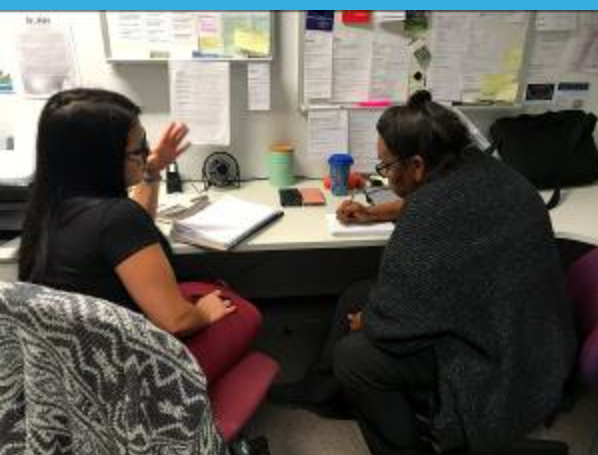


Choices Post Discharge Project

Evaluation Report



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We acknowledge and pay respects to the traditional owners of the land, the first people of this country, on which we work and live. We pay our respects to their culture, their Elders past and present and to their emerging leaders.

Disclaimer

The opinions expressed in this report reflect the views of the authors and do not necessarily reflect those of Ruah Community Services or WA Primary Health Alliance. No responsibility is accepted by Ruah Community Services or WA Primary Health Alliance for the accuracy or omission of any statement, opinion, advice or information in this publication.

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LIST OF ACRONYMS

ANZSOC	Australian and New Zealand Society of Criminology
AOD	Alcohol and Other Drugs
DDI	Data and Digital Innovation
ED	Emergency Department
FDV	Family and Domestic Violence
HREC	Human Research Ethics Committee
IHPA	Independent Hospital Pricing Authority
NGO	Non-Government Organisation
PLN	Psychiatric Liaison Nurse
RPH	Royal Perth Hospital
RGH	Rockingham General Hospital
SASH	Safe as Houses
US	United States
UWA	University of Western Australia
VI-SPDAT	Vulnerability Index – Service Prioritisation Assistance Tool
VRO	Violence Restraining Order
WA	Western Australia
WAPHA	Western Australia Primary Health Alliance

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EXECUTIVE SUMMARY

The Choices Post-Discharge Program aims to reduce recurring presentations to the Emergency Department and frequent attendance at justice services.

BACKGROUND

There is a well-established body of literature that demonstrates that there are socially determined drivers of frequent health and justice system interactions, often relating to underlying social and/or escalating physical and mental health issues that would be better addressed in the community.

Commencing in November 2017, the Choices Post-Discharge Program was established at Royal Perth Hospital, Rockingham General Hospital and Perth Magistrates Drug Court to recruit clients who are discharged from Emergency Departments (EDs) or attending justice services. Through peer support and case management Choices is a short-term program that works to co-ordinate and facilitate access to primary and secondary care and community support services in order to address underlying, unmet needs in the post-discharge period.

This report describes the Choices program and investigates changes in hospital utilisation or contacts with police among clients supported, using administrative hospital and Western Australian Police Force data.

DEMOGRAPHICS

Demographic and administrative data is presented for 392 Choices clients who received support up until March 2019. Overall 54% of Choices clients supported were male, with the average age of clients 39 years. Nearly a third of clients (31%) identified as Aboriginal and/or Torres Strait Islander.

Mental health, alcohol and other drug use and accommodation were substantial issues for Choices clients at the time of their first contact with the program, affecting 66%, 62% and 55% of clients respectively.

HEALTH SERVICE UTILISATION

Choices clients were high utilisers of health services in the year prior to support with ED presentations and inpatient admissions in this period equating to over \$6 million. This is unsurprising however, given that the remit of the Choices program was to support frequent ED attenders. In the year following support from Choices there was a 35% reduction in the number of clients presenting to ED and overall the number of ED presentations declined by 18%. The number of inpatient admissions also decreased by 7% in the year following support. In the six-months following support from Choices there was a 37% decrease in ED presentations and 38% decrease in inpatient length of stay, equating to a hospital use cost reduction of over \$1 million across 392 clients (or \$3,462 per person) in this period.

JUSTICE SYSTEM INTERACTIONS

There was a significant reduction both in offending and in the frequency of victimisation amongst the Choices clients post support. In the 12 months post Choices, there was an 18% reduction in number of people offending and 44% reduction in the proportion of clients who had been victims of offences.

