50 Lives 50 Homes

A Housing First Response to Ending Homelessness in Perth

Second Evaluation Report

September 2018

Shannen Vallesi, Nicholas Wood, Lisa Wood, Craig Cumming, Angela Gazey and Paul Flatau.

Centre for Social Impact, UWA Business School
School of Population and Global Healh, UWA

50 LIVES 50 HOMES
A campaign to house and support Perth's most vulnerable homeless people

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CENTRE for SOCIAL IMPACT

THE UNIVERSITY OF WESTERN AUSTRALIA

*"Basically the public treats you like s***. They turn around and say go get a job, go do this, and when there's nothing really that you can do since you're in that catch 22... you can't get a job...You have to try and get into accommodation where you can actually start your life back up... So it was a really big opportunity for me when I got offered 50 Lives, I took it all hands on deck which has proved to everyone that if you put me to the test, give me something really good to do, I will prove you all that I can do it. It just takes me a little bit longer than everyone else to understand it before I'm able to do it...I've shocked myself even with my mental problems... I've actually achieved a lot more than I've ever achieved [since being housed]."*

- 50 Lives Client

Photography by Tony McDonough.

50 Lives 50 Homes: A Housing First Response to Ending Homelessness. Second Evaluation Report.

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The After-Hours Support Service team is a unique feature of 50 Lives and we are privileged to have met some of the team and accompanied them to see their work in action.

50 Lives is a collective impact project with lead workers supporting clients from a range of organisations – the evaluation team is grateful to the support received from lead workers and 50 Lives partner organisations in our developing of case studies.

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Photos taken by Tony McDonough within this report are used with permission from Homeless Healthcare.

Finally and by no means least, we are very grateful to the homeless and formerly homeless clients engaged with 50 Lives 50 Homes; whose journeys, stories and changes this evaluation seeks to capture and honour.

Disclaimer

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ACRONYMS AND ABBREVIATIONS

50 Lives	50 Lives 50 Homes
ABS	Australian Bureau of Statistics
AHSS	After-Hours Support Service
AOD	Alcohol and other Drugs
BIU	Business Intelligence Unit
CBD	Central Business District
CRN	Centrelink Reference Number
CSI	Centre for Social Impact
CPFS	Department for Child Protection and Family Support
DCP	Department for Child Protection
DOB	Date of Birth
DSP	Disability Support Pension
ED	Emergency Department
EMHS	East Metropolitan Health Service
FAR	Further Assistance Review
FDV	Family and Domestic Violence
GP	General Practitioner
HHC	Homeless Healthcare
HoH	Head of Household
ICU	Intensive Care Unit
ID	Identification or Identity Document
IHPA	Independent Health Pricing Authority
JP	Justice of the Peace
MCOT	Mobile Clinical Outreach Team
NPAH	National Partnership on Homelessness
NAHA	National Affordable Housing Agreement
RPH	Royal Perth Hospital
S2H	Street to Home
SasH	Safe as Houses
SD	Standard Deviation
SHS	Specialist Homelessness Services
UK	United Kingdom
US	United States
UWA	University of Western Australia
VI-SPDAT	Vulnerability Index and Service Prioritisation Decision Assistance Tool
WA	Western Australia
WAAEH	Western Australia Alliance to End Homelessness

EXECUTIVE SUMMARY

Background

The 50 Lives 50 Homes project (hereafter referred to as 50 Lives) is a Housing First and collective impact response to ending homelessness in Perth, and the first of its kind in Western Australia. The 50 Lives project commenced in 2015 and takes a collaborative approach to house and provide support for Perth's most vulnerable people experiencing homelessness.

This second evaluation report describes the progress to date of the 50 Lives project in relation to housing and supporting vulnerable rough sleepers. Administrative hospital and police data has been used to look at preliminary changes in contacts with these sectors once clients are housed. This report draws on a wider range of data including interviews with clients, lead workers and After-Hours Support Service (AHSS) staff, hospital, police and AHSS data, research team observations and, data collected by 50 Lives from clients and partnering organisations. This report highlights both successes and challenges faced in this project to date and provides evidence to support future Housing First projects nationally and abroad.

Key Findings

After Hours Support Service

International and Australian evidence has shown that the risk of returning to homelessness, loss of tenancy and eviction are far higher amongst people who have been chronically homeless, if they are housed without additional support. Foundational to the 50 Lives project from the outset has been the commitment to provide wrap-around support, individualised to client need. Both empirical data and the recounted experiences of clients and staff attest to the significant difference made by the AHSS. The close working relationship between the AHSS, lead workers and Homeless Healthcare has enabled important continuity of care and quick responses to issues as they arise. The AHSS is able to unravel underlying issues that may arise once housed or may have contributed to homelessness in the first instance and provides assistance in clients' housing, health and psychosocial needs.

> *The AHSS has been my saviour… its not just the practical support, but how it helps with my mental health –* ***50 Lives Client***

In the 18 months between January 2017 and June 2018, the AHSS provided support to individuals over 7,800 times. The majority of these clients (75%) were housed in long-term accommodation. Over 70% of AHSS visits involved emotional or mental health support regardless of housing status, and over 60% of visits resulted in provision of self-care or physical health support as well.

Client Housing Outcomes

On average, **individual 50 Lives** clients had spent an average of 5.6 years homeless and **family clients** had spent an average of 2.8 years homeless prior to completing the VI-SPDAT. With some clients spending upwards of 20 years living rough sleeping or cycling in and out of homelessness.

As at June 30 2018, 147 people had been housed in 109 properties with an 88% retention rate. From June 2018 until time of publication at least an additional 10 people have been housed. The majority of people have been housed within 10km of Perth CBD enabling access to support and services, including the AHSS.

Between April – June 2018, approximately one client a week was housed. For the 12 individuals housed during this period, two-thirds were housed in less a year; considerably shorter than the 1,000 odd days one would spend on the public housing waitlist.

Client Health Outcomes

A unique strength of the 50 Lives evaluation is the access to longitudinal administrative hospital data that enables comparisons of hospital use before and after housing. The revolving door between homelessness and the health system is well documented, and demonstrating the potential to improve health and prevent hospital attendance is an important metric for the sustainability of 50 Lives as a 'whole of system' response to ending homelessness. In this evaluation report, health administrative data was available for 192 clients from four hospitals in the East Metropolitan catchment (Royal Perth Hospital, Bentley, Kalamunda and Armadale).

In the three years prior to joining the 50 Lives project, 192 clients had an aggregate of 1,606 ED presentations; an average of 2.8 per person per year. In this same period, these clients had an aggregate of 582 inpatient admissions totalling 2,408 days spent admitted as an inpatient. *Crude costs equate to almost $7.8 million in a three-year period prior to housing across these 192 clients alone*; or about $13,500 per person, per year.

Changes in ED Presentations Once Housed: For those who had been housed for at least six months (n=68), there was a 24% reduction in the number of people presenting to the ED and 39% reduction of total presentations when comparing the six months pre to six months post housing. For those who had been housed for at least 12 months (n=44), there was a reduction of 26% less people presenting to ED and 57% reduction of total ED presentation when comparing the 12 months pre to 12 months post housing.

Changes in Inpatient Admissions Once Housed: For those who had been housed for at least six months (n=68), there was a 28% reduction in the number of people admitted to an inpatient unit, a 46% reduction of total admissions and a 59% reduction in total days spent admitted when comparing the six months pre to six months post housing. For those who had been housed for at least 12 months (n=44), there was a reduction of 36% less people admitted to an inpatient unit, a 51% reduction of total admissions and a 53% reduction in total days spent admitted when comparing the 12 months pre to 12 months post housing.

Changes in Associated Health System Costs Once Housed: Crude costs associated with the observed changes in ED presentations and inpatient admissions have been calculated for those both housed for at least six months, and for at least 12 months. Overall, for people housed for at least six months there was a reduction of over $5,000 per person associated with the observed reductions in hospital use (comparing six months pre to six months post housing). From this preliminary data, it appears the longer someone is housed the more opportunity for greater reductions in health service usage, with individuals that were housed for 12 months or more having an average reduction of over $9,000 per person in the 12 months pre to 12 months post housing. The total estimated cost saving associated with reductions in hospital use for the 44 clients housed for 12 months or more was just over $400,000.

Client Justice Outcomes

The over-representation of people who are homeless in police, courts and prison statistics is well documented, and the 50 Lives evaluation is fortunate to have been granted approval to link longitudinal police data to other client outcomes. In data provided by WA Police at the end of August 2018, data was available for 89 housed 50 Lives clients; who collectively in the four years prior to housing committed over 400 offences (150 of which were in the year directly prior to housing).

Changes in Offending Once Housed: For those housed who had been housed for at least six months (n=67), there was a 45% reduction in offences committed, with large reductions seen in drug-related offences (80% reduction), fraud (83% reduction) and public order offences (100% reduction) when comparing the six months pre to six months post housing. For those who had been housed for at least 12 months (n=46), the largest reductions in offending were also in drug-related offences (53% reduction), weapons offences (80% reduction) and public order offences (100% reduction) when comparing the 12 months pre to 12 months post housing.

Changes in Victimisation Once Housed: It was initially hypothesised that the likelihood of being a victim of crime would decrease once housed, as the literature purports that many of the heightened risks of crime victimisation arise from the vulnerability of living on the street. In the analysis of police data however, some contradictory evidence emerged, and it is clear that the relationship between prior homelessness and being a victim of crime once housed is more complex and nuanced. What was surprising from the WA Police data, was the increase in number of offences against 50 Lives clients once they had been housed (i.e. increased likelihood of being a victim). After being housed for six months 50 Lives clients were 76% more likely to be a victim crime, and for those housed for 12 months their likelihood more than doubled (105% increase). Overall, of the 89-housed clients for whom police data was available for, 38% were victims of assault, and 56% were victims of stealing or robbery in the 12 months prior to being housed. Possible explanations for the observed initial increases in crime victimisation once housed will be investigated in the

next evaluation phase. In sum, this further highlights the vulnerability that still exists when people are housed, and the critical role of 50 Lives in supporting clients in this transitionary phase.

Conclusion

The 50 Lives project has made massive strides towards ending chronic homelessness in Perth, with the original target to house 50 of the most vulnerable homeless people in Perth met back in June 2017. Whilst housing people 'first' and as rapidly as possible is a key pillar of 50 Lives, this second evaluation report has highlighted the challenges of sustaining a tenancy after years of rough sleeping, and the coupling of housing with longer term and individually tailored wrap-around support has been critical to the success of 50 Lives to date.

There is no typical 50 Lives client (nor typical person who is homeless for that matter) and every trajectory into homelessness and journey out of homelessness is unique. Through interviews with clients and staff, and our observations of AHSS and working groups in action, it is clear that the commitment to client focused and individualised support is by no means rhetorical. The ability of 50 Lives (and its collaborating partners) to simultaneously work at the individual and organisational level whilst also engaging in advocacy and innovation at a strategic and systemic level is another unique feature of the project. The citing of 50 Lives and its Housing First response to homelessness in a range of public policy submissions over the last year is but one example of how it is contributing to reforms at the more macro level. At the client level, the identification of gaps and barriers to ending homelessness are also being elucidated as 50 Lives unfolds; leading to a number of innovative solutions trialled by 50 Lives and its partners to tackle challenges head on.

There is growing attention internationally and in Australia to the economic impact of homelessness, with accumulating evidence around reducing hospital and justice demands through targeted interventions. While, other evaluations of Housing First programs have cautioned against expecting dramatic changes in health, justice and other outcomes in the short term. Even with the relatively small number of people housed for at least six or 12 months, this report has already demonstrated some significant reductions in hospital use among those housed for six months or more, with an associated cost saving to the health system.

50 Lives from the outset sought to embed an action research approach, whereby ongoing learnings from the evaluation and project implementation are taken on board as they unfold. As the 50 Lives project continues to expand, there are a number of challenges surfaced by this evaluation that merit consideration and these have been outlined in the concluding chapter.

Long term and sustained funding for the project and the AHSS is needed, with recent UK evidence highlighting the risk of lapses back into homelessness within the first five years of housing, and the ongoing challenges pertaining to health, financial insecurity and social isolation. As reflected by one of the AHSS staff, it will take years for some clients to unravel the many issues that have led to them becoming homeless, and there will sadly always be some residual impact from the high levels of trauma and adverse life experiences faced by many 50 Lives clients. There is a need to bolster AHSS and lead worker capacity to take on new clients, whilst remaining available to support currently housed clients where required.

The *availability of suitable housing options* for the volume of rough sleepers in Perth continues to a key blockage to ending homelessness in WA, and particularly for 50 Lives as it seeks to house people rapidly and 'first'. Equally critical however is *the need for more lead workers* who can take on new clients.

Finally, the 2016 census has provided a sobering snapshot of homelessness across Western Australia, highlighting the imperative to explore ways of bringing the Housing First model to other parts of the State, into suburban areas of Perth with higher levels of homelessness, and in regional WA more broadly.

1. INTRODUCTION

"I've been homeless ever since I was 15... Before 50 Lives I didn't really think I'd be that lucky to get a house. I thought I'd be on the streets forever."

- 50 Lives Client

This report is the second of a series of three, evaluating the 50 Lives 50 Homes project (hereafter referred to as 50 Lives). The first evaluation report[1] provided a baseline picture of the homelessness history and vulnerability of 50 Lives clients and, outlined the collaborative nature and service delivery model of the project and the partners involved. Available data on the four main outcome domains (housing, risk of returning to homelessness, health and justice) was included in the first evaluation report as a comparative baseline for future reports.

This second report describes the progress to date of the 50 Lives project in relation to housing and supporting vulnerable rough sleepers. Administrative hospital and police data has been used in this report to look at preliminary changes in contacts with these sectors once clients are housed. This report draws on a wider range of data including interviews with clients, lead workers and After-Hours Support Service (AHSS) staff, hospital, police and AHSS data, research team observations and, data collected by 50 Lives from clients and partnering organisations.

1.1 Homelessness In Perth

Since the first 50 Lives evaluation report, more recent population data on the prevalence and needs of people experiencing homelessness in Western Australia (WA) has emerged. The release of the 2016 Census revealed a 4.6% rise in homelessness in Australia since 2011, with over 9,000 individuals in WA experiencing homelessness on census night.[2] WA has one of the highest rates of rough sleeping in the country, with 434 people indicating they were homeless on census night in the CBD.[3]

Whilst homelessness is more concentrated and visible in the Perth CBD, the 2016 Census data shows that people are experiencing homelessness all across the metropolitan area. The adjacent map shows the twenty suburbs in the Greater Perth Area with the highest numbers according to the 2016 Census (Figure 1). The City of Stirling was the Local Government Area with the highest number of people experiencing homelessness.

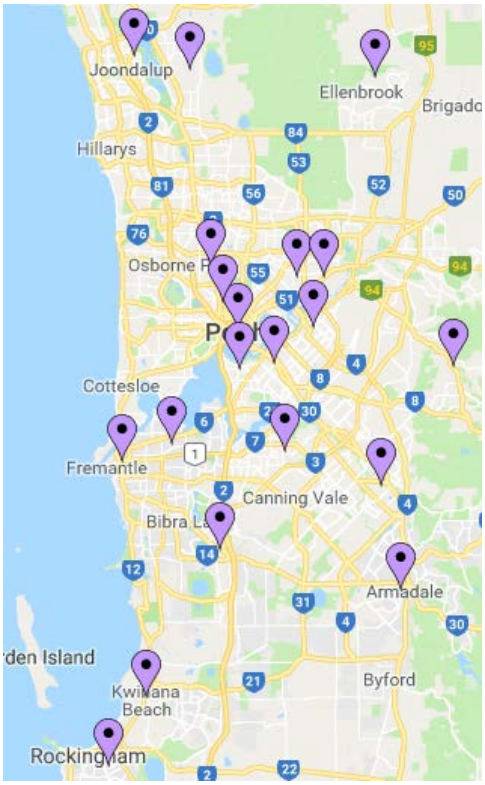

Figure 1: Perth Suburbs with Highest Number of People Experiencing Homelessness

The acute nature of homelessness in WA is also reflected in national Specialist Homelessness Services (SHS) data (2016-17), where around one third of the unmet requests for housing across Australia occurred in WA, and that the average length of support received was only 12 days, compared with 33 days in Australia.[3] This is consistent with increasing rental stress in WA over the last decade, with the proportion of people on lower incomes

paying more than 30% of their income of rent rising from 27% in 2007 to 47% in 2016.[4]

1.1.1 Increasing Awareness of Homelessness in Perth Since 50 Lives Began

Greater public, media and policy attention has also been drawn to homelessness in Perth over the last 12 months. In the media domain, this has ranged from media coverage generated by the release of the 2016 census statistics on homelessness; a run of news stories about a rise in complaints about homelessness in the Perth CBD; and a recurring focus in WA (and nationally) on housing unaffordability and the growing number of people at risk of homelessness as a result. Much of the discussion fails to recognise that homelessness in inner Perth (or Fremantle) represents a relatively small proportion of the overall homelessness problem in WA, the deep-seated structural drivers of homelessness and the many effective interventions developed in WA which have reduced homelessness below what it would otherwise be.[3] More positively, public discourse has also been generated also through media stories arising from the establishment of the WA Alliance to End Homelessness (WAAEH) in 2016 and the launch of the *Strategy to End Homelessness in WA* in April 2018.[5] The launch of the WAAEH Strategy also coincided with the release of a major report in Perth on the State of Homelessness in Australia's cities.[6]

In the public policy domain, 2018 has also seen the release of the City of Perth's *Homelessness Sector Review,* and most recently, the Department of Communities announcement of the development of a state-wide strategy to tackle homelessness in WA.[7] The latter reflects the recent requirement that all states and territories have a publically available homelessness strategy as a requirement of the new *'National Housing and Homelessness Agreement'* that came into effect July 2018 and replaced the former NPAH (National Partnership Agreement on Housing) and NAHA (National Affordable Housing Agreement).

Against this backdrop of heightening focus on homelessness in Perth, there has been further cementing of the critical and unique role of 50 Lives as a collective impact project housing and supporting Perth's most vulnerable rough sleepers.

Box 1: Aims of the 50 Lives Project

The 50 Lives project aims to:

1. Sustainably house and support very vulnerable homeless people using a Housing First Model
2. Use a collective impact model to harness existing supports and services
3. Evaluate the effectiveness and relevance of the Housing First Model in the Western Australian context to inform future funding decisions in homelessness in WA

1.2 50 Lives 50 Homes

The overall aim of 50 Lives is to house and provide support to Perth's most vulnerable homeless people, guided by Housing First principles. The three overarching aims of the project are depicted in Box 1. The core premise of the Housing First model is that the most pressing and primary need for people experiencing homelessness is to acquire and maintain stable housing (see Box 2).[5]

Box 2: Housing First Principles

Immediate access to housing with no readiness conditions

Consumer choice and self-determination

Recovery orientation

Individualised and person-driven supports

Social and community integration

The 50 Lives project is founded on a collective impact model, with 28 partner organisations from a range of sectors (i.e. homelessness services, housing agencies, health providers, and mental health and community services). Appendix 1 provides a list of current (April – June 2018) Lead Agencies. There are also a growing range of other organisations that are involved in supporting the project and its clients in a myriad of different ways (ranging from donated items for setting up home through to services that can provide counselling and legal advice to clients). This collaborative approach stems from the understanding that homelessness is a deeply set multi-factorial and multi-faceted issue.

In practice, the 50 Lives model endeavours to provide rapid access to housing for the most vulnerable individuals and provide the necessary supports to maintain their new tenancy and reduce the risks of returning to homelessness. The scope of assistance is broad, and includes:

Housing needs - support ranges from management of bills, rent and property standards, to the management of neighbours, visitors and other unforeseen issues.

Health needs – linking to primary care services (such as the Homeless Healthcare General Practice), and reminding people of- or taking them to appointments.

Social needs – working on goal setting, job searching, lifestyle changes, linking individuals to community groups and reunifying families.

1.3 50 Lives Relevance to Current WA Policy Priorities

From its inception, 50 Lives has sought to help build the evidence base for the effectiveness of its Housing First and collective impact approach, and to contribute more broadly to ending homelessness in Perth and WA. The raft of social, economic and political factors shaping homelessness are not static, and it is important to be able to anchor the ongoing relevance of 50 Lives against some of the broader policy reforms and directions in WA and nationally. Moreover, and encouragingly, there is increasing evidence of 50 Lives being referred to in a number of key strategic and policy initiatives.

1.3.1 Housing and Homelessness Policy Context

In April 2018, the *Western Australian Alliance to End Homelessness* launched their inaugural Strategy to End Homelessness.[5] The Alliance is spearheaded by Uniting Care West, Ruah Community Services, St Bartholomew's House, Foundation Housing Limited, Anglicare WA and UWA's Centre for Social Impact. A 10-year strategy to end homelessness in WA has been developed. The 50 Lives project is a novel and flagship endeavour for WA that is featured in the WAAEH strategy as a successful example of a collective impact Housing First response to homelessness in Perth. Indeed the WAAEH notes in that the principles of Housing First underpin its approach to chronic homelessness in the 10-year strategy.[5]

The *Homeless Sector Review* undertaken by the City of Perth in 2018 also made strong calls for a Housing First approach in its recommendations as to how the City can support the homeless sector in Perth. This review also noted that 50 Lives and its Housing First approach is a sound economic investment for government, with potential to reduce the burden born by the health system as a result of prolonged homelessness in WA.[8]

A number of peak bodies in the housing and homelessness sector have advocated for the merits of Housing First and the 50 Lives project in recent *Pre Budget submissions* to the WA Government. As articulated in the WA Council of Social Services submission:

> *The project [50 Lives] uses a model based around collaborative case management and housing allocation, collaborative working groups, a backbone support agency, and a dedicated after-hours support service that provides outreach workers and nurses, recognising that the issues people face do not fall neatly within a nine-to-five day. This kind of a model is essential to breaking the cycle of chronic homelessness, in which contact with police, prisons and hospitals so regularly form a part, and actually support people to improve their wellbeing and live the life that they want to live. By using a Housing First collective impact model, we can put an end to the experience of chronic homelessness in WA.*[9]

1.3.2 Health Policy Context

Health and homelessness are deeply intertwined, and there have been several key policy directions within the WA health sector that reinforce the merits of the 50 Lives approach and its impact to date. In June 2017, the WA Government announced the *Sustainable Health Review*, which commissioned a panel to advise the government on developing a more sustainable health system. The interim Sustainable Health Review Report[10] was released in February 2018 after over 300 public submissions and 19 forums across the state. The panel's findings included the need for more consumer focused models of care, improved integrated continuity of care and the imperative to reduce health inequalities experienced by vulnerable population groups.[10] Furthermore, the panel called for a more efficient use of resources by providing more care in the community, specifically exploring different models for reducing emergency department (ED)

admissions.[10] These recommendations align well with the community support model of healthcare provided to 50 Lives clients through the AHSS, and the significant reductions in hospital use observed among housed clients (described later in this report) provide a strong cost effectiveness argument to WA Health and government more broadly.

In late 2016, WA Health convened a *Clinical Senate Hearing* on homelessness and health, a high level forum that provides recommendations to the Director General of the Health Department and to the Minister for Health. A number of presentations to this hearing made reference to 50 Lives, and one of the 50 Lives clients shared her experiences in the plenary session.

1.4 Structure of this Report

Following on from this chapter, *Chapter 2* provides an overview of the methodology for the different elements of the evaluation and findings presented in this report. *Chapter 3* explores the collaborative nature of the 50 Lives project and provides examples of activities undertaken through the Working Group model and a brief overview of a number of micro-projects established as a result of the flexible nature of the 50 Lives model. Following in *Chapter 4*, data is presented on the types and patterns of support provided by AHSS once clients are housed. *Chapter 5* looks at client housing outcomes, including the types of support provided to clients to assist in sustaining tenancies. This is followed by *Chapter's 6 and 7* which provide a comprehensive overview of health service usage and justice use in the years prior to 50 Lives in provided. For those who had been housed for at least six and 12 months, preliminary changes comparing health service usage and justice contacts pre- and post- housing are also reported. Finally in *Chapter 8* we draw brief conclusions from the findings presented in this second evaluation report and discuss some of the challenges going forward.

2. METHODOLOGY

The 50 Lives project is multifaceted, and this has been mirrored in the evaluation process and the outcomes being tracked across three domains; clients, agency and partner organisations, and the wider homelessness sector. As described in the first evaluation report,[1] the evaluation methodology was designed in consultation with Ruah in response to the projects stated aims and program logic model.

The 50 Lives evaluation uses a mixed methods design, drawing on numerous sources of empirical and qualitative data. Quantitative data sources include the Vulnerability Index and Service Prioritisation Decision Assistance Tool (VI-SPDAT), administrative health data from WA Health Business Intelligence Unit data for most hospitals in the East-Metropolitan Health Service (EMHS), administrative data from WA Police and Homeless Healthcare data (HHC). Additionally we have drawn on 50 Lives administrative data and survey data collected by 50 Lives from lead workers. Qualitative data sources include semi-structured in-depth interviews undertaken with a sample of 50 Lives clients, and information gathered from interviews and discussions with lead workers, the AHSS team, and staff from HHC and RPH Homeless Team. The case studies included throughout the report draw on a mix of quantitative and qualitative data to contextualise client experiences and outcomes.

A visual overview of the data sources is shown in Figure 2, and the data collection processes and methods of analysis are described in more detail in the pages that follow.

