the primary referred or at point of presentation.

They agreed that where homelessness is identified it should be listed as a co-diagnosis in all hospital correspondence and discharge summaries.

They recommended that the clinical senate should ask the DG to inform the MfH on the need to establish a cross jurisdictional cabinet committee (health, education, child protection etc.) to coordinate initiatives to reduce homelessness and its sequelae of prison, high hospital admissions, sub-optimal school attendance and other social issues. Importantly, this should include strategies to ensure there is return on investment.

A specific recommendation was developed for HSBs to specifically include within their community engagement framework a process that ensures Aboriginal Elders within their catchment have input into service delivery and hospital culture.

Group 5 – Theme: Outcome measures

They determined there was a need to enhance existing datasets to collect and track homelessness. Agreed was the need for development of and information 'hub' for WA Health and Non- government/ Community services.

Clinicians recommended the need for agreed WA Health outcomes and a dashboard of status/improvements/services (i.e. refuge bed status).

A total of eleven recommendations were developed by participants in workshop two with the top five taken to the final session.

6. Final Session

In the final session senators reviewed each of the recommendations presented from all working groups. A total of ten recommendations were put forward for final voting with eight progressed after merging of some recommendations.

Like the many faces of homelessness there are also many issues. There is no solution, one size does not fit all, and the issues related to healthcare are often complex requiring multiagency collaboration, coordination and a long term plan.

Dealing with the health of homeless people involves much more, we must work to address their health issues and address the social determinants. There is a need for a collaborative comprehensive approach to homelessness. If we are truly interested in change then we must set targets to the change. We need this for homelessness and we owe it to the many homeless West Australians.

In conclusion, perhaps this quote shared by Dr Wright by the late US President Harry S Truman describes the key message from the day "It is amazing what you can accomplish if you do not care who gets the credit." WA Health must lead the change in this area and partner with their cross jurisdictional partners and the many community service organisations to ensure the homeless population of Western Australia receive better healthcare.

The Clinical Senate recommendations provide the opportunity for the Director General and System Manager to collaborate with Health Service Boards and their cross jurisdictional counterparts to ensure better healthcare for some of our most vulnerable citizens.

7. Clinical Senate Recommendations

Homelessness – No fixed address – Can we still deliver care?

Part A: For the attention of the System Manager

1. The Clinical Senate asks the Director General to brief the Minister for Health and seek his views as to whether or not he wishes a Cabinet submission to establish a cross jurisdictional Cabinet Committee (Department of Health, Department of Child Protection & Family Services, Department of Education, Department of Corrections, Mental Health Commission) to coordinate initiatives to reduce homelessness and its sequelae of prison, high hospital admissions, sub-optimal school attendance and other social issues.
2. That WA Health adopt a standardized definition of homelessness. This definition should be used when collecting information from Health Services. The definition should be incorporated into central referral notices from primary care and in discharge summaries to assist with data collection.
3. WA Health gather and analyse data on our homeless patients to inform the development of a WA Standard of Care (previously model of care) for homelessness that includes the elements of:
 - Education and Training
 - Professional practice standards
 - Code of ethics
 - Code of conduct
 - Culturally safe care
 - Culturally safe practices
 - Safety and quality frameworks
 - Patient experiences/evaluation of care

It is noted that EMHS (RPH) has a model and it should be examined and considered for adoption by other health services.

4. The System Manager add an alert to referrals which identifies people who are homeless or at risk of being homeless and:
 - Allows referral to choose appropriate facility or service for patients care outside of Central Referral Service post code boundaries
 - Notifies patients GP of appointment details
 - Patients referral to be prioritised
 - Homeless people to be identified at triage
5. That the System Manager determines the presenting diagnosis of the high cost or prolonged length of stay (LOS) admissions in homeless people and then considers pro-actively sending specialist care in these disciplines into the community to reduce admissions and LOS e.g. Dental/Podiatry.