SUCCESSSES, BARRIERS AND CHALLENGES

The core successful elements of the Choices program are peer engagement, individualised support and flexibility. Challenges include the multiple and varied client needs, limited period of support and lack of availability of external services.

CONCLUSION

With an unsustainable demand on hospital beds in WA, Choices has demonstrated that recurrent hospital use can be reduced through peer support, clinical care coordination, person-centered case management and connecting clients to existing community-based services.

1 INTRODUCTION

1.1 BACKGROUND

There are well-documented socially determined drivers of frequent health and justice system interactions. Recurrent emergency department (ED) presentations can often relate to underlying social and/or escalating physical and mental health issues that are better addressed in the community (Figure 1). There is growing evidence indicating that interventions need to go beyond the health sector to effectively reduce recurrent hospital presentations among vulnerable groups.^{1, 2}

The Choices Post Discharge program was developed in response to substantial Australian and international evidence documenting the over-representation in ED presentations of individuals with multiple health and social needs.³⁻⁶ These presentations are often related to underlying social issues, or the escalation of physical and mental health conditions that would have been more appropriately addressed by primary care providers.^{7, 8} Given recent evidence estimating that of 1 million attendances to WA EDs in 2017–18, around 19% of these could have been potentially avoided with treatment in primary care or community settings, this demonstrates the potential for the role of Choices more broadly.⁹ As articulated by Dr Rock from WAPHA, Choices enables clients to navigate the system whilst providing personalised support (Box 1).

Box 1: Observations on the Choices Program

Stepped care is not characterised by a divisional boundary between hospital and community care, nor between secondary and primary, nor is it care by condition. It is, instead, care that centres on individual needs and preferences and with care systems, pathways and supports organised accordingly. Coordinating treatment and supports for people with severe and complex mental illness is one of eight priority areas specified in the Fifth Plan, and in achieving this outcome consumers “*should be at the centre of, and take an active role in shaping the way in which services are planned delivered and evaluated.*”

Choices’ triage protocols and shared-care pathways from ED, personalised to consumers preference to the extent possible, coordinating follow up treatments and support and creating an integrated pathway sufficient to establish a safe and stable connection back into their community (Action 8), which links to the post-discharge community care indicator in the Plan (PI 16).

Moreover, the in-reach aspect of the program challenges the culture of separation between hospital auspiced “specialist” provision and NGO community-based treatment supports. It proves the possibility of front-line reform in one of the more congested and contested settings (hospital emergency departments). ED staff (clinical and professional) are committed to achieving the best possible outcomes for all their patients and recognise the inequity of the current system for people presenting with mental health issues. Recognising and building on their tacit knowledge and expertise is crucial if the policy intent of the Fifth Plan is to be realised in practice and at scale.

-Dr Daniel Rock, Principal Advisor & Research Director WA Primary Health Alliance

1.2 WHAT IS CHOICES?

Choices Post Discharge Service is a pilot program that aims to reduce recurring presentations to EDs and justice services, through provision of peer support and case management to vulnerable and disadvantaged individuals.

Choices commenced in November 2017 and is delivered by Ruah Community Services funded by the Western Australia Primary Health Alliance (WAPHA) as part of the Australian Government PHN program. It works to co-ordinate and facilitate access to primary and secondary care and navigate and access community support services to clients discharged from EDs or attending justice services, in order to address underlying, often multiple unmet needs. A key component of the Choices model of care is the peer workers. Peer workers have lived experience that is relevant to the client cohort they work with. Choices peer workers engage potential clients in the ED and are able to relate and build quick rapport with clients (further discussed in Chapter 2).

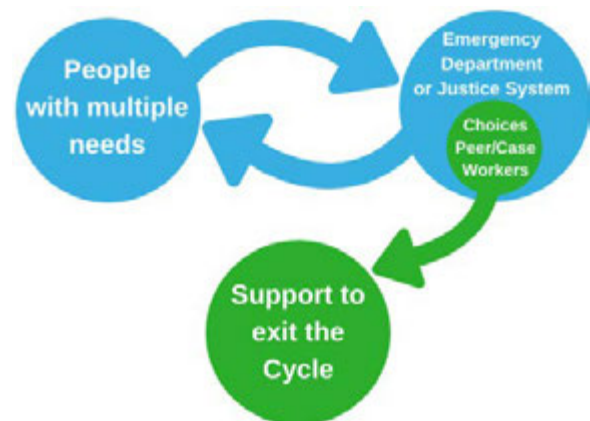


Figure 1: Breaking the Cycle of Frequent Presentation

Choices is the first project of its kind - it is trying to help the large group of people in our community seen frequently in hospital Emergency Departments or by the Justice system—people with lives of constant chaos that leaves them one step away from homelessness or other social disasters - Dr Amanda Stafford, ED Consultant RPH