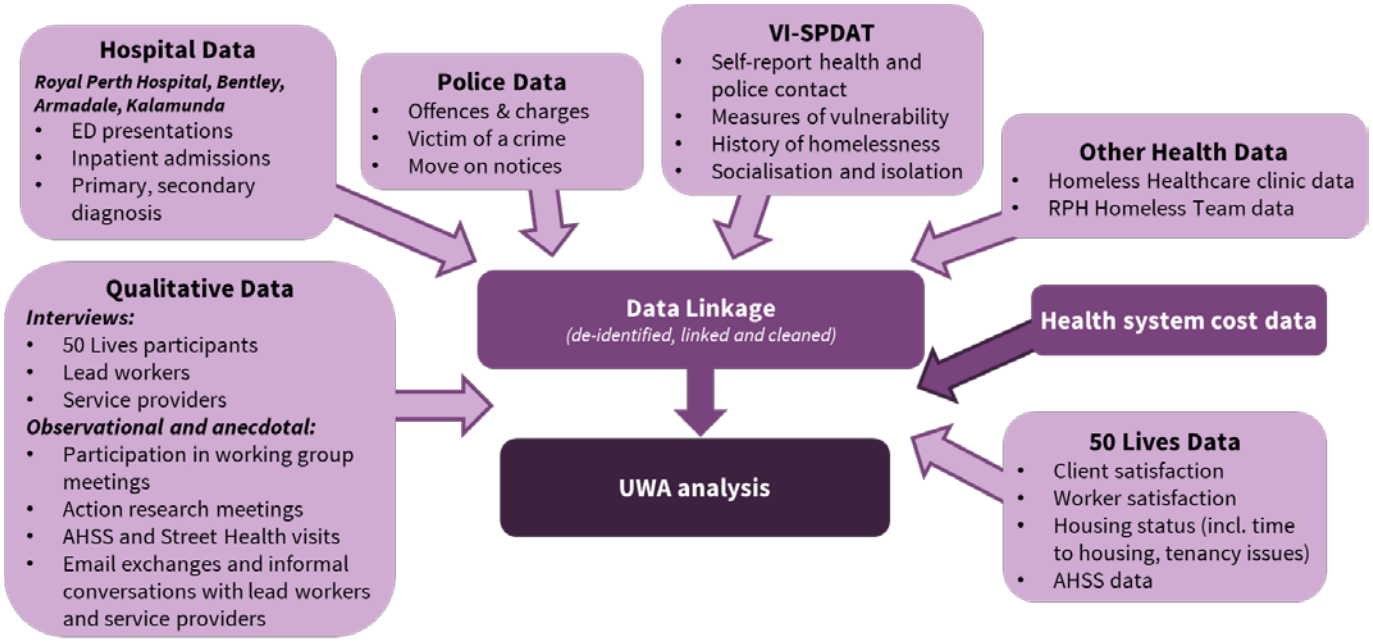

Figure 2: Summary of Data Sources

In this second report, longitudinal analysis comparing hospital use and contacts with WA Police before and after housing has been undertaken. The potential cost savings to the health system associated with observed reductions in hospital use have been computed. Complete WA Police data de-identified for 50 Lives clients was only received 30 August 2018, hence the analysis in this report is preliminary. The research team is working with WA Police towards the inclusion of economic analysis associated with this data in the next evaluation report.

Approval to conduct this evaluation was granted by the UWA Human Research Ethics Committee on 20 January 2017 (ref: RA/4/1/8813), by RPH ethics on 26 May 2017 (RGS0000000075), and by WA Police on 21 June 2017.

2.1 Qualitative Data

2.1.1 Client Interviews

Five semi-structured interviews were undertaken with six clients lasting an average of 55 minutes (range: 39 – 76 minutes). A semi-structured interview guide was used to facilitate conversation over numerous topics including: engagement in 50 Lives; history of homelessness; experience of the project, services supported by; differences compared to previous homelessness support; (if housed) the process of being housed and their confidence of maintaining their tenancy; health and/or justice concerns, and finally how they perceived their life would be in a years' time.

A purposive sampling method was used to guide recruitment of clients, reflective of different experiences of homelessness, demographic backgrounds, and varying health and psychosocial needs. The 50 Lives project manager and the clients lead workers played an integral role in identifying and arranging interviews. Lead workers invited clients they were supporting to participate in a voluntary interview and advised the clients that their choice to accept or reject an interview would not affect their relationship with the lead worker or the 50 Lives project more broadly. All interviews were taken at a time and place convenient to the client. All clients were provided a $40 gift voucher upon completion of the interview as reimbursement for their time.

Participants will be followed up one-to-two years after the initial interview date to determine any changes in their circumstances and subsequent experiences associated with 50 Lives.

2.1.2 Interviews with those Working with Clients

Interviews and discussions with lead workers, AHSS staff, working group participants and 50 Lives backbone staff has provided enormous insight for the project evaluation to date. While only five 'formal' and transcribed interviews with staff or other individuals working with 50 Lives clients have been undertaken for this report, other insights pertinent to the observation have been gathered from informal meetings and telephone conversations with a range of people involved in 50 Lives. This has been facilitated by the positive working relationships established across partner agencies, and strong support for the evaluation of 50 Lives from staff and organisations involved. This mix of formal and informal data gathering has delivered more information than otherwise would have been available from a limited number of one-off interviews alone. Interview recordings were transcribed verbatim by a transcription service and coded using QSR NVivo, a qualitative data analysis computer software package[11] following each interview. Thematic analysis and coding of the data was undertaken.[12]

2.1.3 Observation and Action Research

An additional harvest of ideas, information, input and discussion has been afforded through:

- Action research meetings between key members of the UWA evaluation team and the 50 Lives project manager. This is framed around the notion of organic evaluation, with feedback loops and reflective processes to look at how to best capture the impact and outcomes of the project to solve data and evaluation challenges collaboratively as the project evolves.
- Research team observations of 50 Lives processes and activities through periodic attendance at working group and steering group meetings and field visits with AHSS, HHC and a number of organisations partnered with 50 Lives.

2.1.4 Client Case Studies

Case studies are a powerful, yet underutilised complement to program or service evaluation,[13] and provide a counterpart to empirical and qualitative data by triangulating a narrative through the eyes of the client experience. These case studies provide an in-depth insight into how 50 Lives and the services involved in the collaborative program have provided support to vulnerable individuals.

Case studies are developed from a variety of resources, namely interview data from both the six 50 Lives participants interviewed, their lead workers and AHSS staff, hospital records, and in analysis of these records a further estimated economic component.

These case studies are interspersed throughout this report to illustrate key points that they exemplify.

2.1.5 Working Group Case Studies

Summaries of the working groups have been compiled based on observational notes from attending the groups, an analysis of meeting minutes and drawn from qualitative feedback from attendees.

2.2 Quantitative Data

This report draws on numerous sources of quantitative data including self-reported health and homelessness data, administrative hospital data, administrative police data and 50 Lives-specific data (See Table 1). Triangulation of multiple sources of data provides a richer evaluation.

Table 1: Quantitative Data Sources, Time Periods and Variables

Data Source	Time Period	N^	Variables
VI-SPDAT	13 May '14 – 11 Jun '18	219	Self-reported history of housing and homelessness; risks; socialisation and daily functioning; wellness.
Administrative Health Data	1 Jan '13 – 30 Apr '18	192	Demographic information; ED presentations, arrival mode and LOS; Inpatient admissions, admitting ward and LOS; triage score; diagnosis/es; discharge destination.
Administrative Police Data	17 Jun '92 – 17 Jun '18	169	Offences; victimisation; judicial outcomes; call outs (to incidents or to house); notices given; complaints against house and individual; family and domestic violence data.
AHSS Clinic Data	1 Jan '17 – 30 Jun '18	n/a^^	Type of support provided.
50 Lives Quarterly Data	As at 30 Jun '18	221	Demographic information; consent, priority listing and housing dates; lead worker/agency; support needed; issues experienced.

^ Due to the rolling recruitment of clients, lists of clients name as at different time points were sent to each organisation for linkage. N equals the number of people data was available for at the time of linkage/data extraction.
^^ AHSS clinic data not available per person, but per episode of support given due to the way it was recorded.

2.2.1 VI-SPDAT Data Collection

Prior to consenting for 50 Lives project involvement, all participants complete a VI-SPDAT to assess for project eligibility.[1] The VI-SPDAT is administered by numerous homeless agencies and health services throughout Perth, on an ongoing basis. The Tool has been used in Perth since 2014 as part of the Registry Week counts, and to date has been used to survey 1,600 people.

The VI-SPDAT[14] is a widely used survey that measures the vulnerability and service needs of individuals and families experiencing homelessness. The VI-SPDAT measures this using responses from questions across four core domains:

- *History of Housing and Homelessness* - assessing current housing, episodes of homelessness and time spent homeless;
- *Risks* - encompassing health status and service use, risk of incarceration and risk of exploitation;
- *Socialisation and Daily Functioning* - capacity to self-manage finances, self-care, engage in meaningful activities and relationships, and;
- *Wellness* - chronic physical health conditions, disabilities, mental health, substance use and ability to manage medications.

Responses from across these domains are weighted and used to develop a vulnerability score which is used by 50 Lives to identify those most in need of rapid housing (a score of 10+ is assessed as high vulnerability). Much of this data also provides a valuable self-reflection of the clients demographic, health, justice and housing profile.

2.2.2 VI-SPDAT Data Analysis

VI-SPDAT data was extracted for all VI-SPDAT respondents in Perth (n=1,600) on 3 Jul 2018 by Ruah (the agency in which holds the software license). VI-SPDAT records were compared against a list of 50 Lives clients as at 30 Jun 2018, and after removal of duplicates, data was available for 219 clients. Where there were duplicates, the most recent survey was used. VI-SPDAT data for these 219 clients was analysed, with the responses to homelessness, health and justice related questions included in this report.

2.2.3 Administrative Health Data

As part of a larger inter-related project, a list of 3,387 names of homeless or formerly homeless people in Perth was provided to the Business Intelligence Unit (BIU) at WA Health. This list was compiled based on individuals who had contact with 50 Lives, the RPH Homeless Team, HHC and VI-SPDAT responders.

The BIU was able to match 192 of the people who were 50 Lives clients as at 30 June 2018. This matching was undertaken using names/aliases and date of birth. De-identified data was provided back to UWA via secure link. The matching of the de-identified data was facilitated by the creation of a unique identifier that corresponded to a flag indicating if they were a 50 Lives client.

The tranche of data provided to the research team for this second report included administrative hospital data for four hospitals in the EMHS (RPH, Bentley, Armadale and Kalamunda), for a three-year period prior to 50 Lives consent date, and up until 30 April 2018. Table 1 lists the variables provided for analysis in this evaluation.

While the bulk of the hospital data at this stage is only from RPH and the three other EMHS hospitals mentioned, our collaboration with the RPH Homeless Team enabled provision of data (from the TOPAS database) for all public hospitals in Perth for the case studies included in this report.

An ethics and governance amendment is in progress to provide access to other public hospital data for all 50 Lives clients for the next evaluation report. Subject to research and evaluation funding, future analysis could also compare hospital use and health outcomes for 50 Lives clients with data for the much larger cohort of people experiencing homelessness in Perth (1,600 of whom have completed a VI-SPDAT survey).

2.2.4 Administrative Police Data

The Business Intelligence and Analytics Department of the WA Police Force extracted administrative Police data between 17 June 1992 to 17 June 2018 for 2,794 individuals identified as homeless in Perth. Retrospective Police data was restricted to records for individuals who were over 18 years of age at the time of the relevant event for privacy reasons.

A password protected list including 50 Lives clients as at the 30th April was provided to Police at the beginning of May for extraction and linkage. The list contained the names, and housing status of 186 of the 50 Lives clients, of these 91% (n=169) were matched based on three ID points including first name, surname and date of birth.

De-identified data was provided back to UWA via a clean USB for analysis. See Table 1 for a list of variables that were provided for analysis.

2.2.5 Administrative Data Analysis

Stata version 14 was used to conduct all data analyses. All data were analysed to produce counts, summary statistics, and to conduct comparison tests for different time periods where applicable.

2.2.5.1 Health Data Analysis

Two separate analyses have been presented in this report to compare ED presentations and inpatient admissions.

- Comparison of hospital utilisation data for the whole 50 Lives cohort (n=192) for the year, two years, and three years prior to consenting to join 50 Lives;
- Comparison of changes in hospital utilisation data associated with housing. Analyses have been computed for the subsample that had been housed for at least six months (n=68) and for at least 12 months (n=44).

2.2.5.2 Police Data Analysis

Police data for the periods six and 12 months pre and post-housing for offences, charges, infringement notices and move-on notices were analysed for clients who had been housed for a minimum of six or 12 months respectively. Offence data were also analysed for the four years pre-housing for the total group housed as of 17 June 2018.

2.2.6 50 Lives Data

Regular data is routinely collected and recorded by 50 Lives workers to capture the current circumstances, needs and progress of clients. Statistics are provided to the research team by the 50 Lives project manager each quarter. These spreadsheets include data on VI-SPDAT scores, current lead worker survey data, housing status (e.g. completion of priority housing application) and any tenancy issues. 50 Lives also undertakes periodic satisfaction surveys of workers and clients and this data is shared with the research team. Longer term this data will be linked to other evaluation data.

Data from 50 Lives spreadsheets has been used to calculate time to housing and housing retention rates. Data provided through these quarterly updates have been used as a "live" list to determine consent and housing dates for analysis of the hospital and police data.

Statistics and open-ended responses from the second Lead Worker survey administered in April 2018 (39 responders, 81% response rate) has provided an additional source of data for this report.

2.2.7 AHSS Clinic Data

Daily data sheets collated by AHSS staff between January 2017 and June 2018 were provided to UWA for analysis. Aggregate data was analysed in Excel to determine changes in the provision of basic needs, support, planning and referrals provided once clients had been housed. Data for various sub-groups were simplified into two groups, housed and unhoused clients to enable any changes to be compared. These changes were compared as basic frequencies, as well as relative to each by calculating the frequency of services engaged as a percentage of the different client sub-groups.

2.3 Economic Evaluation

Building a robust evidence base for the economic benefits of 50 Lives is critical in the current policy and funding climate.

With current evaluation funding and the lengthy processes involved in accessing administrative data, the economic evaluation in this second report focuses primarily on estimated cost savings associated with reduced use of health services, as it is the health system that bears much of the cost and consequences of recurring homelessness. A comprehensive economic analysis is dependent on outcome data from two time points and follow up data for a larger cohort of clients housed for at least one-year, hence the economic costings in this report are indicative only. As noted earlier, complete WA Police data was only received 30 August 2018, and the team will be working with WA Police towards the inclusion of economic analysis associated with this data in the next evaluation report.

As an interim strategy for providing some indicative assessment of the economic benefits yielded by 50 Lives to other government sectors, available cost data has been applied to case studies in both the health and justice chapters. Costs associated with case studies have been estimated using Independent Health Pricing Authority (IHPA) Round 20 national public sector estimated average costs for ED presentations, psychiatric admissions and other inpatient admissions.[15] There is no equivalent current costing data available in the public realm for the police data unfortunately, but WA Police are assisting the research team with this for the next evaluation report.

3. COLLABORATIVE APPROACH

So I was very lucky…having the three services, after hours, the Ruah day centre and Homeless Healthcare GP… [they] are all not judgmental, helpful. You know they are really there to help you. So it's massive and they're all connected so they know what's going on without going against your privacy, so you don't get a pop quiz all the time.

- 50 Lives Client

As a collective impact project, partnerships and collaboration are central tenets of the 50 Lives project, and it is critical to evaluate the contributions and effectiveness of the collaborative model over time. There is tendency in the published literature to primarily report on the key activities and outcomes of Housing First projects, and evaluation of the collaboration itself is comparatively rare. Yet it is the latter than can significantly determine the level of client engagement and housing, health and other outcomes attained. To this end, each 50 Lives evaluation report includes reflections and findings pertaining to the collaboration itself and the mechanisms that facilitate this.

Historically, human service delivery has been siloed across sectors (e.g. health, housing, social services) with separate funding streams, operational practices and service delivery locations. Such silos and fragmentation within, and between the sectors interacting with people who are homeless can result in gaps in service provision and individuals feeling as though they are bouncing from one service to another, regardless of how well services operate individually.[16]

Interestingly, clients themselves have alluded to this in a number of interviews:

> *I think 50 Lives is trying to get them to all work together… because at the moment all services are split… it's good if they're all on the same page. You know what I mean?* ***– 50 Lives Client***

3.1 Mechanims of Collaboration

With 50 services from 28 organisations participating in the 50 Lives collaborative, the establishment of three working groups (rough sleepers, youth, and housing) provides a mechanism that cuts across traditional sectorial silos, allowing "key players" to make immediate decisions and facilitate action on behalf of 50 Lives clients. In addition, there is overall strategic guidance provided by the steering group, which is made up from senior executives from key organisations.

When clients consent to participate in the 50 Lives project, they consent to an overarching data-sharing policy, which enables organisations to share and discuss information about each individual. This has multiple benefits to both the organisations involved in service delivery and provision of support, but also to the clients themselves, as articulated by one client who valued not having to repeat the same story to every worker they came in contact with:

> *I think [lead worker] is brilliant… She liaises with the other support services and gets them so they're all on the right page. So we're not constantly repeating ourselves all the time* ***– 50 Lives Client***

A common feature of Housing First programs and something that has been adopted by the 50 Lives project is the "by-name-list" approach. This means that there is a literal list of names of vulnerable homeless people in Perth, and services are aware of who is working with who. In part, this is a deliberate recognition that 50 Lives clients are not anonymous homeless people are but real, valued citizens with histories and needs that are known intimately by many different service providers.

Additionally, this process allows a rolling referral of potential clients in 50 Lives through multiple entry points. For example directly through a **lead worker/ agency** that may be working with a client who would benefit from additional 50 Lives support; through **other organisations that don't offer case management** but are able to advocate on clients behalf (Drop-in centres, HHC, RPH, Tom Fisher House); through **registry week data** where

individuals have previously completed the VI-SPDAT and scored highly; through **new services** involved in 50 Lives who can advocate for their current clients and through **existing 50 Lives clients** who recommend friends or family.

We have attempted to depict the primary ways in which 50 Lives clients have come into the project to date (See Figure 3), but acknowledge that there may well be other pathways given the flexible client focus of the 50 Lives collaborative.

The 50 Lives project has adopted a 'no wrong door approach' with multiple entry points across numerous sectors throughout Perth increasing accessibility for vulnerable rough sleepers.

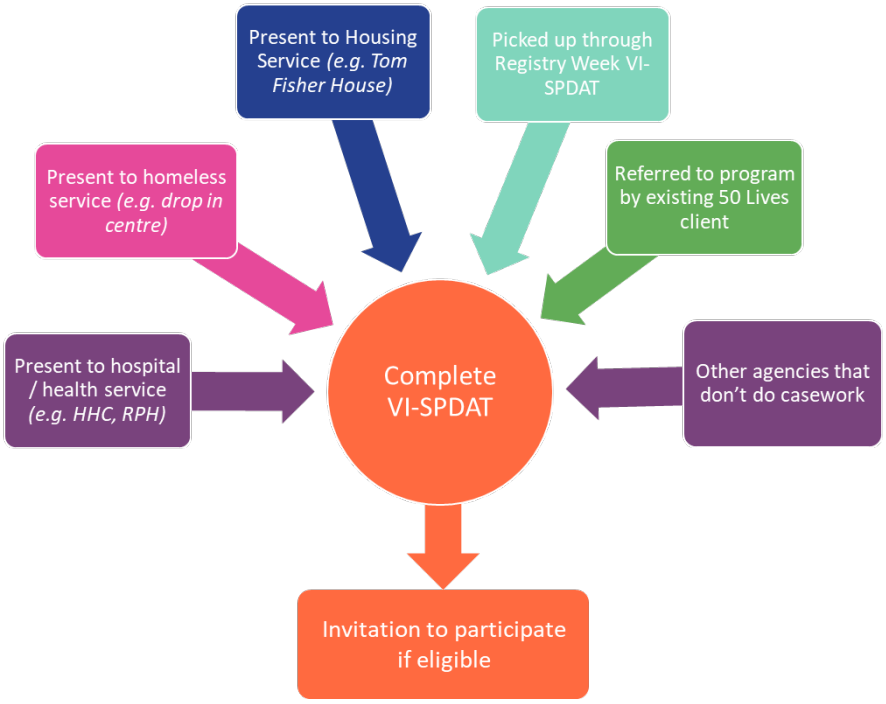

Figure 3: Different Referral Pathways from Collaborative Partners Involved

3.2 Working Groups

Currently there are three working groups operating as part of the 50 Lives project. Each of the groups have different focus areas (current rough sleepers, youth experiencing homelessness, housing availability), with different aims and attendees.

These working/steering groups bring together agencies beyond the usual housing and homelessness sector players including (but not limited to) hospitals, mental health services, police, Centrelink, domestic violence services and other community services. Bringing together these diverse services allows for increased coordination, resource sharing, improved decision-making and ultimately improved outcomes for the individual involved in the project.

The working group model used in the 50 Lives project was adapted from the model and learnings from the Brisbane 500 Lives 500 Homes project.[17] What 50 Lives and other Housing First models have recognised is that no single organisation can achieve its goals in isolation and that by bringing together the expertise of all these agencies they are able to transform isolated impact into a collective systematic response to end homelessness.[17] In order to elicit large-scale social change across a broad range of sectors (in this case, the WAAEH goal of achieving zero homelessness in Perth), there needs to be a systematic approach focussing on relationships

between organisations and the progress towards a shared objective.[18, 19]

While the working groups have key differences (such as the organisations that attend and the decisions that are made), all three have overall similar functions and act as a conduit for providing:

- *Troubleshooting space* regarding clients (i.e. a space to discuss a client you need help with, if you have been unable to locate clients, discussing prioritisation for housing);
- *information sharing* on available services (i.e. if a crisis accommodation currently has vacancies, if there are new services support or opportunities available);
- *referring new clients* and negotiating new lead workers to meet case-load capacity (see Figure 3);
- *rapid decision making* through physically bringing together key players with differing expertise into the same room at the same time to facilitate unique solutions to problems for each client (See Box 3).

Box 3: Dyanamic Decision Making

During one working group meeting it was noted that it would take six months to process a Disability Support Pension (DSP) application through Centrelink. A solution was decided on between the project manager, the Centrelink worker and a clinician. The Centrelink worker would be able to fast-track the application if there was a support letter provided by the 50 Lives project manager stating the clients' vulnerability and a referral support letter from a clinician. This process enabled a rapid response to an issue that could of taken months to achieve outside the program.

Additionally as reflected by one lead worker, it provides a knowledge sharing space and allows you to meet other people working within the homelessness space.

> *I think with the collaboration side of things. It's good - not everyone can attend every meeting but it's good to touch base with people or you're always calling people but you might not have met them… it's good for networking as well, and if you're struggling with something, somebody may be more knowledgeable on a subject and be like, there's this, this and this; I'll send you the details…*
> ***- 50 Lives Lead Worker***

While the 50 Lives working group model was based off the Brisbane 500 Lives model, each Housing First project has to evolve to the local context, hence some differences in working group composition and ways of operating may emerge. The WA iteration of the rough sleepers working group for example has a really strong health sector presence, as it includes the Clinical Lead from the first dedicated homeless health hospital in-reach team in Australia based at RPH,[20] and the Medical Director of Homeless Healthcare, the largest dedicated General Practice in Australia for people experiencing homelessness. Other players in the 50 Lives working groups also reflect the dynamics and capacity of the homelessness sector in WA.

Below each working group is discussed in more detail, based on the observations and data collection of the research team.

3.2.1 Rough Sleepers, Family, and Housed Working Group

The rough sleepers working group has been meeting fortnightly since October 2015. With a sub-group to specifically discuss housed clients at every second meeting (i.e. once per month). Between Oct 2015 and June 2018, they met 68 times with an average of 15 attendees (ranging from 8 to 25 participants per meeting).

The family working group met monthly between April 2016 and mid-2017 before being merged into the rough sleepers working group. It currently meets directly after the rough sleepers working group on alternative months from the housing sub-group (once per month).

The working group begins with an update on the total number of people who have been housed through the project and in how many houses (i.e. x people have been housed in x properties with x% retention). This not only commences the meeting on a positive note, but reiterates the work and successes of every agency involved in the collaborative to date.

The primary focus of the rough sleepers working group is to discuss individuals who are yet to be housed and to provide updates to all services involved in their support. Specific terms of reference are outlined in Box 4.

Box 4: Rough Sleepers Working Group Terms of Reference

- Collaborate to provide a coordinated response to people sleeping rough who are identified as being the most vulnerable;
- Work towards clients being housed with adequate support; and
- Contribute to the coordination of further actions to complete VI SPDAT's to enable the register to be added to.

Examples of specific updates and decision-making made during the working group meeting are provided below and have been collated from a sample of meeting minutes and observational data.

- *Location of missing clients*; in one instance it was noted by a lead workers that they had been trying to pass a letter onto a client for a number of days but were unable to locate them. During the meeting they asked the room if anyone had seen the client in the past week. One of the support workers from a different agency stated that they had recently seen the client. In this instance the lead worker emailed the other worker a copy of the letter to pass onto the client if they saw them first.
- *Offers of housing and lack of readiness*; while the very nature of Housing First is to get someone into a house first, one client felt they weren't ready for the responsibility of a key when they were allocated a new house. The meeting provided a space to come up with an alternative solution to help temporarily house the client in a supported environment to get them more 'housing-ready". In this instance, the 50 Lives project manager advocated with the housing agency for another 50 Lives client to be offered the rejected property.
- *Arranging check-ups and appointment attendance;* the AHSS provides a key support for the housed clients and are able to assist to keep these individuals housed. In one instance, a lead worker had spent considerable time to arrange their client to get an appointment for a gastroscopy. To ensure that the client not only attended this appointment but was prepared for it, they arranged for the AHSS to visit the client the night before to ensure they fasted before the appointment.

The efforts of the working group are not limited to the above three examples, but these have been provided to illustrate some of the ways in which they work together to achieve collective outcomes for 50 Lives clients.