Continued on next page

Part B: For the attention of the Health Service Boards

1. The Health Service Boards consider investing in staff education that evaluates the social determinants of health and the linkages to homelessness. The package could address:
 1. The relationship between mental health and homelessness
 2. Personal bias towards homeless people and how attitudes effect care
 3. The knowledge to connect homeless people into community services
 4. Trauma informed care models
2. That Health Service Boards consider how they will manage homeless patients within their catchment area. A Hub and Spoke process is recommended by the Clinical Senate, with a centralised source of expertise that peripheral facilities may access as required.
3. That Health Service Boards should specifically include within their community engagement framework a process that ensures Aboriginal Elders within their catchment have input into service delivery and hospital culture.

Appendix 1: Program

Homelessness No fixed address - Can we still deliver care?

Friday 11 November 2016
Banquet Hall
The University Club of Western Australia
Crawley, Western Australia

7.45am – 08.30am	Registration	Tea & coffee
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8:30am – 9:50am Presentations

Executive sponsor: Professor Gary Geelhoed, Chief Medical Officer; Assistant Director General
Clinical Services and Research, Department of Health

Facilitator: Adjunct Associate Professor Kim Gibson

8.30am	Welcome to Country	Mr Brett Collard
8.40am	Welcome and senate update	Professor Julie Quinlivan
8:50am	Director General's response to recommendations	Dr David Russell-Weisz
9.00am	The economics of homelessness	Professor Paul Flatau Professor Elizabeth Geelhoed
9:20am	Aboriginal homelessness	Dr Michael Wright
9:35am	WA Health initiatives- RPH model	Dr Amanda Stafford

9.50am – 10:10am	Morning tea	Banquet Hall Foyer
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10:10am – 10:30am Poster Presentations

10:30am – 12:00pm Plenary - Caring for the homeless

Introductory talk - A consumer perspective – Ms Bernadette Harrison

Additional Expert Witnesses: Dr Aresh Anwar, Dr Andrew Davies, Ms Debra Zanella, Ms Ros Mulley, Mr Chris Twomey, Superintendent Kim Massam, Mr Paul Whyte, Mr John Berger, Mr Todd Gogol, Ms Sue Ash AO, Ms Beverley Wilson-Malcolm, Ms Adele Stewart, Mr Esben Kaas-Sorensen, Ms Clare Askew, Ms Trish Baldwin, Dr Carmen Quadros, Ms Traci Cascioli, Mr Chris Hall, Assoc Prof Lisa Wood, Ms Trish Sullivan and Mr David Axworthy

12.00pm – 12:45pm	Lunch	Banquet Hall Foyer
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12.45pm – 2.15pm Workshops

Workshop 1 – Banquet Hall South Improving access

- Facilitator: Adj Assoc Prof Kim Gibson
- Expert: Dr Andrew Davies
- Executive Member: Ms Tanya Basile

Workshop 2 – Banquet Hall North Coordinated, continued care

- Facilitator: Ms Nerida Croker
 - Expert: Dr Amanda Stafford
 - Executive Member: Prof Julie Quinlivan
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2.15pm- 2.35pm	Afternoon tea	Banquet Hall Foyer
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2.35pm - 3.15pm Final session

2.35pm	Presentation and prioritisation of recommendations	Facilitators
3.00pm	Closing remarks	Professor Gary Geelhoed Ms Tanya Basile
3.15pm	Close	