The Choices team works with clients to achieve the following aims:



Figure 2: Choices Post Discharge Program Aims

The Choices program is based in three different sites, Royal Perth Hospital (RPH), Rockingham General Hospital (RGH) and the Perth Magistrates Court. As shown in Figure 3, the pilot first commenced at RPH, and five months later at RGH. The Perth Watch House was added as a pilot site based on evidence suggesting that some individuals with multiple health and/or community support needs enter a cycle of frequent ED admissions and justice system contact, which interrupts continuity of care, contributing to worsening health and further ED presentations.^{10, 11} In late 2018, it was decided that the Perth Magistrates Court would replace the Perth Watch House as pilot site. The locations of the Choices

service across hospital EDs and the Perth Magistrates Court are important for facilitating referrals and engaging with clients.

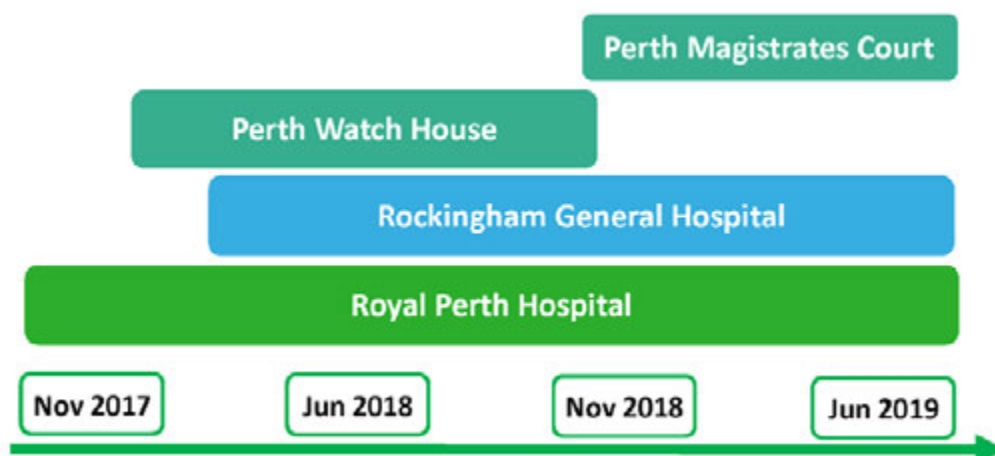


Figure 3: Timeline of Choices Pilot Locations

1.3 PURPOSE OF THIS REPORT

This evaluation report follows on from preliminary findings in the brief evaluation report (October 2018).¹² This report describes the progress of the Choices Post Discharge program and investigates whether there were changes in hospital utilisation or contacts with police among clients supported. The report draws on administrative hospital and Western Australian (WA) Police Force data, as well as client service data provided by Ruah, interviews with Choices staff and hospital stakeholders, and case studies.

1.4 EVALUATION METHODOLOGY

Ruah commissioned The University of Western Australia (UWA) School of Population and Global Health to undertake an independent evaluation of the Choices Post Discharge Service. Evaluation of interventions that span health and justice settings is critical for building the evidence for more 'joined up' responses.

This evaluation draws on multiple sources of data, including linked administrative hospital and police data for Choices clients; focus groups with Choices peer and caseworkers; research team observations of Choices in action at RPH, RGH, Perth Watch House and Perth Magistrates Court; Choices client data, and case studies compiled with the assistance of Choices staff and the Ruah evaluation team. Where possible, hospital and police data has been incorporated into case studies. The inclusion of linked health and police data reflects not only the implementation of Choices in both hospital and justice settings, but also enables examination of the inter-relationship between health and justice system contacts in the lives of the client cohort.

1.4.1 ETHICS AND GOVERNANCE APPROVALS

The approval to conduct this research project was granted by the RPH HREC on 17 April 2018 (Reference No. RGS0000000737), with reciprocal approval granted by the UWA HREC on 13 March 2019 (Reference RA/4/20/4695). Governance approval was required for the hospital sites, approval for RPH was granted on 16 April 2019 and for RGH on 6 September 2019. Approval to access police data was granted by the Research Governance Unit on 8 April 2019.