3.2.2 Youth Working Group

The youth working group brings together key players from Youth Services in Perth. Between July 2016 and June 2018 the youth working group met on 26 occasions and had an average of nine attendees (ranging 5 to 17 participants per meeting).

As with the rough sleepers working group, this working group also commences with an update on the number of people housed to date and if anyone was housed in the week of the meeting. This working group is much smaller than the rough sleepers working group, and brings together a number of different organisations that work in the youth space. While the needs of the clients discussed in this working group are no different to the needs of those discussed in the rough sleepers working group, due to the limited youth services in Perth, generally all clients discussed are known to all agencies around the table. It was noted that due to the limited services, vulnerable youth typically bounce between all available services, and as a result this working group requires less facilitation than the other working groups.

While the three examples provided in the rough sleepers subsection above are relevant to the ways in which the youth working group operates. Below are a number of specific examples for the youth working group collated from a sample of meeting minutes and observational data.

- *Advocating for safety;* one housed client has been experiencing ongoing issues with a neighbour for an extended period of time. While the youth service supporting this client assisted to make a formal complaint about the neighbour, by bringing the issue to the working group the 50 Lives project manager was also able to raise the issue with the housing agency that manages the property. The housing agency has since stated that they would be taking action to sort out the issue.

- *Gaining priority listing;* One client was declined to be priority housing listed, the lead worker was able to arrange for an appeal. With support from other services they were able to engage the client with a debt-discount scheme, and the 50 Lives project manager was able to provide a letter of support to assist with the appeal. As a result from the collaborative effort across agencies and the 50 Lives project the client was able to successfully appeal the decision and has now been added to the priority housing list.

3.2.3 Housing Working Group

The housing working group has been meeting monthly since May 2016. It is attended by the housing providers involved in 50 Lives (Foundation Housing, Community Housing Ltd, Access Housing and the Housing Authority). Between May 2016 and June 2018, they have met 26 times with an average of six attendees (ranging from 4 to 9).

During meetings, providers can highlight (from a list of housed clients), any 50 Lives tenants they have updates regarding. Examples of updates include flagging when annual reviews are due/outstanding, if there are outstanding bad debts, if someone has a payment plan in place or if someone has applied for a rental.

While the 50 Lives project engages with the most vulnerable of rough sleepers in Perth, the relationships formed through involvement in the project and participation in the working groups enable frank discussions about priority and enable innovative solutions to be found to house people.

3.3 Collective Impact

The 50 Lives project is congruent with a collective impact ethos, with the five key conditions for success as identified through the works of Kania and Kramer[19] reflected throughout all working groups. These working groups provide a mechanism to achieving the five key conditions of a collective impact model. Using examples from across these working groups, the five conditions (a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support) are discussed below.

3.3.1 Common Agenda

Participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.[18]

Agencies involved in the 50 Lives project have an overarching goal to achieve zero homelessness in Perth. Specifically within the working groups, organisations work together to find appropriate housing for some of the most vulnerable rough sleepers in Perth and once housing is found, to provide wrap around support for them to maintain their tenancy.

Working group attendees are genuinely passionate about improving their clients' circumstances and finding alternative solutions to achieve the best outcomes for each person involved. This passion shown by attendees and having an underlying common agenda, enables quick and appropriate decision making to keep client needs foremost, and continually challenge the group to 'think outside the square' to find innovative and timely solutions.

This collaboration is also a key factor noted by 50 Lives clients as important to their service delivery, ensuring that all organisations are on the same page.

> *So one of the things I think with 50 Lives that they're trying to do, because there's always been lots of different homeless services and homeless healthcare. But I think 50 Lives is trying to get them to all work together... it's good if they're all on the same page.* ***– 50 Lives Client***

The benefits of the collaboration in achieving things that are of shared importance across the sector were also frequently mentioned in the most recent worker survey (April 2018). See Box 5 for example of comments to this open ended question.

Box 5: Lead Worker Feedback – Collaboration Responses

What has 50 Lives 50 Homes been able to deliver for clients that would not have happened before?

- *Coordination between services*
- *collaborative wrap around support - more stability and sustainable housing*
- *extra ideas for supporting my clients through being able to meet with the other services on the program*
- *Similar to the S2H program, working collaboratively has been beneficial for my clients.*
- *Integrated approach of Housing and Support - we know our common goal is to sustain the tenancy together so we communicate better with this shared understanding.*
- *Knowing we can link clients into services when staff change*
- *Police Information sharing*

3.3.2 Shared Measurement System

Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.[18]

As noted in the first report, this is one area that could be improved across the 50 Lives project. Currently agencies record and capture information in many different mediums, and systems are not set up well for rapid information sharing. Organisations also often have differing outcome measures which is an impediment to measuring collective impact; for example only some organisations capture Outcome Star data. However, there is currently a move to more agencies using this system, which will improve data sharing and transparency. Inconsistencies in data collection and reporting of client outcomes, makes comparison of client progress difficult, and may mean the impact of the 50 Lives approach is underestimated or not captured. Additionally as reflected by one lead worker, services like AHSS may not be able to access all 50 Lives client's casework notes and thus depend on the case manager updates, without which could mean they could be entering potentially dangerous circumstances during home-visits.

> *After Hours can see [Ruah] caseworker notes whereas external services, they can't… so it's dependent on case managers' updates and that's where it's crucial because if they don't get an update then they don't know what's going on for the person.* ***– 50 Lives Lead Worker***

A core set of shared process and outcome measures across involved agencies would help to ensure that the right data is collected in a timely fashion to demonstrate the key outcomes. Given that partnering agencies are generally time poor, discussion of shared measurement can assist with identifying the most critical data to collect and report in a standardised way, and more efficient ways of collecting and extracting such data for evaluation purposes can be collectively problem solved.

3.3.3 Mutually Reinforcing Activities

Participant activities must be differentiated while coordinated through reinforcing actions.[18]

Agencies bring to the working groups their unique knowledge, experiences and access to resources. This helps to fill gaps in each other's knowledge about the services available and related to specific clients. There are multiple examples observed in the working groups where attendees have been able to use their positions to assist other attendees as demonstrated throughout this chapter. Mutually reinforcing activities enable the agencies and community workers involved in the 50 Lives project to more efficiently house the most vulnerable rough sleepers in Perth.

Importantly, there are wider benefits from the 50 Lives collaborative ways of working that have had a ripple effect on (i) the homeless and related sector in Perth through the demonstrated benefits of more 'joined up' solutions and (ii) some of the individual partnering organisations, whereby 50 Lives has opened doors to a different way of 'doing business' when it comes to rough sleepers. The latter was poignantly noted in a recent interview with the previous WA Police Northbridge District Superintendent, Kim Massam:

> *50 Lives, for me, was really transformational in my thinking about how we would manage what the community saw and particularly the businesses in Northbridge saw as a real antisocial behaviour problem. We just saw a revolving door of Band-Aid treatments for individuals that really were not going to have long term outcomes that were*

beneficial for either the community and in particular, the homeless person themselves…

What I loved about it was the fact that people who were in the program could opt to have alerts put against their name so we could say, I've come across a homeless person and there's an alert for police officers to look at it and say, I'm part of this project, here's a person who's here to help me. ***– Kim Massam, Detective Superintendent, WA Police***

3.3.4 Continuous Communication

Consistent and open communication is needed across organisations to build trust, assure mutual objectives, and appreciate common motivation.[18]

Not only are the agencies coming together either every month or every fortnight to discuss clients, they also have each other's contact information to allow for continuous communication with one another. By fostering a collaborative environment, it reinforces that everyone is there to help and that everyone wants to achieve the best outcomes for the clients involved. There are many benefits of multiple communication mediums, including:

- Enquiring whether hospital or transitional housing services have seen a particular client;
- Finding out what other lead workers have done in a similar circumstance;
- Notifying other services that have regular contact with the same client of changing circumstances (i.e. admitted to hospital, approved for housing, separated from partner, incarcerated etc.);

Having open communication streams allows for agencies to address problems, source relevant information and update each other rapidly in response to client needs, enabling all relevant players to be on the same page at all times.

There is evidence that the open and fast lines of communication extend well beyond the working group meetings, and the way in which people from various organisations recount 'picking up the phone' or 'flicking an email' to resolve a client related dilemma is heartening. An example of this is illustrated in Box 6.

Box 6: Collaboration Beyond the Working Groups

A man in his late sixties had been homeless for over 40 years, most of which has been spent rough sleeping. Whilst he initially reported having no major health issues, he did admit to having alcohol and drug issues.

In one instance he attended the ED in relation to a large head wound but left untreated, and against medical advice. The Homeless Team at RPH worked closely with the clients' 50 Lives lead worker to return the man to hospital for treatment. The Homeless Team were able to complete an aged care assessment for the patient leading to his admission to an age-care facility. Shortly after, the patient left the age care facility, and was eventually diagnosed with late stage cancer. Through the work and advocacy of both 50 Lives and the Homeless Team he was admitted into palliative care until he passed away, allowing him to die in dignity and not on the street.

3.3.5 Backbone Support Organisation

Creating and managing collective impact requires a separate organisation and skills to serve as the backbone for the entire initiative and coordinate participating organisations and agencies.[18]

Ruah, through the 50 Lives project manager and 50 Lives project coordinator play the role of the backbone organisation, and provide overall coordination of the project. Regarding the 50 Lives working groups and the effectiveness of this collaborative approach, one attendee highlighted the unifying role played by the backbone support:

As well as fulfilling the important administrative function of the group of setting agendas and minutes, the 50 Lives project manager and supporting team, have been able to bring diverse stakeholders together, encourage collaboration, identify opportunities, unify the group, keeping everyone client focused. She has also been able to offer different perspectives and introduce/ encourage new ideas in the working group to deal with homelessness- this is critical in terms of stimulating the innovation that is required to break through institutional and social barriers to homelessness. ***– Working Group Attendee***

As noted in the collective impact literature, many collaborations flounder in the absence of a dedicated role facilitating dialogue, coordinated actions, and feedback loops across participating organisations. Having Ruah provide this backbone role is particularly valuable given the many elements, working groups and partners involved in 50 Lives.

3.4 Other Innovative Collaborations

One of the benefits of the 50 Lives project is that it has been designed to respond to needs organically as the project develops. The project has deliberately aimed to be adaptive, not being stuck in a mould or stubborn to change. Below are some examples of creative solutions and sub-projects that have developed in response to issues identified during the working groups.

3.4.1 ID Clinics

When thinking of challenges faced by individuals experiencing homelessness, lack of identification (ID) probably doesn't spring to mind – though it immediately makes sense. The issue is three fold; in the first place there is the very present difficulty of maintaining and keeping identification. People experiencing homelessness are consistently facing challenges from weather, theft and a lack of safe and secure storage – and this makes keeping ID extremely trying. A second issue faced is the difficulty found navigating and accessing systems to obtain new or updated ID's. Many of these systems rely or are streamlined by internet and computer access are much harder for rough sleepers to work through. Additionally, obtaining new ID often actually requires other forms of ID to be provided (i.e. you need 100 points of ID such as a birth certificate, Medicare card or license to even obtain a photo ID card). Lastly, the costs of paying for identification is often beyond what many can afford and so presents a significant and often insurmountable barrier.

Having photo ID is an important necessity for modern day life, and without it, individuals can experience further challenges to exiting homelessness i.e. not being able to access Centrelink payments, not being able to open bank accounts or not being able to complete housing applications. Additionally, lack of ID poses additional problems with law enforcement. Street present people can feel harassed by not being able to produce ID to police or security.[21] A lack of ID can make it difficult for law enforcement to find and record people in their systems. An experience reiterated within this evaluation was one 50 Lives client had 49 different unique ID's in Police administrative data that was provided to the research team.

Identified as a need through 50 Lives, it was observed that there were numerous requests from clients needing assistance to accessing ID. Through the projects extensive collaborations and networks an innovative solution was found; ID clinics.

The ID clinic developed by 50 Lives provided a single point of access to source birth certificates, other ID and enabled individuals to complete priority-listing application forms. The clinic ran successfully for several months after commencing in June 2017. Once demand declined, the participating agencies developed a streamlined process for 50 Lives clients to access their assistance in the future. During this period, approximately 20 individuals were assisted to obtain ID.

Agencies that participated in the clinics included:

- Centrelink – which issued health care cards and assisted with proof of income statements;
- Births, Deaths and Marriages issued birth certificates for those who were born in WA (and had a registered birth);
- Housing Authority attended to conduct Priority-Housing interviews; and
- A Justice of the Peace (JP) was there to notarise copies of originals and sign statutory declarations.

Upon conclusion of the clinics, feedback was sought from participating organisations to determine what worked well and what could be improved in future clinics.

Overall it was felt that positive aspects included the relaxed environment in which the interviews were conducted, and the fact that clients were given the time to ask questions.

> *…there was space and time to have the necessary conversations with providers, which gave the clients opportunities to ask the questions they wanted answering. –**ID Clinic Feedback***

It was also noted that Births Deaths and Marriages felt it was useful having a list of clients provided to them in advance. This enabled them to look up birth records prior to the interview enabling the whole process to run more smoothly.

Suggestions for improvement were largely around logistics such as rostering, the order in which clients saw each service and signage on the door.

Organisational benefits of participation include being able to engage with clients that would not normally attend an office, assisting clients with debt to be considered for housing in the future and providing a space where multiple services can be accessed all on the same day.

> *Attending the clinic meant the client could access services which are often avoided, not prioritised or get re-arranged. It also enabled the client to access a copy of [their] birth certificate, which had been problematic until the clinic... Attending the clinic was the equivalent of having four appointments with clients. Also provided the opportunity for the clients to ask questions that they may not feel confident to ask in one of the services offices. –**ID Clinic Feedback***

An additional benefit from the clinic that also arose is the need for services that don't necessarily work in the homelessness space to be flexible when dealing with vulnerable clients.

> *It demonstrated the need for JP's to be flexible in their dealings with people! –**ID Clinic Feedback***

All seven respondents stated that they would participate in any future clinics.

3.4.2 Wongi Mia

Wongi Mia is a new micro-project that provides a different way of meeting the needs of Aboriginal families experiencing homelessness. The program focuses on providing support that acknowledges kinship obligations that often lead to overcrowding and breaches when Aboriginal families are housed through mainstream programs.

In late 2017, 50 Lives was successful in securing a grant to fund a part-time caseworker to specifically work with Aboriginal rough sleepers using an alternative model based on feedback from Indigenous organisations. This model looks at working with whole families and extended family networks to support everyone in the family system with housing and other support needs to take a positive approach to those who are seen as "overcrowding". The case worker began work with one 50 Lives client 'patient zero' and identified members of their family who also required support.

Community involvement has been a core component of the program. The name 'Wongi Mia' was chosen by the first client and their family in memory of their grandmother who advocated for housing for her relatives.

3.4.3 Police Information Sharing Initiative

A novel 50 Lives and WA Police initiative was instigated in 2017, whereby 50 Lives clients could consent to be flagged in the police system. Frontline police can thus be aware of that a person has an existing support network if they get called about a 50 Lives address (for example about sounds of shouting, disruptive visitors etc). The system alerts the police officer to the option of being able to contact the clients lead worker. As a lead worker is familiar with their clients history and has established a relationship of trust, it is beneficial to both the police and 50 Lives client if the worker can provide support that averts the need for punitive police intervention.

This fits with growing calls for more preventive models of policing and as reflected in the quote below, has significant benefits from the WA Police perspective.

> *Often, we simply just don't have the support for police and ultimately support for the person that's 24/7. So we're very - the first thing we would be doing is picking up the phone and ringing the [50 Lives] social worker whose role is to help this person, who understands. Who might give some really great, salient advice to the police officer on the ground about how to deal with this person. –**Kim Massam, Detective Superintendent, WA Police***

3.5 Future Evolution of the 50 Lives Collaboration

Whilst the founding partnership base of 50 Lives is large and broad, as noted by the project manager, further growth of the project will be facilitated by drawing additional services into the collaboration, particularly where there are areas of unmet client need. The benefit of further expanding the mix of

organisations and sectors involved has been noted in a number of discussions with the research team.

> *It would be great to include a representatives from; local government (City of Perth); Department of Immigration; and Department of transport. Currently appears to be a lack of awareness within these departments, as to the difficulties faced by non-residents who have lost their primary ID documents.* ***– Lead Worker Survey Feedback***

It is pertinent to note that there is an expanding array of organisations (that are not formal 50 Lives partners) across Perth involved the support of different clients. Examples include counselling services provided through Relationships Australia, Starting Over Support, Men's Shed, Derbarl Yerrigan Health Service, TAFEs attended by some 50 Lives clients, Women's refuges and many more.

Feedback from interviews has also suggested that there is an overall need for more caseworkers as the demand for the program continues to rise. It is therefore strategic to continue to develop partnerships with other organisations and tap into their potential availability and expertise to further support vulnerable people in Perth.

> *the main frustration is that I'm finding that there's so many people but there isn't enough caseworkers even within the collaboration* **– 50 Lives Lead Worker**

RPH Homeless Team in action. Photography by Tony McDonough.

4. AFTER HOURS SUPPORT

[The] After hours, service has been very useful in supporting me with medical issues, financial support and in the community. It has been very important for me to have access to the After Hours workers to support me to process different situations and discuss.

- 50 Lives Client

There is a growing body of evidence showing rates of tenancy loss and eviction are far higher amongst people who have been chronically homeless, if housed without additional support. A 2013 study highlighted this where 50% of formerly homeless men that were housed without support were eventually evicted into homelessness.[22] The underlying basis for these evictions is that even when housed, an overwhelming number of issues and problems remain, many of which were likely incubators for homelessness in the first place.[1] Foundational to the 50 Lives project is a commitment to unravelling these issues and troubleshooting arising problems in order to effectively transition chronically homeless people to stable and enduring tenancies.

A vital component of the 50 Lives project therefore is the AHSS which provides assistance in clients' housing, health and psychosocial needs. The service is firmly linked in with the partner agencies and the integration of client case management makes the AHSS an important adjunct to 50 Lives.

The AHSS is a critical element in enabling 50 Lives to sustainably house and support the most vulnerable rough sleepers. The AHSS does this by extending the capacity of existing service providers to work with more individuals with multiple and complex support needs. Whilst the AHSS is also seeking to sustain tenancies, and this is their core work, the service also plays an important role in establishing tenancies, and can thus be found supporting clients who are sleeping rough, in transitional or crisis care, or who have made it into their own home.

The service provides follow-up services in evenings and on weekends to housed 50 Lives clients, and can be booked by the lead worker (from any participating agency), the client themselves or the housing provider. Visits by the AHSS to a client can be in response to current crises, or can be part of planned and proactive work. They can be on an ad-hoc or regular basis. The AHSS team is comprised of staff from both Ruah and HHC.

In the 18 months between January 2017 and June 2018, the AHSS provided support to individuals over 7,800 times. The majority of these clients (75%) were housed in long-term accommodation. Supporting people once housed and to remain housed is a core focus of AHSS, but the reality is that there are 50 clients who are not yet housed permanently, or who are in transitional accommodation, or who have lost their initial tenancy and are working towards re-housing. The AHSS team is able to work with clients in these situations also, hence their statistics also reflects some work with unhoused (7%), street present (7%) or transitional housing clients (10%).

It is important to note that receiving AHSS support is not obligatory and clients can opt not to receive it, and clients can elect to vary the frequency and nature of support and contact over time. As at 30 June 2018, 41% of 50 Lives clients were "currently" receiving support, with a further 19% "previously" supported by AHSS (see Figure 4).

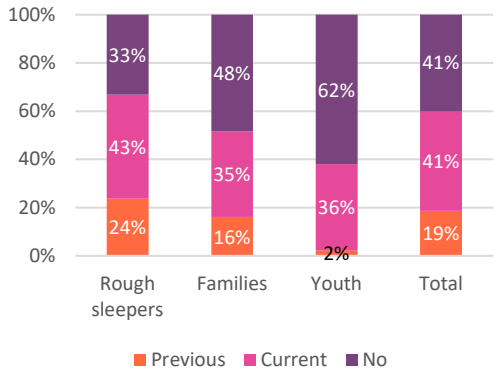

Figure 4: Percent of 50 Lives Clients Supported by AHSS per Working Group Category

The aid and assistance provided by the AHSS is logged under four overarching categories:

1. *Basic needs* e.g. toiletries or clothing.
2. *Planning* e.g. use of outcome measures or initiation/amendment of a health plan.
3. *Support* e.g. self-care, managing money or AOD.
4. *Referrals* e.g. accommodation or crisis care.

In total, there were 7,888 instances of care provided to clients. During these visits the AHSS provided over 3,000 referrals, close to 35,000 different types of personal support, over 6,000 instances of planning and a further provision of 8,000 basic needs (See Figure 5). As the figure shows, a majority of this assistance is provided to clients who are already housed and seeking to remain so.

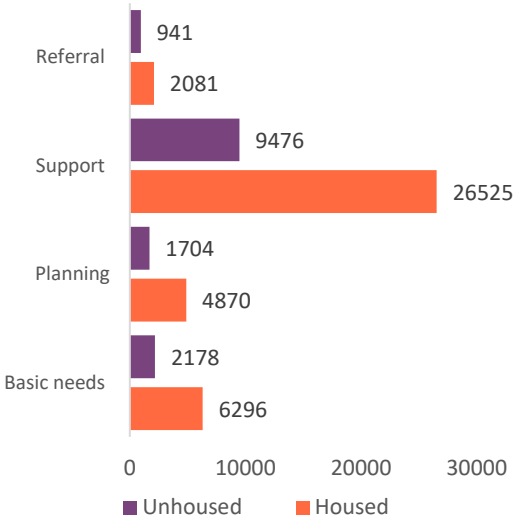

Figure 5: Assistance Provided by AHSS to 50 Lives Clients

Period graphed: Jan 2017–Jun 2018

Currently, AHSS data is unable to be quantifiably linked to other data to indicate specific changes amongst individuals, however data for those who are housed (long-term housing) can be compared to those that are unhoused (either transitional, street or outreach) to indicate broad and mass changes or outcomes from the AHSS. Additionally, rich qualitative data from clients and AHSS data illustrates the impact of AHSS support for individuals.

4.1 Basic Needs

There are seven broad areas where basic needs are provided, including toiletries, clothing, food, blankets, vouchers, transport and information. Overall, material needs are provided relatively sparingly, with providing information accounting for nearly 90% of the basic needs services provided for both housed and unhoused clients (Figure 6).

The sparing nature of material provision reflects the role of the AHSS, pushing beyond hand-outs and 'Band-Aid' options utilising more lasting interventions through education, case management and direction.

AHSS Nurse Supporting Client. Photography by Tony McDonough.

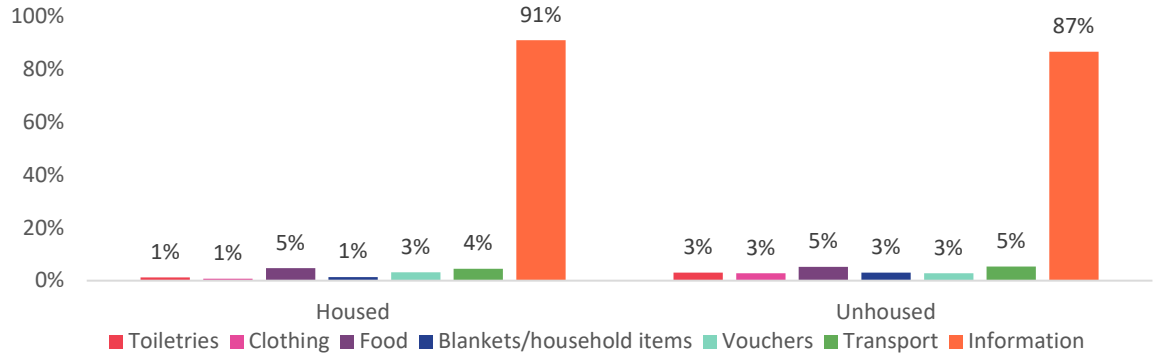

Figure 6: AHSS Instances of Assistance where Basic Needs were Provided
Period graphed: Jan 2017–Jun 2018

4.2 Personal Support

Overall, personal support is provided by AHSS the most. Amongst the long-term housed clients who received more than two thirds of all AHSS assistance (5,517 total visits) – the most frequent reason for support was emotional or mental health (n=4,478), followed by self-care (n=4,151) and physical health (n=3,577) (Table 2). The data demonstrates that the majority of clients received support in multiple areas.

> *They come here and see if I'm okay, even if it's for a chat sometimes because I'd get very upset- like when I went to court for [my son].* **– 50 Lives Client**

Interviews with both clients and members of the AHSS team highlight how critical it is that health and broader support is coupled together via AHSS.

Table 2: Frequency of Supports Provided for Long-Term Housed Clients

Mode of Support	Frequency	
	Housed	Unhoused
Motivation	3,292	1,088
Self-care	4,151	1,376
Managing money	1,480	563
Relationships	1,917	691
AOD	1,734	836
Physical health	3,477	1,405
Emotional/mental health	4,478	1,475
Use of time	2,377	817
Accommodation	2,555	1,043
Offending	461	182

Note: multiple types of support were provided at every visit.

While both housed and unhoused clients rely heavily on AHSS support across a wide spectrum of issues. Over 70% of AHSS visitations involved emotional or mental health support regardless of housing status, and over 60% of visitations resulted in self-care or physical health support as well.