Appendix 2: Presenters & Expert Witnesses

- Mr Brett Collard, Yelakitj Moort Nyungar Association Inc.
- Professor Julie Quinlivan, Chair, Clinical Senate of Western Australia
- Dr David Russell-Weisz, Director General, Department of Health Western Australia
- Professor Elizabeth Geelhoed, Professor in Health Economics, School of Population Health at The University of Western Australia
- Professor Paul Flatau, Chair in Social Investment and Impact and Director of the Centre for Social Impact, The University of Western Australia
- Dr Michael Wright, Professor, Division of Health Sciences, Curtin University and Curtin University National Drug Research Institute
- Dr Amanda Stafford, Emergency Medicine Consultant at Royal Perth Hospital
- Ms Bernadette Harrison, Consumer
- Dr Aresh Anwar, Executive Director, Royal Perth Bentley Group
- Dr Andrew Davies, General Practitioner, Homeless Healthcare
- Ms Debra Zanella, Chief Executive Officer, RUAH Community Services
- Ms Ros Mulley, Executive Manager Operations, RUAH Community Services
- Mr Chris Twomey, Director of Policy, Western Australian Council of Social Service (WACOSS)
- Superintendent Kim Massam, District Superintendent, Central Metropolitan Police District
- Mr Paul Whyte, Acting Director General, Department of Housing Western Australia
- Mr John Berger, Chief Executive Officer, St Bartholomew's House Inc
- Mr Todd Gogol, Director of Consumer Engagement, Royal Perth Group
- Ms Sue Ash AO, Chief Executive Officer, UnitingCare West
- Ms Beverley Wilson-Malcolm, General Manager, Homelessness Services, The Salvation Army Western Australia Division
- Ms Adele Stewart, Executive Manager of Homeless and Mental Health Services, St Vincent de Paul Society
- Mr Esben Kaas-Sorensen, Program Coordinator, Street Connect Program, Anglicare WA
- Ms Clare Askew, Registered Nurse, REACH Program, North Metropolitan TAFE
- Ms Trish Baldwin, Nurse Coordinator, Department of Health Central Referral Service
- Dr Carmen Quadros, General Practitioner, Freo Street Doctor Program
- Ms Traci Cascioli, Day Centre Manager, St Patrick's Community Support Centre
- Mr Chris Hall, Chief Executive Officer, MercyCare
- Associate Professor Lisa Wood, Senior Research Fellow, Centre for Social Impact, The University of Western Australia
- Ms Trish Sullivan, Acting Director Health, Department of Corrective Services, Western Australia
- Mr David Axworthy, Assistant Commissioner for Planning, Policy and Strategy, Mental Health Commission, Western Australia

Appendix 3: Poster Briefs and Presenters

Development of a resource booklet for patients who present to Fiona Stanley Hospital who are experiencing or at risk of homelessness

Presented by: Ms Melissa Stirling, A/Senior Social Worker, ED FSH, Accommodation and support services – Fiona Stanley Hospital

Ngatti House

Presented by: Ms Polly McCann, Team Leader, YouthReach South, NMHS Youth Mental Health and Ms Natasha Campbell, Operations Manager, Life Without Barriers

YouthLink and YouthReach South provide specialist mental health services

Presented by: Ms Kerry Curtis, A/Co-Director, Consultant Clinical Psychologist, YouthLink, Youth Mental Health Services

An Evaluation of the St Patrick's Community Support Centre Health Clinic for the Homeless program

Presented by: Ms Traci Cascioli, Day Centre Manager, St Patrick's Community Support Centre and Adjunct Research Fellow Jacqueline Davis, Project Manager Health Systems & Health Economics, School of Public Health at Curtin University

Mental Health Assessment, Categorization, and Treatment - Innovating a Reduction in the Failure Rate of Homelessness Services

Presented by: Ms Beverley Wilson-Malcolm, General Manager, Homelessness Services, The Salvation Army (WA)

Audit of homeless people attending Sir Charles Gairdner Emergency department

Presented by: Ms Joanne Willox, Senior Social Worker, Sir Charles Gairdner Hospital

50 Lives 50 Homes

Presented by: Ms Ros Mulley, Executive Manager Operations, RUAH Community Services

Housing instability and exposure to domestic violence are risk factors for default from antenatal care

Presented by: Professor Julie Quinlivan, The University of Notre Dame Australia

Additional posters on display

Street Connect - AnglicareWA

A street-based outreach program assisting homeless and at risk young people 15-25 years old in the Perth inner city area – Mr Esben Kaas-Sorensen, Street Connect Coordinator, AnglicareWA.

Assessing the Nature and Magnitude of Health, Economics and Wellbeing benefits of Homeless Healthcare (HHC) services in Peth, WA

Associate Professor Lisa Wood, School of Population Health, The University of Western Australia.

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