1.4.2 QUANTITATIVE DATA

The sources and analysis approach for the different types of data used are summarised below. The population cohort for the health service utilisation and justice outcomes analysis in this report consists of 392 clients (after duplicates removed) seen by the Choices team between June 2017 and March 2019.

Choices Demographic and Service Use Data

Demographic data for the 392 Choices clients who had consented to support as of March 2019 were provided by Ruah. Ruah also provided aggregated data on the number of people the service had contact with and the main types of support provided.

Hospital Utilisation Data

Administrative hospital data between November 2016 and June 2019 was obtained for the 392 clients and includes ED presentations, hospital admissions and outpatient service utilisation. This data was extracted by the Data and Digital Innovation (DDI) team at East Metropolitan Health Service. Data matching was facilitated through use of a unique study ID for each individual, to enable the administrative data to be provided without names or other identifying information. Data was provided in a de-identified form by the DDI, with the UWA unique ID used to add the date of first contact with Choices for the purpose of data analysis. Data was extracted from Emergency, Inpatient and Outpatient datasets for RPH and RGH.

This analysis looked at:

- **Primary diagnoses** – ED and inpatient data
- **ED data** – number of clients presenting to ED, average and total number of presentation (six months, 12 months prior to Choices)
- **Inpatient data** – number of clients with inpatient admissions, average and total number of inpatient admissions, number of admitted days
- **Estimated costs** associated with ED presentations and inpatient days – average per client and total.

WA Police Force Data

The Office of Applied Criminology of the WA Police Force sought to extract administrative Police data for the cohort of Choices clients supported between June 2017 and March 2019. 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. The WA Police Force was able to match data for 381 clients (97% of clients). The police data was categorised using the Australian and New Zealand Standard Offence Classification (See Appendix 1). The administrative police data covers the period 1 September 2016 to 30 June 2019, as this enables us to look at police data prior to and following Choices support for at least one year prior to Choices support for each client.

It is pertinent to note that being in the police data system does not equate with having committed an offence or crime as police data includes matters which are never formally charged or progressed to court, and people may have had an offence committed against them (i.e. a victim of crime), but not have committed an offence themselves.

Quantitative Data Analysis

Both the police and hospital data were matched to the Choices ID number for each client, and the date of support commencement added to the dataset to enable comparison of police and/or hospital contact data prior to and following engagement with the Choices program. Clients with at least six- or

12-months follow-upⁱ from first contact with the Choices team were identified and analyses were restricted to these groups, in order to examine changes in hospital service utilisation or police contact. Hospital admission and ED presentation data were analysed using Stata v15.0 for the periods pre- and post-Choices contact, to produce counts for presentations, admissions and to calculate the number of hospital days admitted, both at a group and individual level. As Choices clients' level of hospital service utilisation increased in the period immediately before enrolment this has the potential to impact pre/post changes in service utilisation. To address this we also examined change in pre and post-health service utilisation excluding two weeks prior to and after enrolment into Choices.

For the analysis of police data, counts were generated for individual participants to determine the number of offences in the periods three, six and 12 months before and after first contact with Choices. This was done separately for offences where the participant was recorded as the offender, as well as where they were recorded as the victim. Offence types were also analysed separately using ANZSOC codes to calculate changes across the periods.

1.4.3 QUALITATIVE DATA

Semi-structured group interviews were undertaken with the Choices case and peer workers at two time points (March 2018, May 2019) and with staff from RPH and RGH between June-August 2019. The Choices case/peer worker interviews followed a semi-structured guide to elicit information on the strengths, benefits, challenges and recommendations of program delivery. Where appropriate, workers were asked to provide examples of case studies. Interview recordings were transcribed verbatim by a transcription service and analysed thematically by the research team. Findings from the qualitative research have been used to develop case studies, to assist with explanations of quantitative findings and to inform the discussion of Choices benefits and challenges in the final chapter.



Photo 1: Choices Poster

ⁱ It should be noted that some individuals may have had reduced time at risk due to incarceration (i.e. had 12 months follow-up but may have spent 8 months of it in prison). Department of Justice data was unavailable for this project to take this into account.

2 THE CHOICES SERVICE

Choices Post Discharge Service is a pilot program that aims to reduce recurring presentations to EDs and justice services, through provision of peer support and case management to vulnerable and disadvantaged individuals. It is a transitional intervention that works to connect clients to other community support services over a period of three months.