> *I mean, you can ask them I guess paperwork or this or whatever you need. For me, I just needed for someone to get me out of the four walls a bit, you know.* **– 50 Lives Client**

Once housed, there were a number of observable changes in the types of support provided (Figure 7). The most notable changes were in the support areas of alcohol and other drugs (AOD), which was required 12% less if housed; physical health which reduced by 10%; accommodation which reduced by 8%; and emotional/ mental health support which increased by 4% for those housed. Changes in support patterns show a change in support priorities, for instance, one could hypothesise that once off the street and in housing, clients are able to stabilise their physical health. At the same time, once housed, clients are in a safe space to be able to deal with mental health and emotional needs – but there could also be increased need for this type of support due to the overwhelming changes. This may also explain the increased demand for self-care and motivation support.

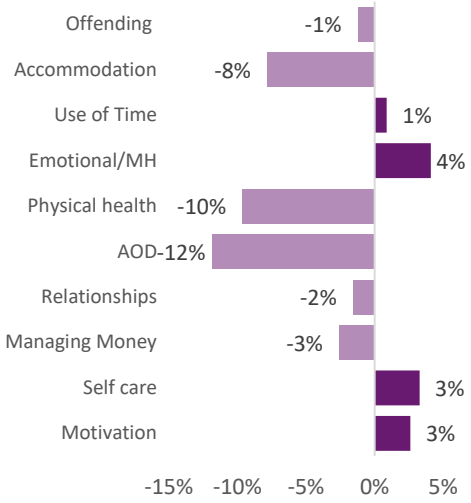

Figure 7: Changes in AHSS Support once Housed
Period graphed: Jan 2017–Jun 2018

Support provided by AHSS is entirely dependent on client need, the below case studies (Box 7 and Box 8) provide examples of how some clients will require multiple types of support concurrently and how sometimes it takes a while to establish trust and rapport with clients.

Box 7: Support Provided by AHSS

Background: Peter has a number of complex health conditions including chronic hip pain, alcohol and drug use issues, and mental health concerns. While initially difficult to engage with, in mid-2016 he expressed interest in finding housing and stated he was willing to engage with the team from HHC. He was offered housing in late 2016, and since then has been provided substantial support from AHSS.

Support provided: AHSS began supporting Peter in mid-2016 while in transitional housing, since then he has been supported on over 80 occasions. These visits are a combination of interactions on the street, at the hospital or at his house depending on his current circumstance.

Peter has been supported by AHSS with provision of medication (such as prescriptions, asthma inhalers, band aids), provided medical counselling, offered social support, supported with life skills (such as how to prepare food, and how to care for his wounds), and given support with accessing Centrelink (amongst other things).

Summary: Unfortunately, like many individuals who have experienced long-term, chronic homelessness, Peter lost his tenancy in early 2018. While the 50 Lives team continues to search for another suitable tenancy for him, AHSS continues to provide him support through reminders of when he is due for his Depot injection and provision of medical supplies (i.e. inhalers).

AHSS Nurse Supporting Client. Photography by Tony McDonough.

Box 8: Different AHSS Approach

From an AHSS Nurse:

There is a client we visit weekly and have been working with for about a year. He had a fall from a big height and now suffers from memory impairment and seizures. His housing was unstable prior to the injury, and after the fall, his condition wasn't well managed as he couldn't remember to go to all his follow up appointments, and unfortunately he just lapsed into homelessness and was completely lost to all follow up. He kept having seizures and reinjuring himself.

We have been working with him quite intensively. Part of this is about encouraging him to take his seizure medication. He has a fear of hospitals and health professionals is petrified of the idea of taking medication. We have been engaging with him to some formal diagnoses and supports for daily living in place. It is hard for him as he is really independent, adverse to having people help him, doesn't want handouts. Over time we have built rapport and he has told us how frustrated he is about his injury, his memory impairment… gradually we can broach things like getting strategies to remember things from the occupational therapist who works with HHC. We have been able to build rapport and unpack things with him that you couldn't do in a hospital setting. That's the strength of afterhours !

4.3 Referrals

A function of the AHSS is to refer clients to more specialised services and support agencies where necessary. This could be in situations where the AHSS cannot provide the necessary help, where the patient would be suited to additional help or where a different service could provide greater aid. The majority of these referrals are to health, accommodation, crisis, and mental health services. The service also makes many other referrals however these are not recorded independently.

As seen in Figure 8, the majority of referrals are recorded as 'other'. For most categories, unhoused clients receive the majority of referrals, which makes sense that clients who are housed and supported,

seemingly do not require referrals to crisis or accommodation services.

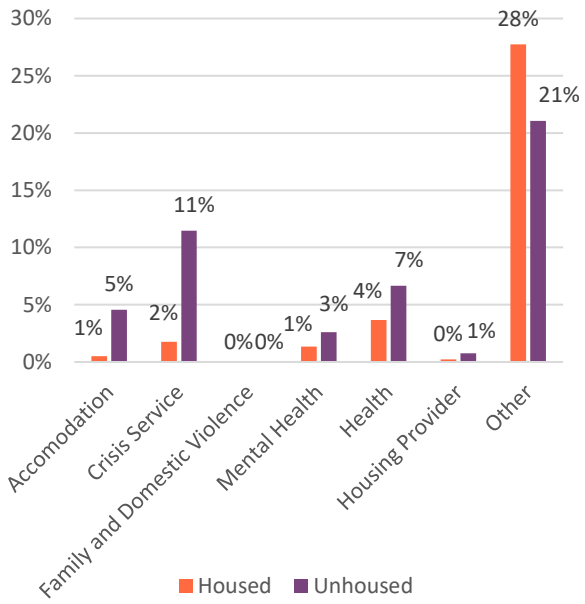

Figure 8: Relative Service Referrals for Housed and Unhoused Clients

4.4 Feedback on the AHSS

Feedback has been collected across a number of mediums, including client satisfaction surveys, where the majority of responders provided positive feedback.

> *…the AHSS has been my saviour… it's not just the practical support, but how it helps with my mental health… well it's really all mental health support isn't it.* **– 50 Lives Client**

> *They are awesome and a really excellent support.* ***– Client Satisfaction Survey Response***

> *The support I have received from you is amazing, my journey has been difficult and complicated but still you have been here for me 100% and I appreciate you whatever the struggle may be!* ***– Client Satisfaction Survey Response***

> *It is fantastic having an after hour support service available to me if I need them* ***– Client Satisfaction Survey Response***

Overall there was only one negative comment about AHSS and this related to a particular client not liking that it was different nurses who visited them each time as they felt they couldn't properly establish trust. From an AHSS team and service provision perspective however, the flexibility to rotate and roster different staff is necessary at a pragmatic level, and also helps to create a unified 'face' of the AHSS service to clients. It is intentional that AHSS be seen as a seamless service not dependent upon an individual staff member. Having said that, AHSS is cognisant of the importance of trust and relationship building with clients, and the Perth 'north' and 'south' teams have different clients that they work with, and the nurses and Ruah workers involved in AHSS typically have routinely rostered shifts and clients.

In the survey undertaken with lead workers in April 2018, they were asked what in their view, 50 Lives has been able to deliver for clients that would not have happened before. The AHSS that accompanies housing was the most commonly mentioned benefit, with 60% of the 25 open ended responses commenting on the value of the AHSS, as reflected in some of the comments (Box 9).

Box 9: Lead Worker Feedback – AHSS Responses

What has 50 Lives 50 Homes been able to deliver for clients that would not have happened before?

- *AHSS means less hospitalisations for our clients. Provides community connection our clients are often disconnected and socially isolated.*
- *the access to after hours and also the ongoing and never ceasing nature of the support.*
- *Reassurance. Someone is always at the end of the phone, sometimes they just need a familiar voice to talk through and help work out the problem.*
- *the bonus of having access to AHSS is a great support*
- *Night time service is an excellent resource.*

5. CLIENT HOUSING OUTCOMES

"Now I've got a house I feel safe. I can finally call something home. We got told it's not a forever home... It's transitional. But for now, having that stability, and that safety net feels really good"

- 50 Lives Client

A key aspect of the Housing First approach is rapidly housing and supporting individuals so that they are able to sustain their tenancy. As the name implies, housing is provided first, not delayed until people are 'housing ready'.

The Housing First approach advocates that people experiencing homelessness are better able to access support and achieve long term positive outcomes from the stability of a home.[5]

Integral to Housing First and to the 50 Lives project is the coupling of housing with wrap-around support. In contrast to many homelessness programs that may only have capacity or funding to support people for a defined time period, 50 Lives, is committed to providing support for individuals for as long as they require, even if they lose their initial housing.

Once housed, there is the potential for a positive cyclical relationship, whereby the stability of housing facilitates the addressing of broader health and psychosocial issues. In turn, supporting clients to address health and psychosocial needs enables tenants to remain housed.

5.1 Homelessness History

Many 50 Lives clients is have cycled in and out of homelessness for years, and this in and of itself brings challenges for housing and tenancy sustainment.

As at June 30 2018, **individual 50 Lives clients** had spent a combined period of 1,075 years homeless, or an average of 5.6 years homeless per person prior to VI-SPDAT completion, AND **50 Lives families** had spent an average of 2.8 years homeless prior to completing the VI-SPDAT.

The average years spent homeless by 50 Lives clients masks enormous variability, with one client homeless for 28 years.

Prior to completing the VI-SPDAT, the majority of **individual 50 Lives clients** were sleeping rough (62%), while **50 Lives families** were more likely to be staying with friends and family (38%) (Table 3).

> *…I was sleeping wherever. Normally I sleep down near the river. At one stage, I was couch surfing. At friends' houses and stuff. But then their parents were just oh you can't stay here anymore… But most of the places where we sleep we find the council puts the sprinklers on us.* **– 50 Lives Client**

Table 3: Where Individuals and Families Slept Most Often

n(%)	Individuals (n=193)	Families (n=26)
Sleeping rough	119 (62)	8 (31)
Boarding houses/hostels	16 (8)	6 (23)
Emergency/crisis accommodation	22 (11)	1 (4)
Friends/family	28 (15)	10 (38)
Other	8 (4)	1 (4)

While the term 'living on the streets' is widely used, one client poignantly noted that life on the street wasn't really living, and went on to describe the huge impact of this on mental health and motivation to change current circumstances.

> *It's an existence rather than a life on the street. It's not an actual life, really. You get by day by day, existing.* **- 50 Lives Client**

The pathways into homelessness is different for every individual, but it is evident that for many clients it is preceded by a raft of adverse life experiences.

> *…I was a ward of the state. Grew up in DCP care. I just kept running away all the time and I didn't like rules and stuff. They were very strict but I didn't like it. Because I got split up from my brothers and sisters… I kept trying to run away to find them. I just ended up - I just liked the street life.* **– 50 Lives Client**

5.2 Housing Outcomes

There are a number of key housing outcomes desired by 50 Lives and the organisations involved. Critical indicators include the number of people housed, how quickly people can be housed, and the extent to which tenancies have been sustained. Data presented in this chapter have been produced using 50 Lives project quarterly administrative data as at the 30 June 2018.

5.2.1 Number of Clients Housed to Date

As at June 30 2018, 221 individuals had consented to join 50 Lives and were being supported by the project. Overall, 147 people had been housed in 109 homes. Since June 30 to the time of publication, at least another 10 people have been housed by the 50 Lives project.

To date, 50 Lives clients have been housed all over Perth, with the majority located within 10kms of the Perth CBD (See Figure 9).

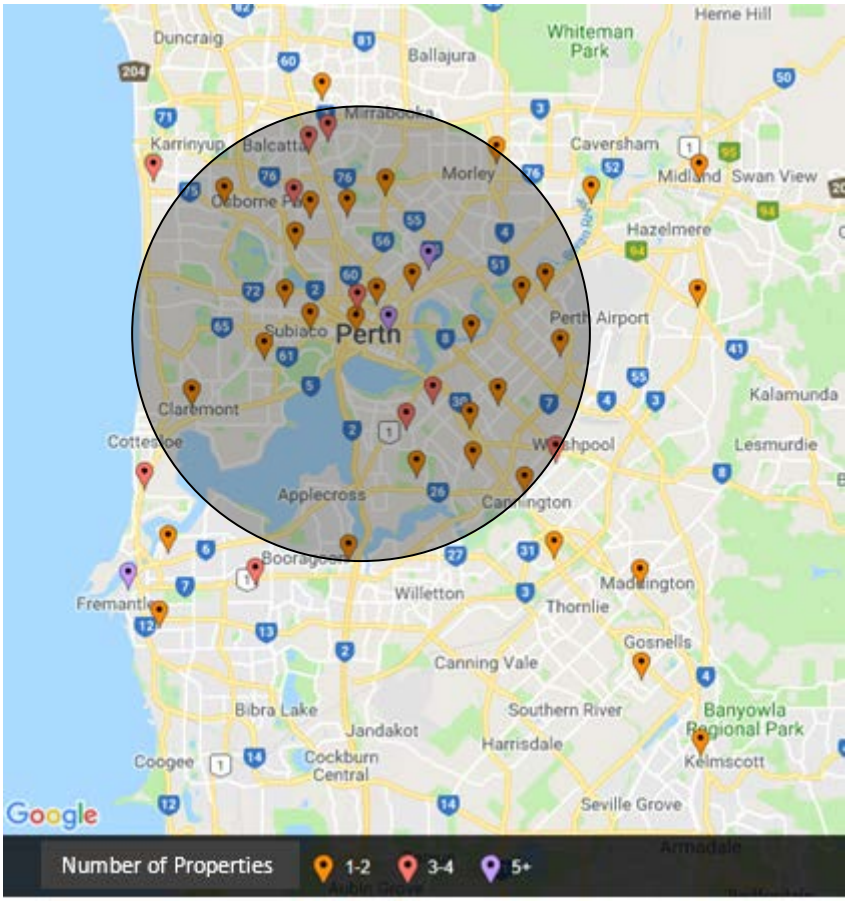

Figure 9: Suburbs Across Perth where 50 Lives Clients have been Housed

Note: Circle represents approximate 10km radius of Perth CBD. Suburbs mapped for 103 properties.

Where possible, the location of housing for 50 Lives clients is carefully selected through the need to ensure clients' can successfully integrate into the community and live in reasonable proximity to relevant services. As noted in one social housing discussion paper, the following factors can all critically impact individual wellbeing:

> *proximity of the house to urban centres and job markets, transport links… the social mix of the community and the provision of public amenities such as parks, clinics and schools* [23, p.19]

Factors such as walkable proximity to shops and public transport are particularly important for 50 Lives clients. Accessibility to other social amenities is

also ideal as community involvement and meaningful use of time are goals that many clients are keen to work on once housed.

The availability of housing suitable for client needs in various suburbs can however mean that the initial type or location of the most 'rapidly available' housing may have some limitations. This is a tension also for those clients placed in transitional accommodation awaiting a permanent housing option.

The challenges of securing appropriate housing for clients with high vulnerability was recently articulated by a WA Police representative involved in 50 Lives from the outset:

> *We have to be smart about where we place vulnerable people in the community. Putting 30 vulnerable people in the same block of units is probably not going to be a success story. In fact, they may very well lapse and probably end up even worse, based on the stress there. So, the challenge is putting them into a more stable community, [but] there's challenges with that… the stable community will be more vocal in relation to reporting antisocial behaviour… less tolerant.* ***- Kim Massam, Detective Superintendent, WA Police***

In a number of interviews, clients themselves mentioned how the location of housing can make a difference to their own confidence to sustain their tenancy and adjust to life post homelessness. For example, two clients with prior drug use issues talked about being wary of neighbours who may be 'into drugs'. Another client living in a larger complex of flats had had some belongings stolen, and talked about wanting to move to somewhere different and where *'I could have a shed for fixing up my bikes'*. One of the younger clients housed in a flat through 50 Lives was very grateful to have a place to call home, but was hopeful of being able to move somewhere closer to his job and to a place where he could have a small patch of garden to go to when he was feeling anxious.

50 Lives lead workers are sensitive to the challenges that some clients may face because of where they have been housed, or due to the nature of the housing itself. There are therefore a number of clients who have relocated to different housing when it has become available.

5.2.2 Time Taken to House Clients to Date

During the 2016-17 financial year there were 16,500 people waiting for housing in WA, 1,590 of whom were on the priority waiting list.[24] The average time to housing for people on the Housing Authority waiting list was 139 weeks in 2016/2017, which is equivalent to nearly 1,000 days.[24] However, there are 2,800 people had been on the Housing Authority waitlist for over five years. As these wait times indicate, even priority listing for social housing is lengthy in WA, and whilst the time to house 50 Lives clients may not be as rapid as would be ideal, it compares favourably to a lengthy wait for public housing.

There continues to be enormous variability in the time taken to housing 50 Lives clients, with a range of factors affecting this, from the paperwork processes required, the availability of suitable housing for that client's needs, and individual circumstances that might impede immediate housing (such as severe health needs or a lengthy hospital admission). Over the last three months (to 30 June 2018), one client a week had been housed on average. Overall, two-thirds of those housed in this three-month period were housed in less than a year (Figure 10).

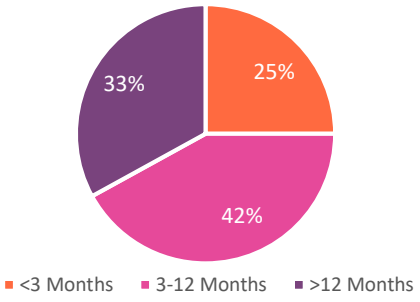

Figure 10: Time Taken to House from Consent Date

For those housed between April 2018 – June 2018

The persevering effort of the collective 50 Lives team (Ruah backbone staff, lead workers in the various partner agencies and the participating housing providers) in working collaboratively to house 50 Lives clients is noteworthy. This has been witnessed by the research team in the rough sleepers working group and deeply appreciated by the clients interviewed as part of the evaluation to date.

> *Within three months I was in the unit that I'm in now which blew my mind away that there was a*

service out there that was able to get me off the streets and all that. Pretty much everyone that I've spoken to have been on the priority waiting list for two to four years, [even] up to eight years, and I got housed within three to six months of being on the priority listing… **- 50 Lives Client**

Looking at the cohort of 50 Lives clients that were housed ***after*** they consented to the project (n= 90), data provided by 50 Lives indicated that the average time to house was 208 days, ranging from 0 to 704 days. It should be noted however, that this figure does not differentiate the difference between time taken to house someone who was priority listed or housed outside of 50 Lives. Further analysis of trends in housing patterns per quarter will be undertaken for the final report to measure if it's taking longer or getting quicker to house people as time goes on. It is also pertinent to note that even for those clients for whom it has taken longer to house, it remains substantially less time than the 1,000 odd days these individuals may have had to wait if they applied for public housing themselves.

5.3 Sustaining Tenancies

The overall housing retention rate of 88% is a positive marker of project success and reflects the enormous amount of work 50 Lives, partnering organisations, lead workers and the AHSS put into supporting people to sustain their tenancies.

… I have never had my own place to live before. I just passed my tenancy inspection with flying colours and in three months will have been here for one year.– **50 Lives Client**

Further, 87% of clients had retained their house after one-year. For those who were unable to sustain their tenancies, 10 properties were lost to eviction, with other reasons including death, prison, relationship breakdowns and, requiring higher levels of support. For those individuals who have lost their tenancy, 50 Lives continues to work tirelessly to rapidly re-house them, of which, six have already been rehoused.

As discussed in the previous subchapter, many of the 50 Lives clients have been homeless for numerous years and have had complex and trauma-filled lives, therefore a significant period of adjustment when first housed is expected. This is not unique to 50 Lives or its clientele. As reported in a recently published UK study that undertook a five year follow up of people housed through the Rebuilding Lives project:

we found that a significant proportion remained vulnerable during the first few years, and required long-term support in order to maintain a tenancy and prevent a return to homelessness. By the end of the Rebuilding Lives study, 89% of our participants were housed, although 16% had become homeless at some time during the five years since they were resettled.[25]

This highlights the critical need for a long-term outlook in Housing First projects, and a pragmatic acceptance that relapses into homelessness may occur. Effective intervention needs to have the capacity to support clients through risk factors for loss of tenancy, and even periods of 'relapse' from housing sustainment, whist retaining optimism for permanent housing as the end goal.

Already 50 Lives has had a number of clients whose first tenancy has not worked out (for a range of reasons) and there is a positive pragmatism among AHSS and lead workers in encouraging clients to maintain contact (housed or not) and to learn from such experiences for 'next time'. Several of these clients returned to living on the streets for a period, but maintained contact with 50 Lives and have been successfully re-housed.

5.3.1 Tailoring of Accomodation Type and Support to Bolster Tenancy Sustainment

The constraints on available housing are an ongoing challenge for 50 Lives in securing the ideal accommodation for individual client needs. It is recognised, however, that housing type or location can have a significant impact on client adjustment and tenancy management. Therefore, where possible these considerations are taken into account, and appreciation for this evident in a number of client and staff interviews. One client for example reflected how they probably wouldn't have been able to maintain their tenancy if the housing provided had been in a large apartment block with many neighbouring tenants:

*When you're suffering mental health issues and trauma and stuff, you want to be as positive as you can…So sometimes you might manage to do exercise or positive things, but then that's where the drugs, the alcohol, the food… to try and comfort and just make it stop. So an environment like that, it's everywhere… I think in a place like that it would just be so easy to give in to your head. You know what I mean; just go stuff it, I feel like s***, I think I'll have a big line of speed or whatever and make everything worse…* **– 50 Lives Client**

This client was housed in a small block of units, with a courtyard and small garden area. This particular client has been housed for almost two years, with no strikes or tenancy issues documented, and has voluntarily reduced the frequency of contact with AHSS because they feel they are managing really well, and that other clients may need the service more.

In another example, a client had prioritised family reunification as one of his goals hence he wanted an accommodation option that would enable this was sought. As shown in Box 10, this tailored responsiveness to the client's need has helped facilitate a really positive outcome.

Box 10: Planning for Family Reunification

Scott is a male in his late forties who was rough sleeping prior to joining the 50 Lives project in early 2017. At this time, his pre-adolescent son was under the care of the Department of Child Protection and Family Support (CPFS).

Scott noted one of his key goals was reunification with his son, with the intention to eventually gain fulltime custody of him. As Scott did not currently have custody of his son, he was technically only eligible for a one-bedroom apartment. Due to the reunification plans, Scott's lead worker alongside the Housing Authority and CPFS were able to come to an agreement that it would be beneficial to house him in a larger property. As a result he was housed in a two-bedroom house in mid-2017.

In early 2018, Scott gained temporary custody of his son, with the aim to have fulltime custody by the end of 2018. His lead worker has been working with him across a number of domains to get him ready for fulltime care, but notes the significant challenges that being homeless has left.

"He's a single dad… he's been doing all that strength based stuff with him…he has his son at the moment for three, four nights a week… he's doing the school drops, that side of things, trying to upskill himself with parenting skills and linking in with supports… [but] his son only goes to school for two hours a day.. so he can't work; he's a tradie so he wants to get back into work but he needs to get in a routine and his son needs to get into full time schooling and stuff…" ***– 50 Lives Lead Worker***

Another example of 50 Lives being responsive to client needs arose when one client was closely attached to their dog, and specifically requested a property that allowed pets and to be close to a park, stating that they would rather not have a house if they couldn't have their dog.

…I said no dog, no home… **– 50 Lives Client**

A housed client's garden.

5.3.2 Averting Loss of Tenancy

The loss of tenancies, in addition to the clear adverse impacts on the evicted tenant, is estimated to equate to an average cost of $10,441 per public housing eviction in WA.[26] Signs that tenancies may be at risk include rent arrears, social isolation and difficulty in maintaining the property to acceptable standards.[24]

To mitigate risks associated with losing tenancies, in early 2018 the 50 Lives project manager started collecting *"tenancy issue"* data across three domains including issues with bills and rent; property standards and behavioural issues. Each of these are considered areas where potential loss of tenancies could occur from issues and where intervention may be required to prevent this from happening.

Each quarter data is collated on the number of individuals who received strikes as a result of not paying their bills or not meeting property standards. Between the first quarter of 2018 (Jan-Mar) to the second quarter (Apr to Jun) there was an increase in the number of people who had no issues in all three areas (Figure 11). In the second quarter, there were

more individuals who received a breach notice as a result of not paying their rent or bills (from 1 to 5) and more people in all three areas who were evicted (from 0 to 1 in all three areas). While there has been an increase in the more "severe" outcomes, this may be due to increased response rates of the survey or due to more people being housed and therefore needs to be explored further before any conclusion can be drawn as to why this pattern has been seen.

Monitoring of these types of risk factors along the tenancy sustainment trajectory are important both at the individual client level (so that multiple strikes and/or eviction can be prevented) and at the 50 Lives project level and for the WA homelessness sector more broadly, so that systemic barriers to sustaining tenancies for former rough sleepers can be tackled.

Evidence from multiple sources confirms that the AHSS is a critical pillar in optimising the sustaining of tenancies among 50 Lives clients who may need ongoing support to increase their confidence and capacity in maintaining their tenancies.

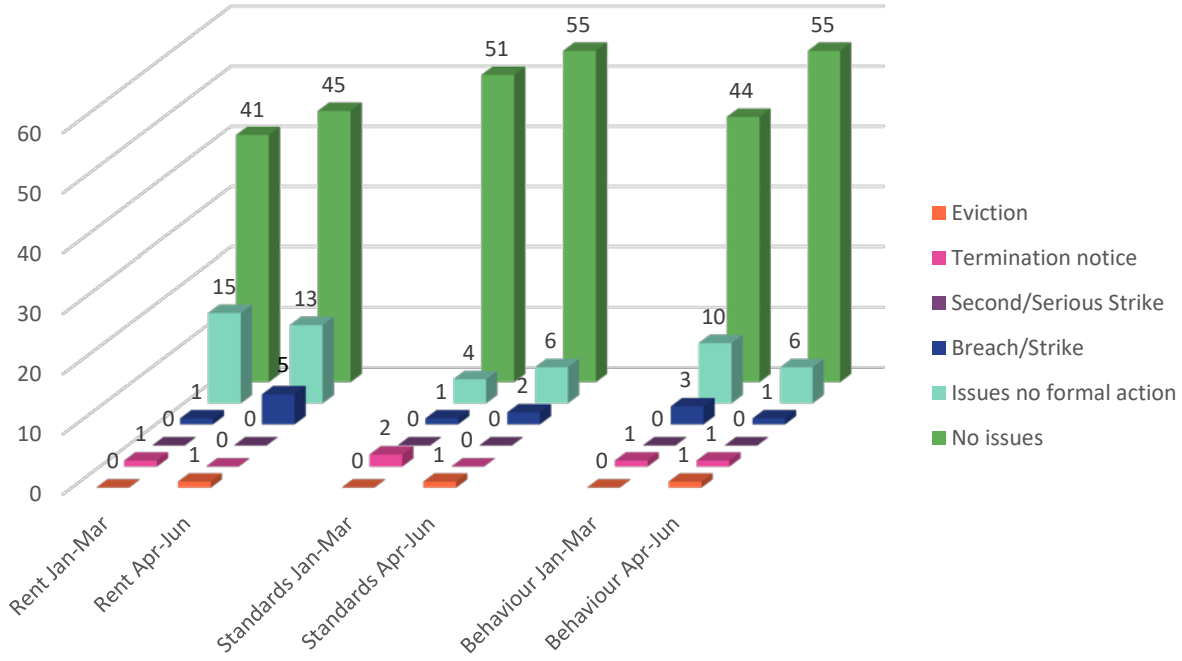

Figure II: Number of Housed People with Issues Relating to Rent, Standards and Behaviour
Number of responses between January to March = 58. Number of responses between April to June = 64.

5.3.3 Learnings from Tenancy Losses

While some 50 Lives clients have lost or come close to losing their tenancy, the benefits of even brief periods of housing and support should not be disregarded. As reflected by an AHSS nurse, a brief period of stability enabled one client to start addressing their mental health and even though they are now homeless again, they are in a better state than before.

> *because even though he lost his tenancy his mental health has improved a lot with the afterhours support during [that period of stability]… managed to get him consistently on an aripiprazole depot because previously he was on oral therapy and he was very inconsistently taking it. So even though he's homeless now I think he's actually better off.* **– AHSS Nurse** [postscript; this client maintained contact with lead worker and AHSS and has just been re-housed].

Several of the AHSS team have noted that it can sometimes take multiple attempts to house someone permanently, and a big emphasis is placed on stressing to the client to not be discouraged, and that

each effort at being housed provides a learning experience for next time.

This philosophy embraces the pragmatic challenges that can precipitate a slip back into homelessness, whilst also recognising that in many human endeavours people move through differing levels of intention and perseverance, and learning from any setbacks is important. This has many parallels to the transtheoretical model of health behaviour change[27] that is widely used in public health, whereby interventions recognise that individuals move through various stages of intention and change (see Figure 12 for a proposed visual application of this model to 50 Lives).

> *I honestly think that people take away some new skill or some new knowledge from each attempt… There's a couple of people now that have had more than one go at living in a house… even though there are still issues, he's still in the house and that was longer than the first time… It's similar to the addiction medicine literature where sometimes people need more than one go at rehab and they take away something each time… But often that's what we sit down and do with people when they are facing eviction is think about next time and what are you going to learn from this experience and what are you going to do differently next time. Reframe the whole experience in that way… The fact that he stayed there for as long as he did… that in itself was a good step for him because when we're rehousing again we'll be able to use that… "it was a period of good stability for you, and I know it was stressful but what can we do differently this time?"* **– AHSS Nurse**

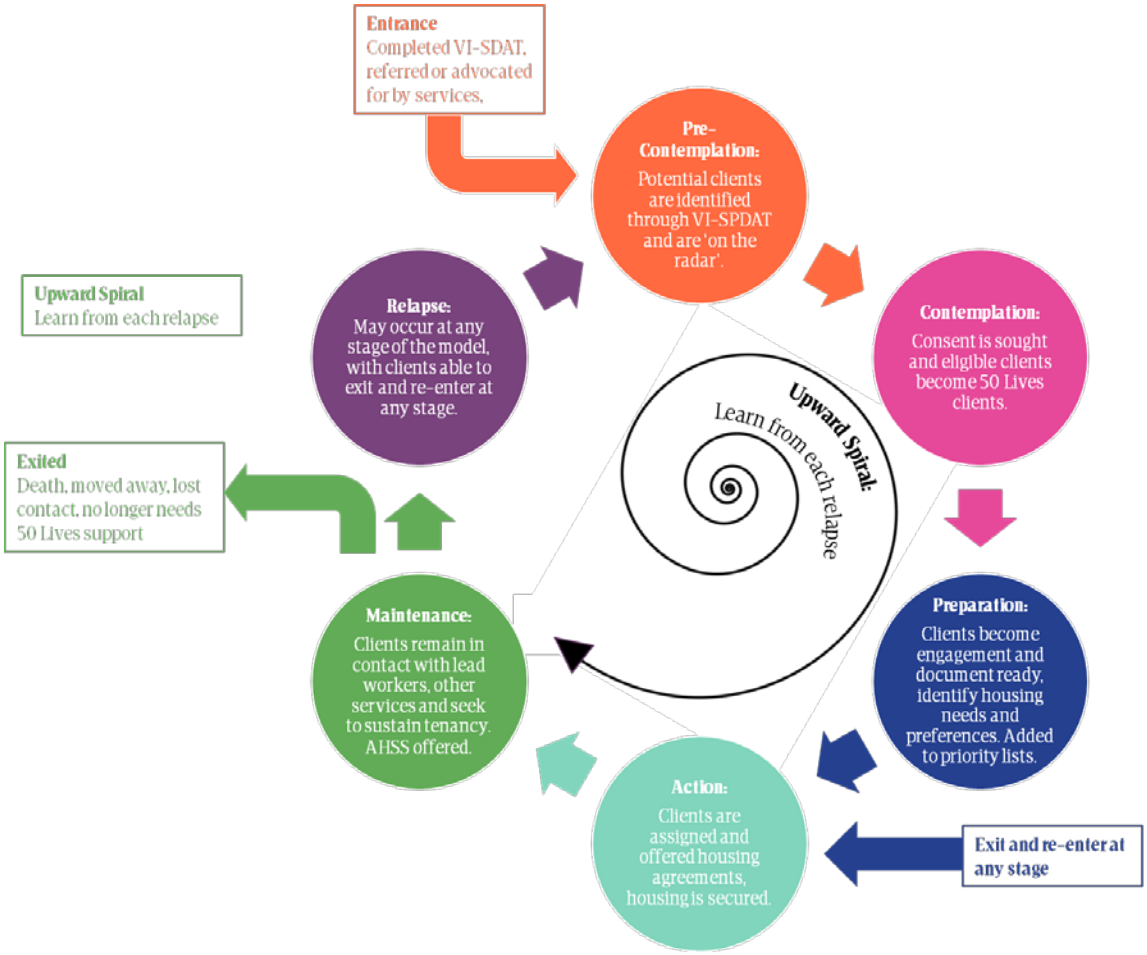

Figure 12: The Transtheoretical Model Applied to the 50 Lives Project

5.3.4 Futher Assisstance Reviews

Under Section 15(2)(e) of the *Housing Act* 1980, the Housing Authority have the power to refuse an application or place conditions on the application based on the applications previous tenancy history.[28] Where an applicant's history raises concerns, a Further Assistance Review (FAR) is completed to determine if their application will be approved, declined or placed under management assessment.

If the review warrants no further action, the application can progress as per the usual process. If issues are identified then it may result in conditions being places on the application and future tenancy. Conditions can include but are not limited to:

- Engaging with support agencies;
- Signing a fixed term Tenancy Agreement;
- Declaring their premises as "Liquor Restricted"

If a decision is made to decline the application or place under management assessment, the decision can be appealed.

As at June 2018, 11 clients had a FAR, over half of which were declined further assistance (Figure 13). Not only can the lead workers help clients to appeal these decisions, the relationships forged through the 50 Lives project have increased clients' ability to successfully manage their tenancies. The additional support, collaboration and AHSS offered through 50 Lives demonstrates that the client has far better resources available to maintain the tenancy on this occasion, and are therefore less likely to experience the same issues as previous attempts.

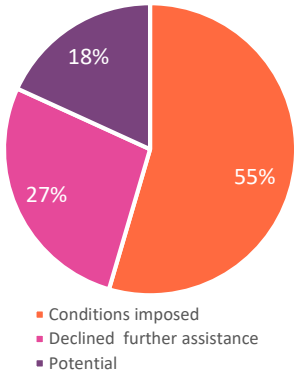

Figure 13: Further Assistance Review Outcomes

5.3.5 Challenges Once Housed

Housing highly vulnerable people isn't without its challenges.

> *…these are people that have multiple issues that affect their tenancy and their retention of housing… I would say that probably in the 70 to 80 percent range of the people that we service in afterhours would have some chronic mental health issues, some longstanding alcohol or other substance dependence, and generally some chronic health conditions as well. Any of those when they're poorly managed lead to behaviours that affect their housing. So whether that's having people squatting with them, having family stay with them that are disruptive, and - or their behaviour itself is just so either bizarre or aggressive towards other people, that kind of thing that lead to breaches.* **– AHSS Nurse**

Below are a number of examples of challenges experienced that arose during client interviews.

Safety

While feedback from clients suggested that they felt much safer overall since being housed, it was noted that a number of people had ongoing issues with neighbours and some safety concerns around this.

> *I feel safer besides a few problems … [there's a] crackhead downstairs who came in and took my Bankcard… and also the ex-fiancé as well. I'm trying to put a restraining order on her and her family…* **– 50 Lives Client**

> *…the lady upstairs, I don't get on with her because she's a thief… Yeah. She's a heroin addict.* **– 50 Lives Client**

Although 50 Lives, through the Lead Workers, has an integral role in supporting clients once housed, some issues may be beyond their scope or occur outside of business hours and in this cases the AHSS can provide necessary support and assistance to housed clients.

Expectations and Responsibility

One of the paradoxes 50 Lives faces is that once clients are housed they want to encourage self-efficacy and independence but this is restricted by the limited financial resources available to clients. People living on Newstart payments the DSP have payments below the budget standard required to maintain a healthy lifestyle.[29] This poses challenges for 50 Lives as it is difficult to build clients' capacity and empower their independence if they have debts to clear and are on a below poverty line income.

For many 50 Lives clients it may be their first time budgeting, maintaining a house and paying bills. The majority of clients have issues that preclude them

from working and are receiving Newstart or DSP payments. These payments rarely result in financial security for clients, the average fortnightly payment for a single adult in 2018 was $545.80[30] and once 25% of this payment has been spent on public housing rental little remains for living expenses. As an example, on a recent visit with the AHSS, a client who regularly enjoyed having a glass of milk said that he now only has milk in his tea as he was struggling financially and had fines to pay off.

Even with intensive support through the 50 Lives project, sustaining tenancies is particularly difficult for individuals when they have spent a considerable period of their life without a home and when they have compounding mental health and other psychosocial issues. An AHSS nurse reflected how clients can struggle to adjust to the expectations and responsibilities associated with housing.

> *he stayed in that place a lot longer than most people would have expected… he found the whole concept and having that weight of expectations of others on him quite stressful.* **– AHSS Nurse**

Balancing Health Priorities

Even for clients who have been stably housed for a long period of time face challenges when it comes to their journey back from homelessness. For one client, they reflect on how their mental health is slowly getting better since housing.

> *It's hard, the big wheel keeps turning and I feel like oh I should be doing this or that…But it doesn't work like that. By being positive and just keep trying and some days it might be that I've done the gardening and made soup and whatever, and other days it might be just that I had a shower and got dressed and watered my plants. So learning to - it's everything in life is just management and management problems for everyone. So - but yeah, my main goal is to just get back into the real world and it's coming slowly -* ***50 Lives Client***

While it is a long journey to get to where they are today, they also noted how they feel less reliant on AHSS and more confident to do things on their own and get *"back to the real world".*

Accepting Housing that does not Fully Meet their Needs

In addition to the general shortage of public and social housing, there is particularly limited housing that meets the needs of people who are single or are larger families. Additionally, due to the shortage of properties, people may accept properties that, although better than rough sleeping, lack key features that would benefit their physical and mental health. Several clients noted that a garden would be beneficial to helping their mental health, whilst others, although grateful to have housing, would have liked a shed or backyard.

> *I've been trying to get transferred to at least a minimum two bedroom so I can actually have a study room as well as my bedroom, and a place where I've got at least a little small backyard where I can have a shed to put my tools, instead of having my tools inside the house… I'm a handyman. I love my woodwork. I love my metalwork.* **– 50 Lives Client**

> *…I can't meditate here because there's not enough environment or nature around.* **– 50 Lives Client**

5.3.6 Support Provided to Sustain Tenancies

There are particular client circumstances that are extremely complex and contributing factors (such as mental health issues, drug use and brain injuries) that would make it unlikely that some 50 Lives clients would be able to sustain a tenancy on their own.

> *The housing could be free… but how is the polysubstance dependent, disorganised person with bipolar disorder ever going to maintain it [without support] -* ***50 Lives Stakeholder***

A part of what 50 Lives offers through both the lead workers and through the AHSS is ongoing intensive support tailored to individual needs. While the end goal would ideally to empower individuals and provide them with the skills and knowledge to sustain their tenancies on their own, the reality is some clients will likely need ongoing support in order for this to occur. Below are a number of examples of the types of support provided to 50 Lives clients to assist with sustaining their tenancies.

Support with Meaningful Use of Time

Meaningful use of time is an important aspect to address after prolonged periods of homelessness. As one AHSS nurse put it, individuals go from busy routines meeting basic survival needs to having quite empty days with risk of boredom:

> *When they're on the streets they have - it's maybe not a great routine - but they have stuff that they have to do so they have to go and find the soup vans or the drop in centres, get something to eat,*

find a place to have a shower, wash their clothes, all of the stuff… it's basically a full time job just trying to meet their basic needs. **- AHSS Nurse**

…but actually getting them to re-engage in the community, get them a routine, and finding some purpose in their days is really crucial in that first couple of months because otherwise they get bored… It's awesome having a house and being able to close that door behind you, but if they don't connect with the community or find purpose in their days then basically after about six to eight weeks the walls start closing in and they're sitting around twiddling their thumbs. They're bored and that's going to be a definite trigger for their drug use to escalate again. – ***AHSS Nurse***

The first six or so weeks can be a bit of a *"honeymoon period"* therefore measures need to be put in place to prevent boredom. For some this is means linking clients into volunteer services or community hubs such as men's sheds. This also helps ensure that their only connection isn't just the services visiting them.

Support to Link in with Other Services

An important aspect to prevent clients becoming too reliant on their lead worker or services such as AHSS is engaging them with other community organisations. An example of this is below, where clients are encouraged to link in with the HHC Transitions Centre (located in Leederville) as a way of attending regular appointments to manage their own health. A key aspect of the role AHSS plays is being able to liaise with lead workers so that similar advice and support can be provided across numerous mediums to encourage and empower clients to take responsibly (where appropriate).

We can take away that barrier that they had for accessing the GPs at the drop in centres …We can get them linked in with our GPs. They can go and see them at the office which is a much more controlled and stable environment. They - we can obviously liaise with their caseworkers to try and support them to actually get to those appointments and then we can refer them back to them - to the system. So whether that's MCOT or Inner City Mental Health, Elm Street, those kinds of places, we can refer them back to there, but now they have an advocate. So they have someone advocating on their behalf…So then when they make that step to go and seek proper tertiary level mental health care again it's on their terms, and they've also got someone looking out for them and referring them and helping them explain what their needs are and they don't have to do it all themselves. **– AHSS Nurse**

Support with Life Skills

As a result of many years spent without a stable roof over their heads, the transition into running a household can be quite difficult. For some, especially if they became homeless at an early age, may have never learnt skills such as cooking or cleaning, for others there may be prolonged periods since using these skills. One lead worker recalls how the AHSS provided cooking skills for their client:

…same with social supports; some of it could be cooking, like they will learn how to cook, they've gone in, they did recipes and went and got the food and then they're teaching them living skills and different things because sometimes people haven't used a cooker in a long, long time and they're like, I don't even know how to cook a meal. **– 50 Lives Lead Worker**

Support provided to clients is highly dependent on their individual needs. Box 11 provides an example of where one client had been housed for the first time in their life and lacked cleaning skills. Through the support of the AHSS and the housing provider this particular client was provided some leniency in their tenancy inspections while they were supported to learn new skills.

Box 11: Support with Life Skills

Robert is a male who had previously been rough sleeping for 20 years who was housed in mid-2016.

On a recent tenancy inspection by the Department of Community Housing, it was noted that Robert's house was *"grubby and smelt like smoke."* While the property currently didn't meet property standards and would typically be ordered a breach, in this situation leniency was provided as the housing provider understood that Robert had never been shown how to clean before and because he had been sleeping rough for so long he didn't know where to start. Instead, the housing provider is working with Robert's lead worker and the AHSS to provide him some cleaning products and to show him how to clean.

As reflected by the housing provider, *"he recognises that he needs to clean but he simply just doesn't know how."*

Support with Social Connections

Engaging with clients to build social connections is an important aspect of the 50 Lives program.

As reflected by one client, it was difficult when she first moved into her house because she missed all her friends that she had made during periods of rough sleeping.

> *It was hard [when] I got my house … the people that you meet when you're homeless, some of the people you get emotionally involved with them, they become your friends, you miss them. You look at them like they're your family.* ***– 50 Lives Client***

In addition to these areas of support described above, numerous other areas arose during client interviews which are depicted in Figure 14.

Figure 14: 50 Lives Client Feedback Over Support Domains

5.4 Feedback and Collaboration

An important aspect of the 50 Lives collaborative is ongoing feedback and improvement of service delivery throughout its course. As such, lead worker feedback has been undertaken twice so far. As part of April 2018 feedback, lead workers were asked to comment on things they wouldn't have been able to achieve without the collaborative, Box 12 lists a number of achievements relating to housing.

Box 12: Lead Worker Feedback – Housing Responses

What has 50 Lives 50 Homes been able to deliver for clients that would not have happened before?

- *access to appropriate housing opportunities for homeless people who otherwise would not have access to housing due to barriers such as documentation, ID, mental health, or the ability to access the Department of Housing due to knowledge, independent living skills or cognitive abilities.*
- *Keeping families together by preventing homelessness*
- *Support and ability to maintain tenancy*
- *Hope for safe housing options*
- *Holistic approach - wrap around support in keeping clients housed*
- *After Hours Supports and suitable housing.*
- *Intensive support at the start of the tenancy.*
- *Integrated approach of Housing and Support - we know our common goal is to sustain the tenancy together so we communicate better with this shared understanding.*
- *I have had offers from Community agencies for housing, for clients. They contacted me rather than me contacting them!!*

The collaborative partnership model underpinning 50 Lives has yielded reciprocal benefits for 50 Lives and for other services working in the homelessness space. The vignette in Box 13 provided by Tenancy WA illustrates this.

Box 13: Safe as Houses: Case Study

50 Lives have been a key partner for the Safe as Houses program (SasH) and provide an excellent collaborative space to work on some of the most difficult cases for people who have been let down by the system. As a recent example, SasH had worked long term with an Aboriginal mother facing eviction to homelessness, and secured new community housing for her and her boys. There were many people experiencing homelessness in the extended family, who often came to her for support, and at times this put our client's home and safety at risk.

So we sought assistance from 50 Lives for our client's parents, who care for three of their grandchildren and who have been homeless for over a decade. SasH took on the lead worker role, and the 50 Lives partnership provided housing for this couple and their grandchildren, Aboriginal elders who now have a home of their own for the first time in ten years. There are ongoing challenges for the family, with a family member going to prison, and SasH and 50 Lives will continue to support the family.

6. CLIENT HEALTH OUTCOMES

"That's why getting a house was very important because of my deteriorating health. Because I'm not on top of it. Because being on the streets and stuff is hard. But having my insulin, not being in the fridge. Just keeping on top of my medications and all that, it was pretty hard. Now I've got a house I can keep on top of that."

- 50 Lives Client

The revolving door between homelessness and poor health is explicit, with many social determinants of health (such as addiction, trauma and social isolation) contributing to poor physical and mental health outcomes. Additionally, physical and mental health issues can exhibit a negatively compounding relationship which becomes more complex and difficult to address over time.

As Fazel et al. describes, those experiencing homelessness are well over represented in areas of mortality, physical and mental health when compared to the general population.[31] On any measure, their health inequalities are great.[32] With these high health needs comes a high use of healthcare, especially acute services[33]. This seems to be due to a lack of engagement and access to preventative or primary healthcare, lending to many only seeking treatment for issues with great severity and complications.[34, 35]

There are great costs and consequences for the health sector associated with homelessness.[26] This new epoch of seemingly uncontrollable health spending has created a strategic imperative for reducing the revolving door in homeless health. Marmot has said that is futile to treat homeless patients and send them back to the social circumstances that made them sick,[36] and so the ideals of projects like 50 Lives have come to the fore. A recent systematic review of the literature, Rog et al[37] has already concluded that there is evidence to suggest that permanent supportive housing reduces homelessness, and decreases ED visits and hospitalisation.

> *At the core of the poor health of people who are homeless is the absence of a safe and secure house in which to live. You can't 'fix' the health of people who are homeless without addressing housing.* ***- Dr Andrew Davies, Director, Homeless Healthcare***

This evaluation utilises administrative hospital data and clients' self-reported outcomes and service use from the VI-SPDAT to present an overall profile of clients' health and changes in service utilisation since support from 50 Lives.

This health chapter is separated out into three sections;

- Self-report data from the VI-SPDAT;
- Aggregate health administrative data for a cohort of 192 clients in the years prior to joining 50 Lives, and;
- Comparative health administrative data for the cohort that have been housed for six and 12 months.

6.1 Self-Report Health Outcomes and Service Usage

The VI-SPDAT is used as a screening tool to assess for 50 Lives eligibility and collects a broad range of self-report health and health-related information. In this report, the VI-SPDAT data forms an important component of creating a baseline picture of the health of clients participating in 50 Lives.

The VI-SPDAT data provides an overall picture of health, although it should be noted that it does not always identify all health issues experienced, especially for Aboriginal respondents. Self-reported data on health conditions and hospital usage for 50 Lives clients is available for **193 individuals and 26 families.** For family data, the Head of Household (HoH) completed the VI-SPDAT with respect to the circumstances of all family members and thus is presented separately.

6.1.1 Drug, Alcohol and Tobacco Use

AOD Use

There is evidence that people experiencing homelessness are more likely to use tobacco, alcohol and illicit drugs compared with the general population.[31,38] Throughout client interviews, many suggested that their AOD issues either began or escalated after becoming homeless. One client explained that in part, they began using methamphetamine to stay awake to avoid assaults whilst they were rough sleeping. Where a lack of safety and security are constant experiences, many seek release or distraction in alcohol or illicit substances.

> *…when you sleep you've got to keep one eye open. It's hard to fall asleep because you're always worrying about what's going to happen and stuff. That's why I turned to drugs a little bit, to keep me alert and stuff.* ***- 50 Lives Client***

Problematic drug and alcohol use is one of the major contributing social determinants of health and thus makes sense of the broader health struggles of experience by many of the 50 Lives clients. Up to 91% of **50 Lives individuals** reported problematic drug use, additionally 58% reported injected drugs in the last six months, compared to 16% of the general population who reported using any illicit drug in the last 12 months in 2016 (Table 4). [39]

Of the **50 Lives families,** 88% reported problematic AOD use, while overall they reported lower rates of daily alcohol use (30%) and lower rates of drug injection (50%) compared to the individual responders. More than 50% of clients reported drinking alcohol on a daily basis, which is substantially higher than the 6% of Australians adults who reported daily alcohol consumption in 2016.[39]

Table 4: Self-Report Drug, Alcohol and Tobacco Use

n(%)	Individuals (n=193)	Families (n=26)
Problematic drug and alcohol use	177 (91)	23 (88)
Daily alcohol use^	100 (51)	8 (30)
Injected drug use^^	112 (58)	13 (50)
Current smoker	144 (74)	23 (88)

^ in the last month
^^ in the past six months

Many clients express the social consequences they have experienced due to drug use – with drugs often straining relationships on top of relational burden created by homelessness itself.

> *I reckon now I have housing I can work on my alcohol and drugs. Because my parents and my family just cut me off there for a while. When I was seriously doing drugs. They'd say you need to get help, we want nothing to with you until you get the help. So now I can get that help I can get my relationship with my family back.* **- 50 Lives Client**

A further issue noted following drug use is its effect on oral and dental health. This is touched on later in this chapter.

> *From [using] gear… That's how come I've got destroyed teeth on the left-hand side because I only smoked. I never injected.* **- 50 Lives Client**

Tobacco Use

Tobacco use among people experiencing homelessness has been described as the neglected addiction.[40] With smoking related deaths among people experiencing homelessness occurring at double the rate seen among people with more stable housing and accounting for a considerable fraction of the absolute mortality disparities between these groups.[41]

In 2016, the most recent data for WA, it was estimated that 11% of the adult population smoked either regularly or occasionally.[42] In comparison, self-reported data for **50 Lives individuals** shows that 76% were current smokers, and reported smoking an average of 17.7 cigarettes per day or just shy of one pack a day. Amongst the **50 Lives families**, 88% stated that someone in the family was a current smoker, and reported smoking an average of 14.5 cigarettes per day, or three quarters of a pack (Figure 15). The most recent national estimates for tobacco consumption (2016) suggests that smokers in the general population consume 13.6 cigarettes per smoker per day.[43]

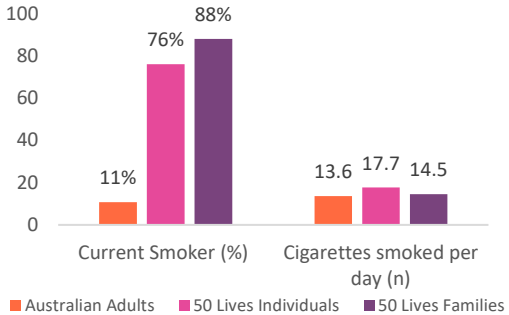

Figure 15: Comparison of Smoking Prevalence and Consumption

There is a common misconception that people experiencing homelessness either don't want to stop smoking or that addressing other issues is a higher priority. A survey of smokers experiencing homelessness found that 59% of current smokers would like to quit, and 71% would like to cut down.[44] Colleagues from HHC have suggested two main barriers for people experiencing homelessness quitting smoking. Firstly, the lack of a safe and secure place to be whilst withdrawing. Secondly, costs of addiction and quitting treatments, as currently the only treatment available on the PBS is nicotine patches.