By the end of this three months we aim for the client not to need us. So that's the aim of it, is that we're a transitional service that connects them to the supports that they need. – Peer Worker

Choices work with vulnerable and disadvantaged individuals in two hospital and one justice setting currently; the ED of RPH and RGH, and the Perth Magistrates Court. Potential clients are offered the support of the Choices program by peer workers in these locations, and if they consent, peer support continues, along with case management provided by Peer Community Workers and/or Senior Community Workers, depending on the client needs and level of support required.

2.1 TARGET GROUP

The Choices program was developed to support people with multiple needs who present frequently to hospital EDs and justice services. Choices is intended for people who do not have existing case management support from another service, and particularly targets people who have a mental health or alcohol and drug issue (AOD) that they are interested in addressing. Clients who are not eligible for Choices are provided with information about other available services to support their needs.

Not all people in WA have fair access to health care and some experience worse health outcomes because of social, economic and cultural inequality.
- Sustainable Health Review⁹, p.2

People who present frequently to ED often have underlying needs and challenging life circumstances, and it is recognised that simply treating the immediate presenting health issue will not break the re-presentation cycle. Social isolation, addiction, family breakdown, homelessness, trauma and domestic violence are among factors that contribute to frequent ED use⁴ and similar underlying issues are also seen among people who cycle in and out of the Justice system.¹³

They have so many issues going on that you address one and then another comes up - Choices Community Worker

Choices is premised on acknowledging this clients' multiple needs, working with clients to identify and address underlying and inter-related needs.

2.2 THE CHOICES TEAM

The Choices service, delivered by Ruah Community Services, is provided by a combination of Peer Support Workers, Peer Community Workers and Senior Community Worker (Figure 4).