6.1.2 Mental Health

The association between homelessness and mental health is well documented, with each compounding the other. In a meta-analysis of homelessness studies, the prevalence of psychotic illnesses and personality disorders was considerably higher among people who were homeless compared with the general population.[45] This is also reflected through the 50 Lives cohort.

Whilst it is pertinent to note that the scoring methodology for the VI-SPDAT defines mental health quite broadly[i] and that the data is self-reported and is therefore not supported by clinical diagnoses, it is still true that 99% of **50 Lives individuals** perceive themselves to have a mental health issue (Table 5). Whatever gap there is between self-reported perceptions and actual diagnoses can only reflect a chasm in providing necessary support and or treatment for the mental health of those in homelessness. Amongst **50 Lives families**, mental health issues are reported less than for individuals but still far higher than the general population (65%).

Table 5: Self-Report Mental Health, Dual Diagnosis and Tri-Morbidity

n(%)	Individuals (n=193)	Families (n=26)
Mental health issue	192 (99)	17 (65)
Substance use issue	184 (95)	24 (92)
Dual diagnosis^	185 (95)	17 (65)
Serious health condition	167 (86)	24 (92)
Tri-morbidity^^	163 (84)	10 (38)

^ mental health and substance use
^^ mental health, substance use and serious medical problem

People with a history of sleeping rough often experience severe and enduring mental health issues along with entrenched alcohol and/or drug use. For services in the homeless sector, this dual diagnosis and lack of a stable address result in great difficulty accessing appropriate support to assist people in these circumstances. Even where specialist services are willing to take on cases with co-existing mental health and AOD issues, their lack of experience in homelessness results in our client group being excluded or exited early. ***- 50 Lives Project Manager***

6.1.3 Dual Diagnosis and Tri-Morbidity

The abundance of patients reporting tri-morbidity suggests a very poor level of general health and is a useful marker of complex health amongst people who are homeless. Of **50 Lives individuals,** 95% report a dual diagnosis and 84% a tri-morbidity (Table 5). Of **50 Lives families**, 65% reported dual diagnosis and 38% report tri-morbidity.

6.1.4 Physical Health

Homelessness both causes and exacerbates poor health and hence people experiencing homelessness are likely to have multiple complex health conditions.[31]

Physical conditions such as heart disease, asthma, brain injuries and mobility limitations are highly represented amongst 50 Lives clients.

In nearly every category, **families** report a higher burden of physical health conditions than **individuals,** except for hepatitis c, tuberculosis and brain injury (Table 6). High levels of physical health conditions among families is commensurate with the high percentage of clients that reported a serious health condition in the table above.

Setting cohort differences aside it is clear in both groups that many life threatening or life limiting illnesses are represented and this no doubt forms part of the relationship between poor health and homelessness and vice-versa. This plethora of physical health conditions is further expressed in the hospital diagnostic data presented later in this chapter.

[i] Note: the VI-SPDAT considers a respondent to have a mental health issue if they report being taken to a hospital against their will for a mental health reason; have gone to ED because they weren't feeling well emotionally; have spoken with a mental health professional in the last six months; have had a serious brain injury or trauma; have ever been told they have a learning or developmental disability; have problems concentrating or remebering things; OR if signs of mental illness were observed.

Table 6: Self-Report Physical Health Conditions

n(%)	Individuals (n=193)	Families (n=26)
Heat stroke	85 (44)	-
Heart disease	60 (31)	11 (42)
Emphysema	29 (15)	4 (15)
Diabetes	27)13)	7 (26)
Asthma	90 (46)	19 (73)
Cancer	20 (10)	4 (15)
Hepatitis C	62 (32)	6 (23)
Tuberculosis	4 (2)	0 (0)
Brain injury	101 (52)	13 (50)
Mobility limitations	44 (22)	9 (34)
Dental problems	141 (73)	23 (88)

Note: Heat stroke data for Families was missing from data set.

For the purposes of this report, only the self-reported physical conditions for **individual 50 Lives clients** have been graphed, providing an overall indication of types of issues experienced (Figure 16).

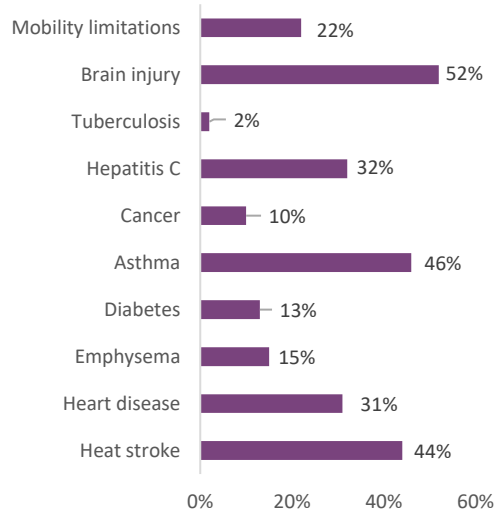

Figure 16: Physical Health Conditions of Individuals

Overall, more than half of **individual clients** and half of **families** (52% and 50% respectively) reported having a brain injury. People with brain injuries often experience challenges in planning, budgeting, employment and social engagement that increase their vulnerability and likelihood of homelessness.[46]

6.1.5 Hospital ED and Inpatient Admission

Self-reported attendance to ED is high among 50 Lives clients who completed a VI-SPDAT. Of the 193 **individual 50 Lives clients**, 86% reported having been to ED in the last six months. As an aggregate, these 166 individuals reported having 1,154 ED presentations in six months, a mean of just under six per person. The highest estimate number of presentations to ED was 78, however it should be noted that this would be the equivalent of presenting to the ED every second day. Further in this chapter we look at administrative health data which suggests that the highest number of ED presentations an individual has (in a one year period) is 45. Reiterating the need to acknowledge the fact that while self-report data can offer some insight into the complexity of individuals experiencing homelessness, it is limited in its accuracy.

Individual 50 Lives clients reported being bought to hospital by ambulance an average of 5.6 times in the six months prior to the questionnaire.

Similarly, admission as an inpatient was also high. Overall, 70% of **individual 50 Lives clients** reported they had been admitted to a hospital inpatient unit in the six months prior to completing the VI-SPDAT, with an average of 2.7 admissions per person. One individual 50 Lives client reported spending 40 days as an inpatient during this period. Once again, caution should be given regarding the generalisability of VI-SPDAT data, for this ***six month period,*** individuals reporting having an aggregate 535 inpatient admissions, which is nearly the equivalent of actual inpatient admissions from EMHS administrative data for a ***three year period*** (n=582).

Overall, self-reported hospital figures are smaller amongst **50 Lives families** with the mean ED presentations being 2.6 per family, and trips to hospital via ambulance occurring 1.3 times on average in the six month period. **Families** were also admitted to an inpatient ward on relatively fewer occasions in the previous six months in comparison to individual 50 Lives clients, with an average of 1.7 admissions per family.

In total, there were 1,221 trips to ED by 50 Lives clients, an average of 5.6 presentations per person.

Table 7: Self-Report Health Service Use in the Previous Six Months

n		Individuals (n=193)	Families (n=26)
Number of people presented to ED (%)		166 (86)	20 (77)
Number of times presented to ED	Mean	6.0	2.6
	Range	0-78	0-7
	Total	1,154	67
Trips to hospital by ambulance	Mean	5.6	1.3
	Range	0-78	1-6
	Total	549	33
Number of people admitted to hospital as an inpatient (%)		136 (70)	20 (77)
Number of times admitted to hospital as an inpatient	Mean	2.7	1.7
	Range	0-40	0-6
	Total	**535**	44

Note: all figures based on self-report data for the last six months
ˆ The family VI-SPDAT relates to if the HoH and/or any of the family members have had interactions with health services

6.1.6 Self-Reported Service Usage

International[31, 47-49] and Australian data[31, 34] indicates that people experiencing homelessness are over-represented in ED presentations, and this is reflected through self-reported data from the VI-SPDAT. When asked *"Where do you usually go for healthcare or when you're not feeling well?"* the most common service by 50 Lives clients was RPH, with nearly half (42%) acknowledging that RPH is the most frequented health care location when they are sick, unwell or in need of healthcare. Street doctor was the next most frequently used service (29%) (Table 8).

Additionally, 26% of clients stated that HHC in-reach to accommodation services and 24% stated that GPs were their most used health service.

Table 8: Self-Report Usual Health Care Locations

N(%)	Total (n=219)
Royal Perth Hospital	93(42.5)
Sir Charles Gardiner Hospital	28 (12.8)
Fremantle Hospital	13(5.9)
Rockingham Hospital	8(3.6)
Joondalup Hospital	12(5.5)
Bentley Hospital	8(3.6)
Other Hospital	20(9.1)
HHC at Accommodation Services	57(26.0)
HHC in the Park	22(10.0)
HHC at Day Centres	31(14.1)
GP	52(23.7)
Aboriginal Health Service	30(13.7)
Drug and Alcohol Service	16(8.7)
Mental Health Service	27(12.3)
Mobile GP	8(3.6)
Street Doctor	64(29.2)
Other	12(5.5)

Note: Respondents could select multiple services

Street Health nurses delivering street outreach. Photography by Tony McDonough.

6.2 Health Service Usage

While VI-SPDAT data provides some self-report data on hospital usage, administrative hospital data is used in this evaluation to provide a more accurate and comprehensive picture of health service use, before and after client involvement in 50 Lives. People experiencing homelessness are often over-represented in ED presentations and inpatient admissions. This section firstly looks at the cumulative burden of this for clients prior to housing, and then examines changes once housed.

Homeless people often seek medical treatment at a later stage during illness, leading to costly secondary health care and worsened health outcomes. Exacerbated by this is the reduced potential for recovery due to many homeless people returning to insecure accommodation or even rough sleeping after medical treatment…. The impetus to address these issues are driven by both the need to reduce inequality and to lessen the inflated costs that delayed healthcare and poor housing inevitably lead to further down the line"[50, p.8]

The analysis is based on administrative hospital data from four hospitals in the East Metro Health Service catchment (RPH, Bentley, Armadale and Kalamunda) for those 50 Lives clients who were part of the project as at 30 April 2018, and for whom hospital data as available. It should be noted that this data does not include administrative health data from Fiona Stanley, Sir Charles Gairdner or other hospitals outside of the EMHS region, where it has been estimated that around 30% of 50 Lives clients have also presented. Therefore, it is likely that data presented in this chapter is likely to underestimate the overall burden of 50 Lives clients on the health system. Ethics approval to obtain data from these other Perth hospitals is currently pending.

Preliminary hospital data and other health service data supplied by the WA Health BIU has been presented to show hospital usage in the one, two and three years prior to joining 50 Lives (n=192) and for those who have been housed, the changes six (n=68) and 12 months (n=44) before and after housing.

6.2.1 Pre-50 Lives ED Presentations

In the three years prior to joining 50 Lives, 76% of clients had presented to the ED on at least one occasion. Cumulatively for these three years, there was a total of 1,606 ED presentations for this cohort. This represents an average of 8.4 presentations per person over the three years prior to housing, or an equivalent of 2.8 presentations per-person-per-year (Table 9). The largest proportion of ED presentations was in the year directly before joining 50 Lives, where nearly half of presentations occurred (n=765, 48%). This trend suggests that acute health care usage increases dramatically the longer someone is rough sleeping, and that in the absence of intervention, this trajectory could continue upwards.

Table 9: ED Presentations for all Clients Prior to 50 Lives

n=192	3 years prior	2 years prior	1 year prior	Total
Total people (%)^	84(44)	95(49)	121(63)	146(76)
Total presentations	386	455	765	1,606
Mean (SD)^	2.0(5.1)	2.4(4.3)	4.0(6.3)	8.4(12.7)
Range	0-45	0-24	0-37	0-71

^ Percent and Mean of total group (n=192), including individuals who did not present to the ED in this period.

6.2.2 Pre-50 Lives Inpatient Admissions

Overall, 60% of clients had an inpatient admission in the three years prior to joining 50 Lives. For these clients, there were 582 individual inpatient admissions totalling 2,408 inpatient days in the three years prior to joining 50 Lives. Similar to the upward trend observed over time with the ED presentation data, the majority of these admissions occurred in the year directly prior to joining 50 Lives (n=269, 46%). This highlights the compounding of vulnerability over time. As shown in Table 10, the average number of inpatient days per client belies the large number of admissions experienced by some clients. Similarly, the cumulative number of inpatient days per client varied markedly, with one client for example hospitalised for 105 days in the year prior to housing.

Table 10: Inpatient Admissions and Days for all Clients Prior to 50 Lives

N=192	3 years prior	2 years prior	1 year prior	Total
Inpatient Admissions				
Total people (%)^	57(30)	64(33)	84(44)	116(60)
Total admissions	144	169	269	582
Mean (SD)^	0.8(2.3)	0.9(1.8)	1.4(2.4)	3.0(5.4)
Range	0-26	0-12	0-14	0-39
Days Admitted				
Total days	869	508	1,031	2,408
Mean (SD)^	4.5 (16.0)	2.6 (5.8)	5.4(14.3)	12.5 (27.3)
Range	0-136	0-35	0-105	0-186

^ Percent and Mean of total group (n=192). Inpatient days calculated per person, not per admission.
Note: inpatient admissions relating to renal/dialysis admissions and chemotherapy have been excluded in the above figures.

As shown in Table 9 and Table 10, in the three years prior to 50 Lives commencement, the volume of ED presentations and inpatient admissions for this cohort of 192 clients constitutes a sizeable burden on the health system. As noted, this is likely to underestimate the total burden as only data from RPH, Bentley and Kalamunda/Armadale hospitals was available for this report.

6.2.3 Associated Economic Cost

Crude costings based on the aggregate ED and inpatient data for these 192 clients equates to a total of nearly $8 million in health service usage over three years alone. This equates to approximately $13,500 per person per year (Table 11). As previously discussed, the highest proportion of health service usage was in the year directly prior to 50 Lives engagement. Looking at just the year prior, this equates to just under $18,000 per person in associated health costs (Table 12).

These cost estimates are conservative as data for hospitals outside of the EMHS catchment was not included, nor data for Midland hospital. The cost estimate also does not incorporate the different costs for psychiatric stays, or other more costly admissions such as ICU. Whilst conservative, it illustrates the enormous preventable cost burden associated with prolonged rough sleeping.

Table 11: Aggregate Health Service Usage in the Three Years Prior to 50 Lives and Associated Costs

	Presentations / Days^	Unit Price*	Aggregate Cost	Cost Per Person (n=192)	Per Person Per Year
Aggregate ED Presentations	*1,606*	*$765 per presentation*	*$1,228,590*	*$6,399*	*$2,133*
Aggregate Inpatient Days	*2,408*	*$2,718 per day admitted*	*$6,544,944*	*$34,088*	*$11,363*
TOTAL			***$7,773,534***	***$40,487***	***$13,496***

^Hospital data from East Metropolitan Catchment area (RPH, Bentley, Armadale/Kalamunda) only
*Costs based on the latest Independent Hospital Pricing Authority (Round 20) figures for the 2015-16 financial year for WA.[15]

Table 12: Health Service Usage in the one Year Prior to 50 Lives and Associated Costs

	Presentations / Days^	Unit Price*	Aggregate Cost	Cost Per Person (n=192)
Aggregate ED Presentations	*765*	*$765 per presentation*	*$585,225*	*$3,048*
Aggregate Inpatient Days	*1,031*	*$2,718 per day admitted*	*$2,802,258*	*$14,595*
TOTAL			***$2,860,783***	***$17,643***

^Hospital data from East Metropolitan Catchment area (RPH, Bentley, Armadale/Kalamunda) only
*Costs based on the latest Independent Hospital Pricing Authority (Round 20) figures for the 2015-16 financial year for WA.[15]

RPH Homeless Team in action. Photography by Tony McDonough.

6.3 Changes in Health Service Usage Once Housed

Having safe stable housing is in and of itself a protective factor for health, and through the AHSS and connecting of 50 Lives clients to a GP and other services, underlying medical and psychosocial issues can also be addressed. However housing is not an instant panacea for people with complex health and psycho—social needs, and in some studies, initial health service use has increased following housing as previously undiagnosed or untreated issues are addressed.[51] Other Housing First initiatives have demonstrated reductions in the use of acute health services longer term.[52-57].

Findings presented in this section indicate that in the 50 Lives project to date, positive reductions in health service usage have been observed even in the first six to 12 months after being housed with support. We have looked at changes in hospital use for two subsets of the 50 Lives clientele - those that have been housed for six months or more as at 30 April 2018 (n=68), and those housed for 12 months or more (n=44). It was predicted that the longer someone is housed (i.e. 12 months versus 6 months), the more likely it is that health issues will have stabilised, and that greater reductions in hospital use would be observed among those housed 12 months or more.

6.3.1 Changes in ED Presentations Once Housed

Fewer 50 Lives clients presented to ED (RPH or Armadale in this data) in both the six and 12-months post housing period, and the total number of ED presentations among those housed six months and/or 12 months also declined.

For the clients who had been **housed at least six months** (n=68), there was a 24% significant reduction in the number of clients presenting to ED (from 54% in the six months prior to housing to 41% in the six months post housing) (Table 13).

For clients that had been **housed at least 12-months** (n=44) there was a 26% decline in the number of clients presenting to ED (from 70% of clients in the year prior to housing to 52% in the year post housing). There was a significant reduction in the average number of ED presentations per person in the year post housing, compared to the prior 12-months from 4.6 to 2.0 presentations per person. The number of people leaving from ED at their own risk halved in the year after housing (see Table 24, Appendix 2).

While this analysis only includes RPH and Armadale ED hospital data, and is limited to the clients housed six months or more for whom there is hospital data, it is clear that there have already been significant reductions in ED use among those housed by 50 Lives.

Table 13: ED Presentations Six and 12 Months Pre/Post Housing

	6 Months (n=68)			12 Months (n=44)		
	Pre	Post	% Change	Pre	Post	% Change
Total people (%)^	37 (54)	28 (41)	-24%	31(70)	23(52)	-26%
Total presentations	127	77	-39%	204	88	-57%
Mean (SD)	1.9(3.1)	1.1(2.5)**		4.6(6.8)	2.0(4.4)**	
Range	0-16	0-14		0-26	0-25	

*p<0.05, **p<0.01

^ Percentage of total housed group for period. For six months pre/post n=68. For 12 months pre/post n=44.

6.3.2 Changes in ED Re-Presentation Rates

People experiencing homelessness often cycle between hospitals and the streets with repeated presentations to the ED.[58] Data from two Australian inner city hospitals (RPH[20] and St Vincent's Hospital Melbourne[13] show that patients with *No Fixed Address* are some of the most frequent ED attenders). People experiencing homelessness also have high rates of early re-attendance to ED (within 7 days and within 30 days), a metric used as a quality measure in Australian Hospitals.

> *Early representation can be an indication that the presenting issues were not adequately dealt with in the first ED visit or that the circumstances into which the patient was discharged have adversely affected resolution, both common issues for the homeless population.* - **Dr Amanda Stafford, Clinical Lead, RPH Homeless Team**

The proportion of people re-presenting to hospital within one week or one month of discharge was computed for the housed 50 Lives clients.

For clients **housed for at least six months,** re-presentations to the ED within seven days of ED discharge reduced by one third (Table 14). The proportion who represented to ED within a 30 day period halved (from 20 to 10 for these clients).

For clients **housed for at least 12 months,** there was almost a two-third (63%) reduction in the number of clients representing to the ED within seven days (Table 14). Representations to ED within 30 days reduced by 71% (from 38 to 11).

Table 14: ED Re-Presentations Pre/Post Housing After Release from Hospital

N(%)^	6 Months		12 Months	
	Pre	Post	Pre	Post
Within 7 days	12(22)	8(28)	24(32)	9(24)
Resulting in re-admission	6	1	9	3
Within 30 days	20(37)	10(34)	38(50)	11(30)
Resulting in re-admission	8	2	11	3

^ % of total discharge

6.3.3 Changes in ED Diagnoses Once Housed

In the six months prior to clients being housed by 50 Lives, the most common primary diagnose in the ED presentation data was injury and poisoning (predominantly self-harm and injury arising from assault), followed by digestive disorders, AOD and mental health diagnoses (Table 15). The greatest changes after six months of housing were observed for diagnoses of genitourinary with an 89% reduction in ED presentations with this as the presenting reason.

For those who had been housed for 12 months or more, the largest reduction was also seen in genitourinary (79%), followed by injury and poisoning (70%) (Table 15). The number of clients presenting to ED with either AOD use or mental health as the presenting reason almost halved. Other changes in reasons for ED presentation for those housed 12 months or more are shown in Figure 17.

Table 15: Top Five ED Diagnoses Six and 12 Months Pre/Post Housing

Diagnosis	6 Months			12 Months		
	Pre	Post	Change	Pre	Post	Change
AOD use disorders	12	10	-17%	21	12	-43%
Mental health	12	12	0%	17	9	-47%
Digestive	14	10	-28%	21	9	-57%
Genitourinary	9	1	-89%	14	3	-79%
Injury/poisoning	27	13	-52%	53	16	-70%

As shown in this data, some of the most frequent reasons for ED presentations among 50 Lives clients prior to being housed included injury, self-harm, poisoning, AOD and mental health issues; - once housed the number of people presenting with these as a primary diagnose declined, with even more substantial reductions once people have been housed for 12 months or more. This supports the contention that housing with wrap-around support is an effective form of preventable healthcare

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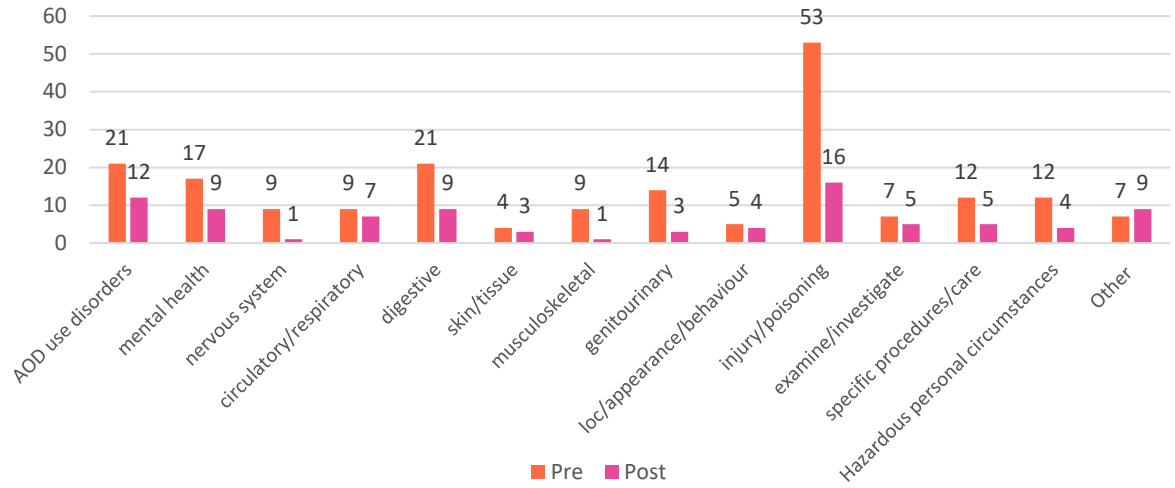


Figure 17: Number of Primary Diagnosis for Presentations Pre and Post 12 Months Housing

6.3.4 Changes in Inpatient Admissions and Days Once Housed

As with the changes in ED presentations, changes to inpatient admissions were looked at firstly, for the subgroup of clients housed for at least six months and secondly, for those housed 12 months or more.

Amongst clients **housed for at least six months** (n=68), there was a reduction both in the number of people being admitted to hospital, and a decline in the total number of inpatient admissions following housing. The number of 50 Lives clients who had an inpatient admission after being housed for six months reduced by 28% (Table 16). Inpatient bed days are a major driver of hospital costs, and there was a positive and significant decline in admitted inpatient days for this cohort of clients housed for at least six months. Specifically, there was a 59% decrease in the total number of inpatient days (excluding admissions for dialysis and palliative care) in the six months after housing (Table 16). When separated out per person, the majority of clients had either a reduction (28%) or no change (60%) in the number of admitted inpatient days, whilst 12% of clients housed for six months or more had an increase in days spent in an inpatient ward.

Amongst clients **housed for at least 12 months** (n=44), the number being admitted as an inpatient reduced by just over a third (36%), and the total number of inpatient admissions for this subgroup of clients halved (from 76 prior to being housed to 37 following housing) (Table 16). The latter is also reflected in the significant reduction in the average number of inpatient days (from 4.9 to 2.3 days per person) in the 12 months following housing. It is pertinent to note however that these averages mask the variability in hospital use among clients, with for example one client having 64 inpatient days in the year prior to housing, and the number of inpatient days following housing ranging from 0-22 days. When separated out per person, the majority of clients had either a reduction (39%) or no change (55%) in their number of inpatient days in the 12 months after being housed.