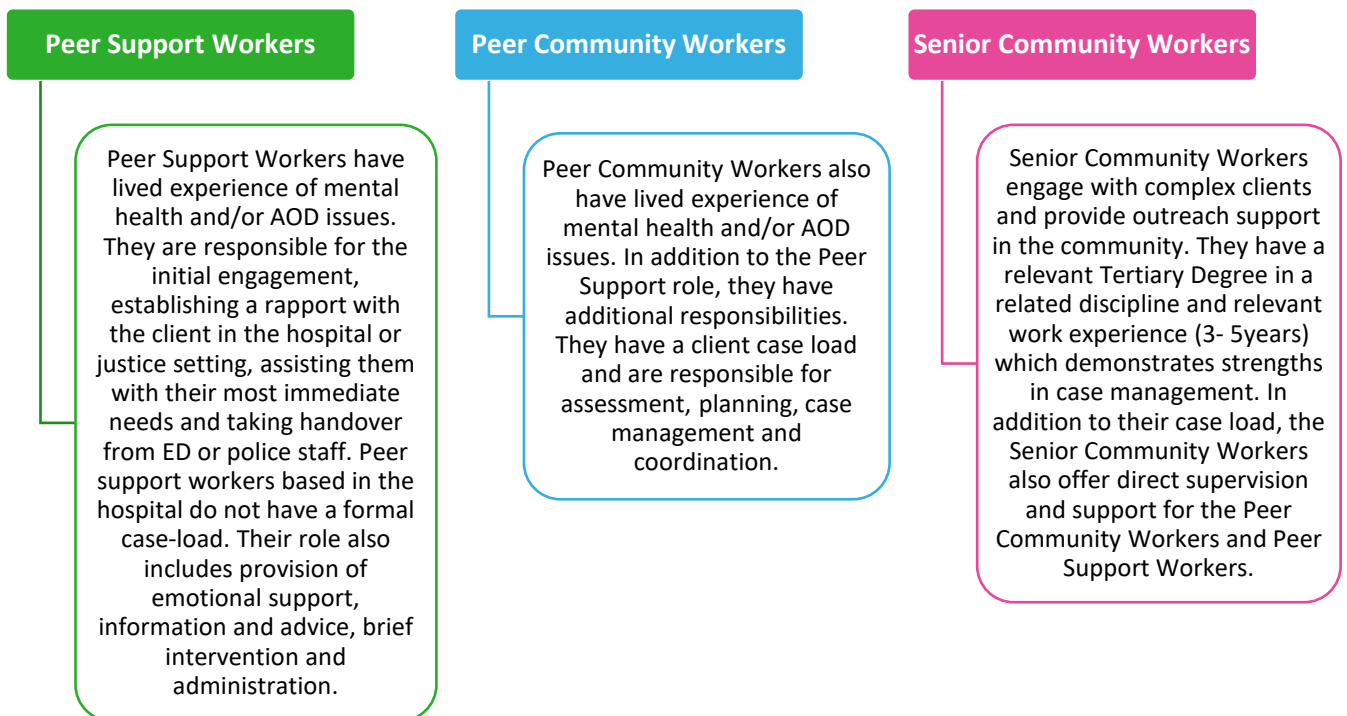


Figure 4: Choices' Workers Role Description



Photo 2: Choices Peer Worker with ED Staff, RGH

The term 'Peer Worker' in this report is used to refer to both Peer Support Workers and Peer Community Workers. Choices Peer Workers offer understanding and support based on own experience and interaction with the system in which they work. Their lived experience of life issues such as mental health challenges, trauma or addiction enables them to listen emphatically, share their experiences and build rapport to engage clients with the service. In some instances, people have been more willing to engage with Choices when the peer worker is the conduit. The development of trusting relationships with non-clinical staff can be key to ongoing and sustained engagement with services. People with multiple health and social needs can experience stigma and negative attitudes from staff, particularly when faced with the complex and inflexible nature of the hospital and justice systems. Peer workers can help to counter these barriers, navigate systems and support clients to engage with services.

Box 2: Evidence for Peer Support

There is strong evidence for the benefits of peer involvement in health interventions. This has traditionally been more common in community based programs (in the areas such as drug education, HIV and mental health) rather than hospital settings. However there is growing evidence for the role of peer support in hospital environment as a conduit for engaging patients through relating to them through similar life experiences. A UK study found that a peer intervention program resulted in a significantly lower hospital readmission rate (compared to a control group) and that time to readmission was longer for this group.¹⁴ A review of peer support for clients with mental health conditions found that peers provide an opportunity for sharing experiences and developing a synergistic understanding, using their own experience to direct others through the experience. The key benefits to patients were reciprocity, reduced readmissions, empowerment and acceptance with peer workers also benefiting by aiding in continuing recovery, and satisfaction through community contribution. There are challenges in the peer support model including developing boundaries i.e., peer workers can be seen as friends rather than a support worker, power (payment and training), stress (from sharing stories) and the increased potential for vicarious trauma.¹⁵

All peer workers receive training, which includes peer work skills, strategies for avoiding re-traumatisation, Mental Health First Aid, as well as training in professional boundaries, advocacy for others, motivational interviewing, understanding of different mental health and addiction issues, and de-escalation. Over time, the role of peer workers within Choices has evolved to enable them to play a greater role in providing primary support for clients.



Photo 3: Choices Post Discharge Team Members

2.3 CLIENT PATHWAY

Choices is based in RPH and RGH EDs and the Perth Magistrates Court where all clients are recruited by peer workers. Referrals to Choices are received from hospital staff at RPH and RGH. Choices staff conduct a weekly presentation at the Perth Magistrates Court, Drug Court information session. Clients that are potentially eligible for Choices are engaged by a peer worker and, if they express interest in participating in the program, their eligibility is assessed, and consent forms are completed (Figure 5). In the hospital settings, various staff are able to provide client referrals, with most referrals coming via ED staff, the psychiatric team or social work team.