6.3.5 Changes in Diagnoses for Inpatient Admissions Once Housed

As with the ED data, Injury/poisoning was the most common diagnosis for inpatient admissions prior to housing. This also showed the most significant decrease as a reason for admission among both those housed for at least six months (halved) and those housed at least 12 months (reduced by nearly two thirds) (See Table 26, Appendix 2).

When people are rough sleeping, most hospital admissions are unplanned, and elective inpatient admissions and/or waitlisting is understandably rare. While the numbers are small, our data shows a slight increase in elective admissions (See Table 25, Appendix 2) which is more feasible once someone is housed and connected to a GP.

Table 16: Hospital Inpatient Admissions Pre and Post Housing

	6 Months (n=68)			12 Months (n=44)		
	Pre	Post	% Change	Pre	Post	% Change
Inpatient Admissions						
Total people (%)^	25(37)	18(26)	-28%	22(50)	14(32)	-36%
Total admissions	54	29	-46%	76	37	-51%
Mean (SD)^	0.8(1.5)	0.4(1.0)*		1.7(2.7)	0.8(2.4)**	
Range	0-8	0-6		0-13	0-15	
Days Admitted						
Total days	201	83	-59%	217	101	-53%
Mean (SD)^	3.0(9.1)	1.2(3.2)*		4.9(11.0)	2.3(5.0)*	
Range	0-61	0-20		0-64	0-22	

*p<0.05, **p<0.01

^ Percentage of total housed group for period. For six months pre/post n=68. For 12 months pre/post n=44.

Note: Admissions with a primary diagnosis code for dialysis, chronic kidney disease and chemotherapy were considered to be "pseudo" admissions and excluded from the analyses.

6.3.6 Associated Economic Cost

Crude costs associated with the observed changes in ED presentations and inpatient admissions have been calculated for those both housed for at least six months, and for at least 12 months. The recent *Sustainable Health Review* highlighted the resource and fiscal burden on the WA health system associated with ED use and hospital admissions, and with the over-representation of people experiencing homelessness in Perth hospitals, the economic benefits associated with the observed changes in hospital use once 50 Lives clients are housed is timely. Using the most recent costs provided by the IHPA, an average ED presentation in a WA hospital was estimated to cost the health system $765, whilst the average inpatient cost in a WA public hospital was $2,718 per day.[15] Beyond the monetary costing of hospital attendance, the freeing up of hospital beds and staff time for other patients is also an important outcome for the State.

As shown in see Table 17, overall, for people housed for at least six months there was a reduction of over $5,000 per person associated with the observed reductions in hospital use (comparing six months pre to six months post housing). From this preliminary data, it appears the longer someone is housed the more opportunity for greater reductions in health service usage, with individuals that were housed for 12 months or more having an average reduction of over $9,000 per person in the 12 months pre to 12 months post housing. The total estimated cost saving associated with reductions in hospital use for the 44 clients housed for 12 months or more was just over $400,000.

Table 17: Change in Cost Associated with Changes in Health Service Usage for those Housed for 6 and 12 Months

	Change in Presentations / Days^	Unit Price*	Change in Aggregate Cost	Change in Cost Per Person
Six Months pre/post (n=68)				
Change in ED Days	*- 50 Presentations*	*$765 per presentation*	*-$38,250*	*-$563*
Change in Inpatient Days	*-118 Days*	*$2,718 per day admitted*	*-$320,724*	*-$4,717*
TOTAL			***-$358,974***	***-$5,279 per person^***
Twelve Months pre/post (n=44)				
Change in ED Days	*- 116 Presentations*	*$765 per presentation*	*-$88,740*	*-$2,017*
Change in Inpatient Days	*-116 Days*	*$2,718 per day admitted*	*-$315,288*	*-$7,166*
TOTAL			***-$404,028***	***-$9,182 per person^^***

^ Cost per person change for the 68 people who had been housed for six months or more

^ Cost per person change for the 44 people who had been housed for 12 months or more

* Costs based on the latest Independent Hospital Pricing Authority (Round 20) figures for the 2015-16 financial year for WA.[15]

It should be noted that there is huge variability amongst clients in regards to health service use pre and post housing, and that for some clients, the reduction in use and associated costs is far more substantial than is conveyed by the client average.

This is illustrated in Box 14 where a client *"Ian"* had dramatic reductions in health services equating to nearly a $100,000 cost reduction to the health system for a 12-month period alone following housing.

Box 14: Reductions in Health Service Use: A Case Study

Ian is a man in his early forties who cycled in and out of homelessness repeatedly. At the time Ian completed the VI-SPDAT he had been homeless 30 times in the previous three years, most often sleeping rough in a park. Ian has multiple health issues including emphysema, asthma, heart problems, hepatitis C, drug use, epilepsy, dental problems and mental health issues.

Ian was supported to obtain housing and within two months of consenting to 50 Lives, he had obtained private rental accommodation. In the 12 months since he obtained housing Ian has had a significant decline in ED presentations (21 fewer than the year prior to housing) and admitted as an inpatient (30 fewer days than the 12 months prior to housing); resulting in a cost reduction to the health system of $97,605.

6.4 Managing Health Issues Once Housed

Many 50 Lives clients have health issues that have worsened or gone undetected whilst surviving day to day on the street. Including conditions such as heart disease, asthma, diabetes, hypertension and dental health. For 50 Lives clients, stable housing, coupled with the primary care support of HHC and the AHSS nurses, enables health issues to be identified and addressed. However, as noted by an AHSS nurse, clients with complex mental health, health and AOD issues with prior poor experiences of the health system may require extensive support to re-engage and begin to self-manage their condition. Particularly for clients with mental health issues, this mistrust of the health system and lack of engagement with treatment can put their housing at risk. In these cases the role of the AHSS in establishing relationships with clients, exploring their concerns and ensuring appropriate management of conditions is central to stabilising their health.

> *There's often this great animosity and fear of the mental health system with our chronic schizophrenic people who are poorly treated by the mental health system, whether that's their perception or the reality. So they are pretty hesitant and don't follow up consistently. [For example] they might get their depot one month and then not for a couple of months… [Nurse] worked with him on his mental health and really breaking down some of those barriers and his hesitance to be on a depot or things like that.* **– AHSS Nurse**

In this second evaluation report, we have looked at two frequently occurring health conditions (diabetes and dental health) that are exacerbated by rough sleeping, yet which can improve through the coupling of housing and primary healthcare services. A combination of current literature, hospital and HHC data and interviews with AHSS staff and clients have been used to highlight the health issues at hand.

6.4.1 Dental Health

The homeless population in Australia have high levels of untreated dental disease,[59] and are more likely to have a higher incidences of untreated cavities.[59] Several factors exist which make it difficult for people experiencing homelessness to maintain optimal oral health: financial barriers, dental anxiety, mental illness, substance abuse and lifestyle factors.[60] With dental care in Australia not covered by Medicare, the cost poses a significant barrier.[61] In a Brisbane study, 67% reported avoiding dental care due to cost, a figure almost twice as great as the general population.[59] Cost is not the only barrier to a dental visit however, as in that same study, more than a third failed to attend the free dental appointment arranged for them.[59] This non-attendance rate is similar to the experiences of a UK program[62] and may in part be explained by chaotic life circumstances and the comparatively lower priority given to oral health when trying to survive on the streets. Long waitlists for public dental care is also a barrier,[63] with dental problems worsening as a result.

> *I don't think anyone can expect people who are homeless to be able to maintain oral health, which an integral part of overall health, without first addressing the issue of housing.* ***- Dr Brian Shih, Dentist***

Self-report VI-SPDAT data, for both individual and family 50 Lives clients shows the majority had dental problems (73% and 88% respectively) (Table 6).

As observed by the AHSS team, people experiencing homelessness struggle to access to dental care and isn't just not a priority when people are on the streets. Once settled into housing however, a number of 50 Lives clients with serious dental issues have been able to focus on addressing and managing their oral health. Prior to getting housed and managing their dental health these clients used to suffer the discomfort and couldn't eat all foods but since getting their dental issues treated their diets have changed leading to better nutrition. Capacity to attend dental appointments is also improved through housing and the support of the AHSS.

> *One client was able to attend all his appointments with the dentist, and got new dentures which gave him more confidence to go out and participate in community activities -* ***AHSS Nurse***

> *We have a client who had terrible teeth due to Meth use, but she was connected to a dental service through Ruah, and now has a whole new set of teeth and a beautiful smile. And she hasn't lost her dentures! -* ***50 Lives Lead Worker***

6.4.2 Diabetes

Diabetes Mellitus affects 1.2 million people in Australia, which represents 5.1% of the population.[64]

The prevalence is much higher however among 50 Lives clients, where self-report VI-SPDAT data, indicates that 13% of **individual 50 Lives clients** and 26% of **50 Lives families** reported having diabetes (Table 6). In the 12 months prior to housing 9% of 50 Lives clients were admitted to hospital for diabetes.

The health consequences of diabetes are often more serious among people experiencing homelessness, as diagnosis may be delayed and the day-to-day management of the condition is difficult if living on the street or in precarious housing.[65, 66] The literature identifies a number of external factors directly impacting the ability of homeless people to manage their diabetes. The most commonly cited factor is the chaotic and survival driven nature of life on the streets: tasks such as seeking food, shelter and clothing take priority and a considerable amount of time.[65, 67] Transient living situations also mean that medications are easily lost or stolen.[65]

> *… I've got diabetes, and my sugars have been real high lately. That's why getting a house was very important… being on the streets and stuff is hard. But having my insulin, not being in the fridge. Just keeping on top of my medications and all that, it was pretty hard.* ***– 50 Lives Client***

Daily checking and monitoring of blood glucose levels is difficult for rough sleepers. Some seek out the Street Health service run by HHC in the Perth CBD to monitor this, but routine self-management of diabetes is hard. Street Health nurses have observed exceedingly high blood glucose levels that have necessitated immediate referral of a person to a GP clinic or hospital. The following quote describes the consequences of diabetes in a young 50 Lives client who was at the time on the streets.

> *Her diabetes is diabolical…she's in her early twenties and already getting peripheral neuropathy symptoms. That state will rapidly progress until we start having to amputate… It's doing untold damage to her vision and her kidney's as well. Terrible diet and meth use is making it worse and being sick all the time makes your blood sugars go crazy because your body is in that kind of inflammatory state -* ***HHC Nurse***

The poverty of homelessness is also associated with a reliance on food from charitable services and greater consumption of cheaper, highly processed foods with limited nutritional value: a risk factor for diabetes.[65]

> *While charitable organisations provide food for those on the streets, people cannot chose what to eat and often the food does not need their nutritional needs, particularly if they have conditions such as diabetes. -* ***Christina Pollard, Principal Policy Consultant, EMHS.***

> *The food available to rough sleepers from the various charities is unsuitable for diabetics as it is often high in fat, sodium, or sugar. -* ***HHC Nurse***

The prevalence of emotional stressors and increased exposure to crime and trauma also makes the management of diabetes difficult, as people can become overwhelmed at their situation.[65, 68] Coalescing physical health, mental health and alcohol or drug issues can also impede management of chronic medical problems such as diabetes.[65, 69, 70]

Box 15: Diabetes Case Study

Harold's diabetes has improved substantially since being housed in late 2016. Prior to being housed Harold was rough sleeping and drinking a lot, however after he was housed he managed to cut down his drinking and is now sober. After being housed, Harold was linked in with Silverchain for regular home visits to manage his insulin, a service he would not have been able to access had he been still on the streets.

The AHSS has engaged Harold in exercise and walking when they visit, and he has become highly motivated to eat well. His improved nutrition has helped with management of his diabetes, and he has lost some excess weight.

Prior to housing, Harold accrued well over 65 admissions to hospital in one year – since being housed and addressing his diabetes, alcohol use and other health issues, he has had no hospital admissions.

Street Health diabetes test. Photo by Tony McDonough.

7. CLIENT JUSTICE OUTCOMES

"Nearly everyone's been hassled by the police. Not doing anything they've just come up and moved them on."

- 50 Lives Client

There exists a complex nexus between homelessness, criminality and victimisation. The strong association between homelessness and increased likelihood of contact with the Justice system is well documented. This occurs across the justice spectrum, from fines, police interactions and legal issues, through to higher rates of offending, imprisonment and recidivism. People experiencing homelessness are also more likely to be victims of crime, and the police data obtained for this evaluation will enable us to look patterns of offending and crime victimisation before and after housing through 50 Lives .

Recent data from the Australian Institute of Criminology reports that 12% of police detainees in Australia in 2015-16 were recorded as "no fixed place of residence" and 19% reported living in unstable, temporary or emergency housing.[71] Other Australian data highlights the much higher imprisonment rates among people who are homeless, and having no safe stable accommodation upon release is a major risk factor for recidivism.[72]

In WA, two out of five people released from prison return to prison within two years.[73] Recidivism has enormous consequences given that it costs, on average, around $120,000 per annum in Australia to keep one prisoner in prison.[74] This could equate to a significant saving per annum for every person not returning to prison.[75]

The causality of the inter-relationship between homelessness and Justice is complex, with the origins often lying in early life circumstances, trauma, mental illness and addiction issues. As observed recently by Eileen Baldry who has led seminal Australian research around the incarceration of people who are homeless and other vulnerable population groups:

More than half the people who go in and out of prison have mental health disorders, cognitive disabilities or some kind of disability that makes their lives more difficult. They are far more likely when they get out, even from remand, to not have anywhere stable to go to and to not have some kind of therapeutic support, or service that they need. So they're more likely to end up going back into prison. What becomes the case is, it's normalised. Being in prison and being in contact with the police is normalised for this group.[72]

Additionally, the very nature of rough sleeping renders people vulnerable to crime victimisation and police and security attention. It has also been argued that people who are homeless are less likely to resort to the legal system for protection or to have access to the information they need about the legal system.[76]

Given that underlying factors contributing to homelessness also contribute to an increase contact with the justice system, programs such as 50 Lives play an important role in averting this unnecessary pathway. In the Brisbane's Housing First program, there were a number of positive justice outcomes observed among people who had been housed for a year, including reductions in arrests, court appearances and contact with police.[77]

7.1 Justice Data Considered in this Report

In this second evaluation report we look firstly at self-reported justice data from 50 Lives clients, and then present preliminary analysis of rich data recently obtained from WA Police for 169 clients. Of these clients, 89 had been housed as at end of June 2018.

This invaluable police data provides a measurable way for identifying changes in incidents, offences, arrests and court procedures for 50 Lives clients following housing. This chapter examines changes in offending for those housed for at least six or at least 12 months. Reducing offending is one of the key outcome domains that lead workers and the AHSS team seek to support clients with. Client experiences as victims of crime before and after housing are also examined in this chapter, and this is a unique feature

of this 50 Lives evaluation that has received very little attention in the published literature to date.

It is important to note that only Police data is currently available for 50 Lives clients, hence this does not purport to cover the wider extent of Justice contacts that would be captured in Courts and Corrective Services data. Ethics approval and a data linkage request for this latter data is currently in progress.

7.2 Offending Behaviour

7.2.1 Self-Reported Justice Contacts

Self-report VI-SPDAT data includes a number of measures relating to contacts with the Justice system prior to 50 Lives. For the 193 **individual 50 Lives clients**, over half (56%) had been to prison, three quarters (75%) had been detained in the Police Watch House at some point in their life and a third (35%) had spent time in youth detention as a child (Table 18). For **50 Lives families**, similar proportions of people had previously been to the Watch House, been in youth detention and been to prison.

Three-quarters of both individual and families (75% and 77% respectively) reported that they had interaction with the police in the six months prior to completing the VI-SPDAT. However, it is important to note that this question does not distinguish what type of interaction occurred with the police and does not necessarily indicate a negative experience.

Table 18: Self-Report Incarceration and Police Contacts

n (%)	Individuals (n=193)	Families (n=26)
Been in the WatchHouse (lifetime)^	145(75)	18(69)
Been in Youth Detention (lifetime)^	68(35)	6(23)
Been in Prison (lifetime)^	109(56)	12(46)
Interaction with Police (last 6 months)^^	144(75)	20(77)
Average no. Interaction with Police (last 6 months)^^	9.1	7.8

^ For family responses these pertain to head of household
^^ For family responses these pertain to anyone in the family

Whilst some of those who had been in youth detention went on to have further justice contacts as adults, one client recounted that his youth experience with the justice system had a positive effect on the likelihood of re-offending.

> *I was a bit of a rebel when I was a kid. I will admit that; I screwed up quite badly. So was in Banksia Hill. I have never ended up going to adult lock-up. I only went to Banksia Hill and all of that. I did my time. It helped me wake up slowly to not screw up because the consequences of screwing up are a lot more severe.* - **50 Lives Client**

7.2.2 Offending Prior to Housing

The very nature of sleeping rough and being itinerant places people at higher risk of committing certain types of offences. Laws relating to loitering, sleeping, or urinating in a public place are case in point – those of us living in the comfort of our own homes are at very low risk of ever committing such offences. As recently retired Chief Justice Wayne Martin commented on the issuing of move on notices:

> *...[laws] intended to help defuse antisocial behaviour… provide opportunities to criminalise the homeless.*[78]

The power of police to issue a notice to 'move on'[79, 80] is an example of an offence for which people experiencing homelessness are vastly over-represented. For the 68 clients housed for at least six months, there had been 90 move on notices issued in the six months prior to housing (Table 20). Amongst all 50 Lives clients, one client had received 341 move on notices in the five years before being housed, whilst another received 113 in the same period. This comes at a significant cost to both people and to the burden on the police issuing these notices.

As recounted by one 50 Lives client, just going about day-to-day life on the streets can be misconstrued by the public or police as inappropriate.

> *There are a few that give us all a bad name. But the majority of the people are not that way inclined. We just want to sit somewhere out of the rain or whatever, and the let the world go by so to speak. But the police always felt the necessity to give you a move on notice. Or you might have been up for two days because you haven't been able to find somewhere to sleep properly. You fall asleep say in front of the library or what not, and you're getting the kick in the shin by a security guard and a move on. Or they want to search you. It's just an existence, it's not really fair on any one… fair enough if you go into the shop and you get caught shoplifting. But when you're doing nothing except sitting… It's like we're being stereotyped.. But now that [we have a place to live] I don't carry a back pack around, you blend back in to the general conception of society. I'm under the radar..* **– 50 Lives Client**

Another client observed that the lack of safety whilst living on the streets had led to their drug use.

> *when you sleep you've got to keep one eye open. It's hard to fall asleep because you're always worrying about what's going to happen and stuff. That's why I turned to drugs a little bit, to keep me alert and stuff.* **– 50 Lives Client**

The predominance of offending associated with living on the streets was also noted in an interview with the inaugural WA Police representative on the 50 Lives Steering Group.

> *.. the majority of the offending is very antisocial based and low-level property crime…That's survival mode. It's breaking and entering into properties to sleep... Trespass offences… nuisance offences…* ***– Kim Massam, Detective Superintendent, WA Police***

7.2.3 Offences Committed Prior to Housing

As of the end of June 2018, 89 of the 50 Lives clients for whom there was data in the police database had been housed. For these clients, data stretching back four years prior to their housing date shows that the number of offences committed escalated in each subsequent year before being housed.

For the subset of housed clients with an offending history in the WA Police database, the number and types of offences are shown in Table 19. As reflected in this data, the total number of offences for this cohort of clients doubled over the four-year period, from 76 offences collectively four years prior to housing, to a total of 150 offences in the year prior to housing. Collectively over the four years, these 89 individuals committed 437 offences.

Table 19: Number of Offences in the Four Years Prior to Housing

Offence Group	4 years prior	3 years prior	2 years prior	1 year prior	TOTAL
Property offences	26	42	56	49	**173**
Offences against the person (e.g. assault, threats, robbery)	15	11	11	12	**49**
Drug-related offences	20	17	25	55	**117**
Offences against justice procedures (e.g. breach VRO)	8	10	12	10	**40**
Driving offences	1	1	0	2	**4**
Fraud	3	3	6	6	**18**
Weapons offences	2	2	4	6	**14**
Public order offences (e.g. disorderly conduct)	1	5	6	10	**22**
TOTAL	**76**	**91**	**120**	**150**	**437**

Offences for 89clients who had been housed at the time of data extraction

This trend is similar to what is seen in the health data, in that the longer a person is homeless the worse their outcomes. For 50 Lives clients, the most common offences in the four years prior to housing were drug offences and property offences.

7.2.4 Changes in Number of Offences Committed After Being Housed

Across 50 Lives clients housed for either six or 12 months, there were observed decreases in the number of infringements, charges, move-on notices and offences committed once clients were housed (Table 20). The biggest decrease was unsurprisingly seen in the number of move-on notices (reduction of 56% and 82% for six and 12 months respectively).

For offences committed by the 50 Lives client there was an observed reduction of 45% after being housed for six months, and a reduction of 31% after being housed for 12 months (Figure 18).

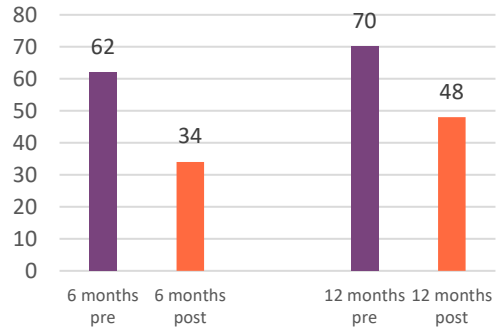


Figure 18: Number of Offences Committed Pre and Post Housing

Table 20: Changes in Justice Contacts 6 and 12 Months Pre/Post Housing

	6 Months				12 Months			
	N	Pre	Post	Change	N	Pre	Post	Change
Aggregate infringements	67	9	7	-22%	47	9	5	-44%
Aggregate charges	70	81	53	-35%	49	114	75	-34%
Aggregate move-on notices	68	90	40	-56%	49	104	19	-82%
Aggregate offences (as offender)	67	62	34	-45%	46	70	48	-31%
Aggregate offences (as victim)	67	21	37	+76%	45	21	43	+105%

Note: N for each category varies depending on the number of 50 Lives clients who were identified in each corresponding database.
Note: Infringements include: disorderly conduct in public, failing to leave licensed venues, street drinking etc.

Breaking down changes in offences committed to broad categories for the six and 12 months pre and post housing, the majority of offences were property related or drug related (Table 21). For both time periods there was a 100% reduction in the number of public order offences committed. For the 12 months post-housing period, there were two offence categories were an increase was observed (driving offences and fraud).

Largest reductions in offences after 12 months housing:
-100% public order offences
-80% weapons offences
-53% drug-related offences

Table 21: Changes in Offences Committed 6 and 12 Months Pre/Post Housing

	6 Months			12 Months		
	Pre	Post	Change	Pre	Post	Change
Property offences	23	20	-13%	26	24	-8%
Offences against the person	5	4	-10%	9	6	-33%
Drug-related offences	15	3	-80%	17	8	-53%
Offences against justice procedures	6	4	-33%	6	4	-33%
Driving offences	2	1	-50%	0	3	n/a
Fraud	6	1	-83%	1	2	+100%
Weapons offences	2	1	-50%	5	1	-80%
Public order offences	3	0	-100%	6	0	-100%
Total	**62**	**34**	**-45%**	**70**	**48**	**-31%**

7.3 Experience as Victim

7.3.1 Victims of Crime while Homeless

It would be false to define and portray the homeless population as predominantly perpetrators of crime, as homelessness also goes hand in hand with susceptibility to suffering harm and crime at the hands of others. Literature from the UK for example indicates homeless people are 13 times more likely to experience violence and an overwhelming 47 times more like to be victims of theft.[81]

The heightened vulnerability to victimisation is reflected in the VI-SPDAT data. The majority (79%) of **50 Lives individuals** reported having been attacked or beaten up since becoming homeless, and over half (54%) had someone stand over them and force them to do something against their will (Table 22). Among **50 Lives families**, nearly three-quarters (73%) indicated that at least one family member had been attacked or beaten up since becoming homeless and 42% had someone stand over them or their family and force them to do something against their will.

The interplay between homelessness, victimisation of crime and trauma is also evident in the VI-SPDAT data. Disturbingly, 82% of **individual 50 Lives clients** and 92% of **50 Lives families** answered yes when asked if they had experienced emotional, physical, psychological, sexual or other types of abuse or trauma that they had not sought help for.

Table 22: Self-Report Victim and Traumatic Experiences

n (%)	Individuals (n=193)^	Families (n=26)
Victim of attack	151(79)	19(73)
Forced into unwanted activities	104(54)	11(42)
Experienced abuse or trauma	155(82)	24(92)

^ missing and refused answers for all questions relating to individuals. N ranged from 190 – 192 per question.

The vulnerability of 50 Lives clients prior to their housing was poignantly articulated by a number of clients during interviews:

> *The crackheads love to mob the homeless to pretty much get their money or what they've been donated to help them get through to be able to have a chance in life, to feed themselves and all of that - get mobbed and all of that and basically almost left for dead with no food, no nothing, just because they want their fix. A homeless person is an easy target because they're trying to get back on their feet* - **50 Lives Client**

> *…a guy asked me if I had any money and any smokes. I said no, and he threatened to punch me in the head. So I thought I can't sleep here anymore because they know where I am* - ***50 Lives Client***

One client reflected how the atmosphere has changed on the street over the last decade and how they used to feel much safer about their personal safety and belongings but that they were now concerned to fall asleep in public places.

> *But you've got homeless stealing off homeless... Prime example, was about three weeks ago before we got this place. I fell asleep for probably half a minute in Supreme Court …My brand-new phone was stolen...* **– 50 Lives Client**

7.3.2 Victim of Crime Following Housing

In the absence of other Housing First studies that have specifically looked at how victim of crime experiences change once people are housed, it was initially hypothesised that the likelihood of being a victim of crime would decrease, as the literature purports that many of the heightened risks of crime victimisation arise from the vulnerability of living on the street. In the analysis of police data however, some contradictory evidence emerged, and it is clear that the relationship between prior homelessness and being a victim of crime once housed is more complex and nuanced.