Photo 4: Choices Post Discharge Team Members

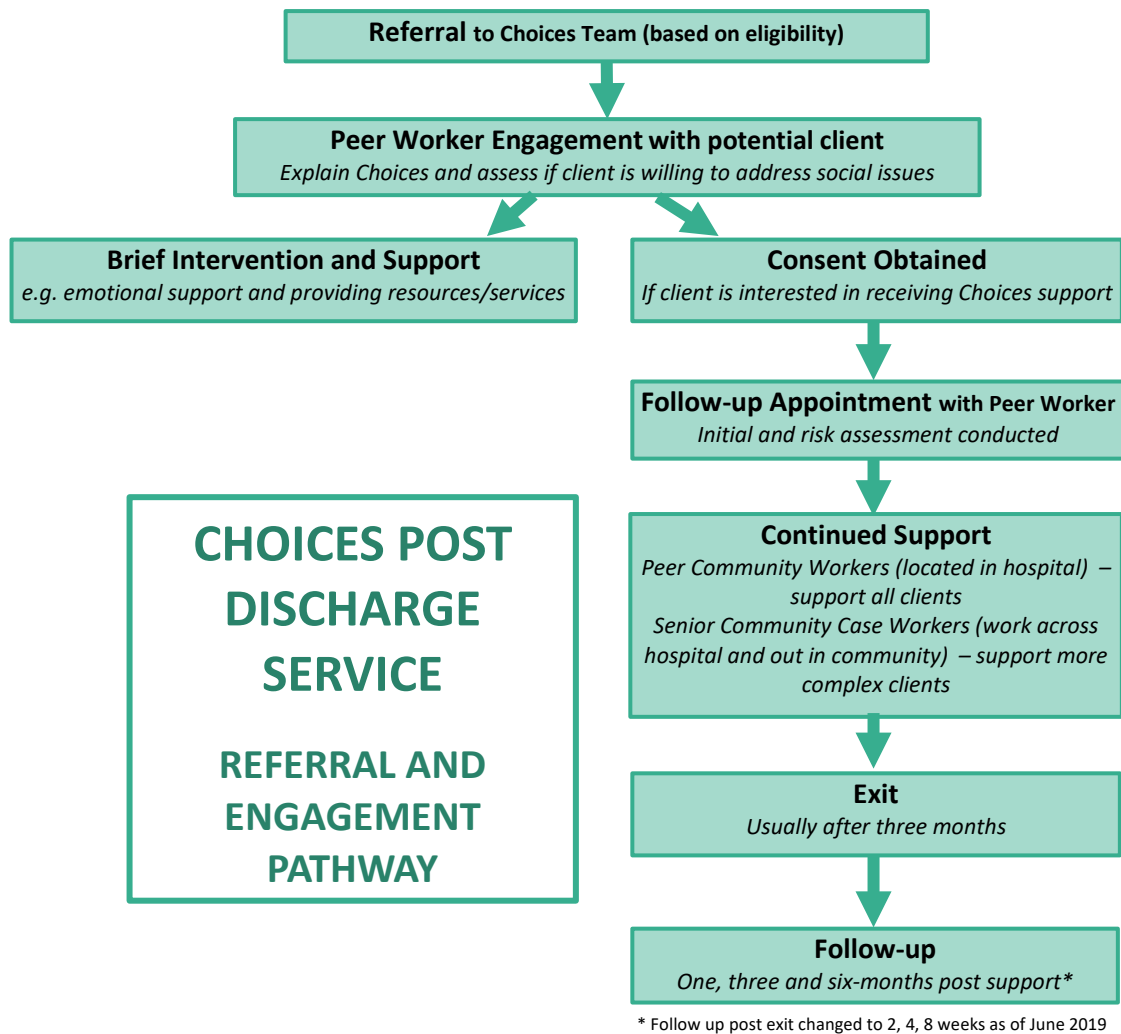


Figure 5: Choices Referral and Engagement Pathway

2.4 WHO HAS CHOICES SUPPORTED

The Choices service has had contact with 2,009 people up until July 2019. Of these approximately two thirds were provided with brief intervention and 683 had consented to more intensive support. Administrative linked health and police data was requested for a subset of 392 people (those supported up until March 2019).

2.5 PRESENTING NEEDS

The initial assessment identifies client's immediate needs, for example, accommodation, food, mental health support, transport, need to access to benefits and Choices staff endeavor to address these as soon as possible (Figure 6). At initial contact with clients, a follow-up appointment is made usually for the following week. At the follow-up appointment a detailed risk assessment is completed with clients and baseline data for the program is collected. Clients with particularly high support needs assigned Senior Community Workers who can visit them in the community and clients requiring less support are assigned Peer Community Workers. Clients can be supported by both Peer Community Workers and Senior Community Workers.