What was surprising from the WA Police data, was the increase in number of offences against 50 Lives clients once they had been housed (i.e. increased likelihood of being a victim). After being housed for six months 50 Lives clients were 76% more likely to be a victim of an offence compared to the six months after and for those housed for 12 months their likelihood more than doubled (Table 20, Figure 19).

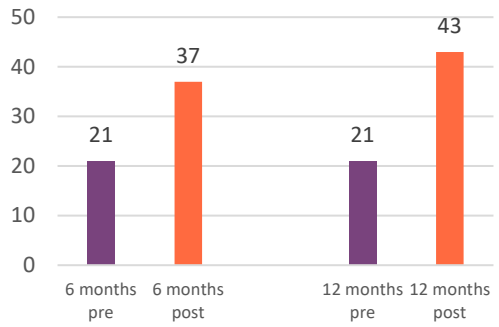
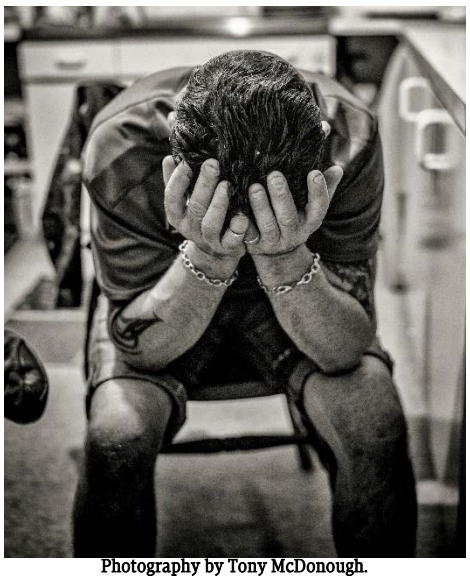


Figure 19: Number of Offences as Victim Pre and Post Housing

The biggest increases in offences committed against 50 Lives clients were observed for property offences (Table 23). An example of this was provided during an interview, where a client recalled how they tried to help friends by letting them stay in their house which resulted in the property getting damaged and being banned from the private rental market.

> *But we've had a private rental…We felt sorry for a couple of people [off the street], for our friends and we said come stay with us, we've got a house… and they just trashed our house. Just ruined it for us. So we got banned from private rental.* **– 50 Lives Client**



Photography by Tony McDonough.

Table 23: Number of Offences as Victim 6 and 12 Months Pre/Post Housing

Offence Category	6 Months		12 Months	
	Pre	Post	Pre	Post
Assault (family)	7	8	5	6
Assault (non-family)	5	3	6	9
Breach of VRO	3	1	1	0
Fraud	3	1	0	0
Stealing	3	8	8	8
Burglary	0	4	0	5
Property Damage	0	7	0	10
Stealing of Vehicle	0	2	0	1
Threatening Behaviour (family)	0	1	0	0
Threatening Behaviour (non-family)	0	0	0	1
Recent Sexual Offence	0	0	1	0
Miscellaneous Offences	0	2	0	3
Total	21	37	21	43

It is still early days even for the 50 Lives clients who have been housed for between 6-12 months, but the mixed findings relating to crime victimisation following housing has led the research team to propose a number of possible explanations that warrant further exploration. In presenting the hypotheses below, we have also drawn on insights from people involved in the 50 Lives project.

Overall, of the 89 housed clients for whom police data was available for, 38% were victims of assault, and 56% were victims of stealing or robbery in the 12 months prior to being housed (Figure 20). This is in stark contrast to the much lower prevalence of crime victimisation in the wider Australian community- in a large ABS survey, only 2.4% of the general population had experienced physical assault in the 12 months prior to the survey, and only 0.4% had been victims of robbery.[82]

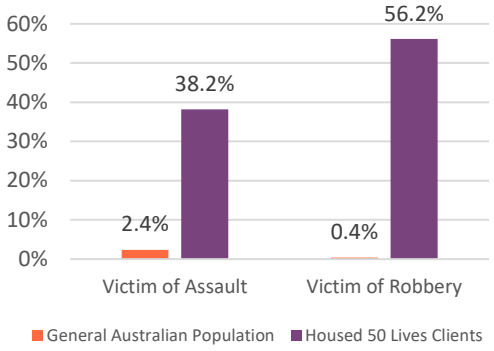


Figure 20: Percentage of Victim of Crime

Why is it that the likelihood of being a victim of crime increases once housed?

It would appear that whilst housing provides protection for violence and assault, it's also a forum for property related crime. During the early stages of housing, clients are still adapting to their new social circumstances and developing strategies to better protect themselves from potential problems that may arise from contact with their social network who may still be experiencing homelessness (and the associated lifestyle risks). In interviews with lead workers and the AHSS team, the vulnerability of some clients to peer influence from people who may be engaging in drug use or illegal activity was evident. Indeed this poses a complex dilemma for clients, who may have limited social networks and who are empathetic to the plight of contacts who have nowhere to live.

> *I let some mates come and stay… they haven't come back but some of their stuff is still here and not long after they left, I had some things stolen from the porch -* ***50 Lives Client***

Burglary offences and/or theft of property against a 50 Lives client are also more plausible once there is a fixed address and more property that could be stolen.

> *…maybe the fact they've got a house to go to. They're easier to find …* ***– Kim Massam, Detective Superintendent, WA Police***

> *The client is enjoying fixing up bikes but has had several things stolen from the flat, and worries about this happening again. -* ***AHSS Nurse***

Another factor that may have an impact on these outcomes is that an individual is likely to have the same family and social network before and after being housed, so many of the risk factors that were present whilst homeless may well remain once they are housed. The difference being, that they may be at greater risk of having property offences committed against them post-housing as they now have a property and, likely a greater number of possessions that could be targeted.

7.4 Benefits to Police of Housing First Approach

The proactive engagement of WA Police in 50 Lives from the outset is a huge asset to the project. In the research team's view, this reflects the immense value of securing an internal champion within sectors and organisations in sectors such as police, housing and health. For 50 Lives, this champion has been Detective Superintendent Kim Massam, and he has articulated a number of benefits of 50 Lives engagement from a WA Police perspective, including providing an alternative, more effective intervention options for Police when someone is in crisis.

> *So when someone's in crisis, police officers are really that circuit breaker. We have a couple of options. To put someone in jail, take them up to the hospital or leave them where they are and manage that behaviour in the street... I think that crisis intervention model that 50 Lives brings… for frontline police is real and it has great benefits to the community.* ***– Kim Massam, Detective Superintendent, WA Police***

When anti-social behaviour occurs for clients who have been housed, 50 Lives provides some less punitive options for Police.

> *There will be unintended consequences of what we do, putting people into [housing]. We knew that they would be social challenges with people in a house - in a small group of houses where they've got mental concerns and alcohol. They won't be your model neighbour. We get it and that's where that support from 50 Lives comes in… our natural assumption from policing would be, we need to move this person away, to bring peace and quiet back to the neighbourhood… So, when someone comes alongside you and they're antisocial and there's seven people in there and they're drunk and they're screaming and yelling, they wake the community up, well from a policing point of view, the simple [point] to us would be try and move them out. Without other options, that's what we'll do. We'll simply blindly go into there and potentially move the problem somewhere else or back to the streets.* ***– Kim Massam, Detective Superintendent, WA Police***

7.4.1 Cost to Justice System

Demands on police resourcing and burgeoning prison populations in WA and across Australia represent an escalating social and economic burden that is presently unsustainable. In the 2018/2019 financial year, the Police and Justice portfolios are estimated to account for 10% of the WA government expenditure – over three billion dollars.[83]

There is currently no specific costing data available in the public realm for police data, but WA Police are assisting the research team with this for the next evaluation report. Based on discussions thus far, the two largest costs to WA Police come through incidents (low cost, high volume) and through custody/court appearances (low volume, high cost). A simplified visual representation of this is depicted in (Figure 21). In other words, only a proportion of incidents and offences progress through to the arrest and charge phase, and fewer again to custody or court or prison, but the demands on police time and therefore the associated staffing costs to WA Policing increases along this trajectory. Custody, court and prison of course also have cost implications for government beyond WA Police, and future access to Courts and Corrective Services data will provide a more in-depth analysis of this in the context of homelessness and the experiences of 50 Lives clients.

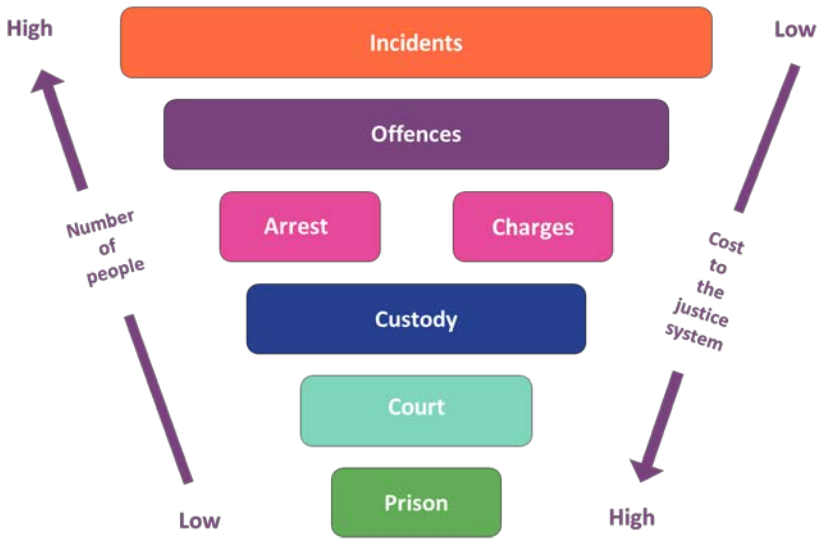


Figure 21: Relationship Between Type of Contact and Cost

7.4.2 Cumulative Cost to Justice and Health Systems

A unique strength of the 50 Lives evaluation is the access that has been granted to both administrative hospital and police data for clients before and after housing. The hospital data goes back three years prior to housing for most clients, and the police data up to 10 years prior. Longer term this will enable the research team to look at the cumulative burden on health and justice systems prior to housing and the extent to which this changes following housing and support through 50 Lives.

As police data was only received early September 2018, linking to hospital data and combined analysis of this will not be possible until the third evaluation report. However, the case studies below highlight the way in which some clients have had substantial interactions with the criminal justice system and police prior to 50 Lives, and some indicative cost estimates have been included (Box 16 and Box 17). In the first of these case studies the cycling of some clients through both health and police sectors is also evident.

Box 16: Cost Burden to Justice and Health Sectors: A Case Study

Wes is in his mid-thirties and had been cycling in and out of homelessness and transient accommodation for about eight years prior to entering the 50 Lives project. In his VI-SPDAT he indicated having spent time in youth detention and in prison and has experienced trauma.

Justice Contact: In the five years prior to being housed by 50 Lives, he received 12 move-on notices, and committed 10 offences leading to charges and court appearances. He was in custody on three occasions between 2011-2017. Charges included assaulting a public officer, burglary, stealing, fraud, and stealing a motor vehicle.

Health Usage: Wes also has a long medical history, including asthma, mental and substance use. His hospital use over a two-year period (2016-2017) was extensive. In 2016 he had 12 ED presentations and spent 62 days in hospital. In 2017 he had 15 ED presentations and spent 106 days in hospital. For this two-year period alone, his hospital use equated to $20,655 for ED presentations and $456,624 for inpatient treatment.

Current Housing, Justice and Health Status: Wes has been housed for over a year and police data confirms there have been no offences since he was housed. Reducing the risk of re-offending is among outcome areas he is being supported with by his lead worker and the AHSS.

Box 17: Changes in Justice Contacts Once Housed: A Case Study

Background -Brandon is in his early thirties and had been street homeless for five years prior to entering prison for burglary. A complex medical condition as a child had subjected him to over 100 medical procedures; in light of this he once noted to his case worker, *"I have [subsequently] been on drugs since I was 11".* Drug dependency developed and Brandon eventually became homeless following the death of his Mother. Additionally, Brandon has mental health issues and an ABI from a fall.

Cost to Justice System prior to 50 Lives: Dating back to 2005, Brandon has what the Perth Watch House describe as an *"extensive custodial history"*. Between 2005 and mid-2016 he was in Police custody (including the Watch House) on at least 90 occasions. Using the conservative assumption that 1 in 3 incidents of being taken into custody were serious enough to warrant detention in the Watch House for a court appearance, this equates to 30 overnight custody instances. Using the OICS short-term custody cost (see note 1), this equates to custodial costs of $13,860.

Between 2008 and 2016, he committed 35 separate offences, more than half of which related to stealing or burglary. Using estimate figures from a recent Ombudsman report (note 2), this equates to a total estimate of $16,730 for police time involved. Additionally, Brandon served eight months in prison at a cost of $76,500 (note 3) before he was released on a community service order. All up, these custodies, arrests and prison instances equate to over $107,090.

Current Housing and Justice Status - Brandon spent around one-year in transitional accommodation prior to being housed through 50 Lives in early 2018. This is the first time in Brandon's life that he has had his own place to live, recently, Brandon proudly noted, *"I haven't had any trouble with the law for 2 years"*. Police data confirms there have been no offences since being housed and supported by 50 Lives. He is not able to work due to health issues, and he himself has identified to the AHSS team that boredom is a risk factor re-offending. *"He said, if I get bored I might start using again but then I might get in trouble again and then I might go back inside and I really don't want that"*. So the AHSS team has been supporting him to identify some community activities he is interested in that could address boredom, with cycling, attending a Men's shed and volunteering some of the options being explored.

Note 1: As noted in a recent report of the Office of the Inspector of Custodial Services (OICS) in WA,[84] short-term custody has a much higher cost/day (estimated at $770/day) than longer term prison incarceration.
Note 2: A recent Ombudsman report[85] estimated that the average arrest for a stealing entails 9.63 hours of police time, reporting a cost per stealing arrest of $478 (based on a cost/hour of constable time at $49.71). In the absence of more accurate and complete costings for police time for other offences, it is conservatively estimated that his other offences (which included assault, drug related crimes, fraud and receiving stolen property) equated to a similar amount of policing effort.
Note 3: In WA, the estimated average cost per prisoner per day in an adult prison is $318, whilst the cost of youth detention is even more costly, and estimated to be $1,074 per prisoner per day.[86]

8. CONCLUSION

"But I'm very blessed with 50 Lives 50 Homes. Everyone there behind the scenes and hands on have been awesome"

- 50 Lives Client

The 50 Lives project has made massive strides towards ending chronic homelessness in Perth, with the original target to house 50 of the most vulnerable homeless people in Perth met back in June 2017. To date, 147 people have been housed in 109 homes; with approximately an additional 80 clients currently supported with lead workers and a range of collaborating organisations working hard to secure them suitable housing. Whilst housing people 'first' and as rapidly as possible is a key pillar of 50 Lives, this second evaluation report has highlighted the challenges of sustaining a tenancy after years of rough sleeping, and the coupling of housing with longer term and individually tailored wrap-around support (through AHSS and the wider collaboration) has been critical to the success of 50 Lives to date. Enormous credit is due also to the clients themselves, who have embraced the opportunity that 50 Lives has enabled as a supported pathway out of homelessness. The statistical finding that 87% have retained their tenancy after one year belies the amount of effort that goes into enabling this at the individual client level. Moreover, in this second year of 50 Lives, the research team has observed the temporary cycling of some clients back into life on the street, and compellingly, witnessed the enormous effort and tenacity that goes into maintaining support for and contact with these clients, with permanent housing and support for this still the penultimate goal.

For any collective impact project with multiple partners (28 in the case of 50 Lives to date), there can be challenges in translating the rhetoric of collaboration at the grassroots level, accentuated by the traditionally siloed nature of government portfolios and health and social sector interventions. In the case of 50 Lives, this independent evaluation has in fact yielded substantial verification of the collaborative processes and outcomes that have contributed significantly to the positive housing, health, client and justice outcomes observed to date. This is demonstrated through triangulation of client and staff perspectives with empirical data and research team observations of 'collaboration in action'.

As reflected in the range of case studies and data presented in this second evaluation report, there is no typical 50 Lives client (nor typical person who is homeless for that matter) and every trajectory into homelessness and journey out of homelessness is unique. Through interviews with clients and staff, and our observations of AHSS and working groups in action, it is clear that the commitment to client focused and individualised support is by no means rhetorical. Indeed ironically, the unique story of each client and their interaction with 50 Lives makes the evaluation task more difficult, as it is abundantly clear that there is no 'one size fits all' solution, nor a formulaic method for demonstrating impact.

The ability of 50 Lives (and its collaborating partners) to simultaneously work at the individual and organisational level whilst also engaging in advocacy and innovation at a strategic and systemic levels is another unique feature of the project that we have sought to capture in this evaluation. The citing of 50 Lives and its Housing First response to homelessness in a range of public policy submissions over the last year is but one example of how it is contributing to reforms at the more macro level. At the client level, the identification of gaps and barriers to ending homelessness are also being elucidated as 50 Lives unfolds; leading to a number of innovative solutions trialled by 50 Lives and its partners to tackle challenges head on. Examples of this include the instigation of the ID clinic and the Wongi Mia project that is taking a 'whole of family' approach to the challenges of housing Aboriginal people with extended families experiencing homelessness.

As reflected in this report, unresolved homelessness places an enormous burden on the homeless, housing, health and justice sectors, hence

demonstrating the economic 'return of investment' of a Housing First response is a key longer term goal of the 50 Lives evaluation. However, other evaluations of Housing First programs have cautioned against expecting dramatic changes in health, justice and other outcomes in the short term, and 50 Lives has recognised from the outset that housing is by no means an instant panacea for the raft of underlying and complex health and psycho-social issues that often go hand in hand with chronic homelessness. Whilst the number of people housed for at least six or 12 months by 50 Lives is still relatively small, this report has demonstrated some significant reductions in hospital use among those housed for six months or more, with an associated cost saving to the health system that compares very favourably to the costs of 'not doing something' to reduce the revolving door between homelessness and health. Currently in WA there is strong government commitment for more 'joined up' whole of government solutions to complex societal problems, and this second evaluation report has highlighted the potential for 50 Lives to reduce some of the burgeoning fiscal burden borne by the health sector, as well as freeing up bed and staff resources for other areas of need.

The recently provided police data is a rich dataset unique to 50 Lives, and preliminary analysis of this also shows the potential for reduced offending (and therefore associated police and corrective services costs) when homelessness is ended. Concerningly however, the likelihood of being a victim of crime after housing did not similarly decrease, and this report proposes a number of possible explanations for this that warrant further investigation. In the health, police and tenancy data, it is clear that many of client vulnerabilities are not simply left behind at the front door when housing is obtained.

Challenges Ahead for 50 Lives

As the 50 Lives project continues to expand, there are a number of challenges surfaced by this evaluation that merit consideration:

However, it should be noted that while there are overall reductions in health service usage and justice contacts, there are a number of clients who increased their usage. This reiterated that simply getting a house does not solve homelessness. Evidence from multiple sources confirm that the AHSS and ongoing intensive support from lead workers are a critical pillar enabling the sustained tenancies among 50 Lives clients. Long term and sustained funding for the AHSS are needed going forward, and this would bolster its capacity to take on new clients as 50 Lives further grows, whilst also being able to the maintain support for currently housed clients who may need some form of ongoing after hours care in the first five years of housing transition.

Further support for clients around post-housing issues; challenges such as boredom, social isolation, building of community connections and engagement all were common themes throughout interviews. From interviews with the AHSS team and clients themselves this has already been identified as critical factors to enable tenancy sustainment and quality of life. Permanent housing provides a foundation for improvements in health outcomes but also needs to come with opportunities for tenants to socialise and engage in employment and educational, sporting and other activities to improve social well-being and reduce isolation (rather than increase loneliness); an issue that has previously been focused on in past Australian Housing First studies.

Ongoing funding to continue and expand the 50 Lives project. The recent ABS Census figures coupled with the wealth of data we have collated on 3,400 people experiencing homelessness in Perth highlights the enormous amount of unmet need. The availability of suitable housing options is commonly lamented as a key blockage to ending homelessness in WA, but equally critical is the need to expand lead worker and AHSS capacity to take on more new clients. Additionally, homelessness isn't confined to the Perth CBD, and therefore there is also a compelling need to explore ways of bringing the Housing First model to other regions of Perth and into rural and regional WA more broadly.

Capacity to support clients longer term. While 87% of 50 Lives clients were still housed after one year, and a number of people are no longer needing a lead worker or AHSS support, recent UK evidence from a five year follow up of homeless people who had been housed, found that tenancy sustainment can be a challenge for many years and that relapses into homelessness will occur. Hence, effective interventions need to have the capacity to support clients through this with a view to permanent housing as the end goal. Already 50 Lives has had a number of clients whose first tenancy has not worked out (for a range of reasons) and there is a positive pragmatism among AHSS and lead workers in encouraging clients to maintain contact (housed or

not) and to learn from such experiences for 'next time'.

Longitudinal follow up of client and project outcomes. This is an ongoing need to resource, and continue longitudinal follow up of client and project outcomes. Very few Housing First programs to date have had sustained evaluation and tracking of client health, justice and housing outcomes longer term. This is recognised in the literature as a gap, as the ultimate barometer of success requires longer term follow up. Further, the potential to yield cost savings to the government (across health, justice and housing portfolios) is expediential.

Addressing wider systemic gaps and barriers to ending homelessness. Many of the learnings from 50 Lives and it's evaluation point to wider systematic gaps. The compelling need for alternative affordable housing solutions is one example that has galvanised the steering group, partnering organisations, and the WAAEH Alliance. The way in which people who are experiencing homelessness are for example, bounced between mental health and AOD services is another systematic gap that has been highlighted by the data on mental health and AOD comorbidity of many clients. Additionally, this brings with it large associated costs borne by the health system as a result. Key 50 Lives partners (HHC, RPH, St Barts and UWA) have drawn on these experiences to apply for a grant to pilot a dual diagnosis outreach service in Perth to work with 50 Lives clients, as well as people in transitional accommodation and rough sleeping. These are but two examples of system and service gaps that the 50 Lives collaborative and the learnings from 50 Lives to date that can contribute to achieving "functional zero" homelessness in Perth.

Photography by Tony McDonough.

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APPENDIX 1: LEAD AGENCIES

From Apr – June 2018

360-PIR

Anglicare

Centrecare

Department for Child Protection and Family Support (CPFS)

Drug and Alcohol Youth Service (DAYS)

Foundation Housing

Freshstart

Graylands

Inner City Mental Health (ICMH)

Mobile Clinical Outreach Team (MCOT)

Mission Australia

Outcare

Passages

Perth Inner City Youth Services (PICYS)

Richmond Wellbeing

Ruah Community Services

Salvation Army

Specialist Aboriginal Mental Health Service (SAMHS)

Southcare

St Barts

St Patricks

Street Connect

Tenancy WA

Uniting Care West

Victoria Park Youth Accommodation (VPYA)

WA AIDS Council

Way Home (Access Housing)

Wungening Aboriginal Corporation

Youthlink

Young People with Exceptionally Complex Needs (YPECN)

APPENDIX 2: ADDITIONAL HEALTH DATA TABLES

Table 24: Discharge Type from ED Pre and Post Housing

N(%)	6 Months		12 Months	
	Pre (n=127)	Post (n=77)	Pre (n=204)	Post (n=88)
Admitted to EMW	17(13.4)	8(10.4)	30(14.7)	6(6.8)
Admitted to ward	30(23.6)	15(19.5)	42(20.6)	23(26.1)
Discharged	59(46.5)	44(57.1)	110(53.9)	46(52.3)
Left at own risk	14(11.0)	6(7.8)	16(7.8)	7(8.0)
Security / police escort out of ED	1(0.8)	2(2.6)	1(0.5)	2(2.3)
Other	6(4.7)	2(2.6)	5(2.5)	4(4.5)

Table 25: Type of Hospital Admission Pre and Post Housing

N(%)	6 Months		12 Months	
	Pre (n=54)	Post (n=29)	Pre (n=76)	Post (n=37)
Elective Direct Admission	2(3.7)	5(17.2)	3(4.0)	3(8.1)
Elective Waitlist	3(5.6)	0(0)	2(2.6)	3(8.1)
Non Elective Direct Admission	3(5.6)	2(6.9)	1(1.3)	3(8.1)
Non Elective Emergency	46(85.2)	22(75.9)	70(92.1)	28(75.7)

Table 26: Diagnoses for Inpatient Admissions Pre and Post Housing

n(%)^	6 Months		12 Months	
	Pre (n=54)	*Post (n=29)*	*Pre (n=74)*	*Post (n=37)*
Diabetes/metabolic	6(11.1)	3(10.3)	10(13.5)	5(13.5)
AOD use disorders	5(9.3)	5(17.2)	13(17.6)	4(10.8)
Mental health	8(14.8)	4(14.8)	5(6.8)	4(10.8)
Nervous system	3(5.6)	0(0)	5(6.8)	0(0)
Circulatory/respiratory	5(9.2)	2(6.9)	3(4.0)	2(5.4)
Digestive	7(13.0)	5(17.2)	10(13/5)	8(21.6)
Skin/tissue	4(7.4)	0(0)	5(6.8)	2(5.4)
Injury/poisoning	12(22.2)	6(20.7)	17(23.0)	6(16.2)
Other	4(7.4)	4(13.8)	6(8.1)	6(16.2)

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LEAD AGENCY

RUAH COMMUNITY SERVICES

CENTRE for SOCIAL IMPACT

THE UNIVERSITY OF WESTERN AUSTRALIA