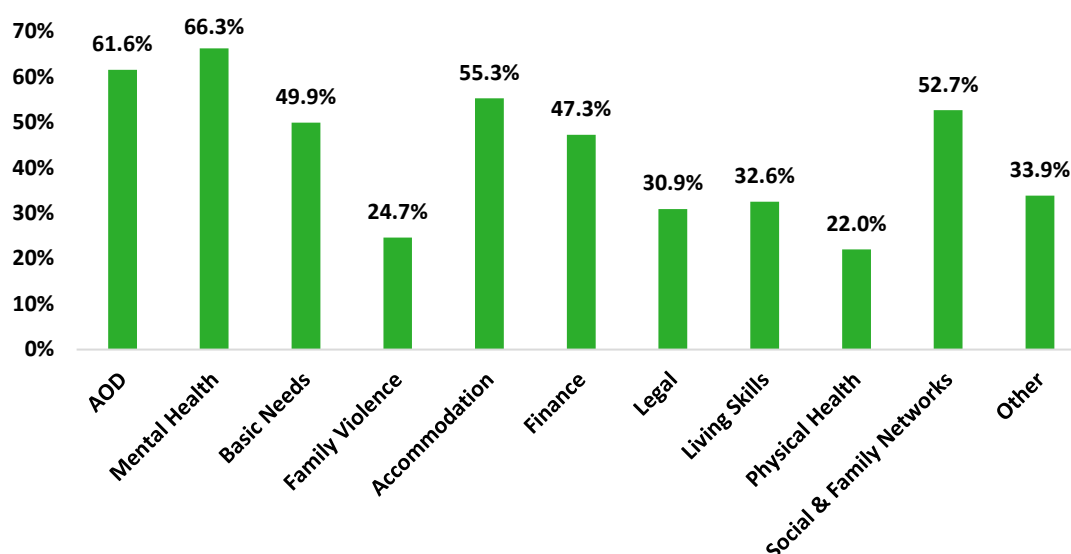


Figure 6: Presenting Needs

More than half of Choices clients presented with issues relating to accommodation and homelessness. For many clients, this had led to deteriorations in health and vulnerability to assault, violence and theft. Addressing AOD misuse has also shown to be fraught with challenges until a client is safely and stably housed. Thus, while Choices is not a homelessness service per se, and has a remit to address mental health and AOD issues, the evaluation indicates that the housing situation of clients is a critical determinant of both health and justice outcomes. As articulated by one of the Choices team members:

*I find that when I'm working with a client experiencing homelessness it's hard for them to address other issues if not housed... because even if you could get them an appointment for mental health, they probably won't attend it because they don't feel the best, they're sleeping rough... But when I find them a place to stay, whether it's crisis or transitional accommodation, at least they can have a good night sleep and then attend for an appointment and start addressing the other things – **Case Worker***

Box 3: Adverse Life Events Preceding Contact with Choices

For many Choices clients, mental health and/or AOD issues have often been preceded by considerable life adversity. This is evident in data available for a subset of 48 Choices clients who had previously completed a VI-SPDATⁱⁱ 16 that measures vulnerability among people who are rough sleeping. On the VI-SPDAT, a score of more than 10 indicates high vulnerability and of concern. Two thirds of these Choices clients had a score greater than 10 (65%). Multiple health issues contribute to a higher VI-SPDAT score, and 69% of this subgroup of Choices clients had tri-morbidity (mental and physical health and AOD issues). The VI-SPDAT also captures data on other antecedents of health and social issues, including trauma, childhood adversity and contact with the justice system. One third of this subgroup of Choices clients had spent time in foster care, and since becoming homeless, over half (55%) reported having been attacked or beaten up.

ⁱⁱ The VI-SPDAT (Vulnerability Index – Service Prioritisation Decision Assistance Tool) is a survey administered both to individuals and families to determine vulnerability and risk when providing assistance to people experiencing homelessness.

2.6 SUPPORT PROVIDED

There is a growing emphasis within health and community services on providing tailored, client-centric care. This is particularly critical when working with vulnerable people with multiple, overlapping needs who struggle to navigate the complexities of the health and justice systems without support. Choices recognises that ‘no one size fits all’ – with the type and duration of support needed varying widely. For some clients, all that is needed may be a brief intervention (e.g. information), or this may be all that is possible in the circumstance. Others require more intense and ongoing support with clinical care coordination. Choices both provides support directly and refers clients to external services.

2.6.1 DIRECT SUPPORT PROVIDED

Choices provides a wide range of supports and services to its clients over its three-month support period. The majority of support provided through Choices is classified as Clinical Care Coordination (98%) defined as “a range of services where the overarching aim is to coordinate and better integrate care for the individual across multiple providers with the aim of improving clinical outcomes.”^{17 p.14}

The service reflects a social determinants of health perspective supporting clients with a wide range of support needs that have an impact on their health (Figure 7). Support can occur as a brief, one-off intervention or as more in-depth case management support for up to three months, with the aim of connecting clients to long-term community-based services. Information and advice, emotional support and mental health were the most common types of assistance provided to clients. The figure below presents the proportion of Choices clients that were provided with each type of support.

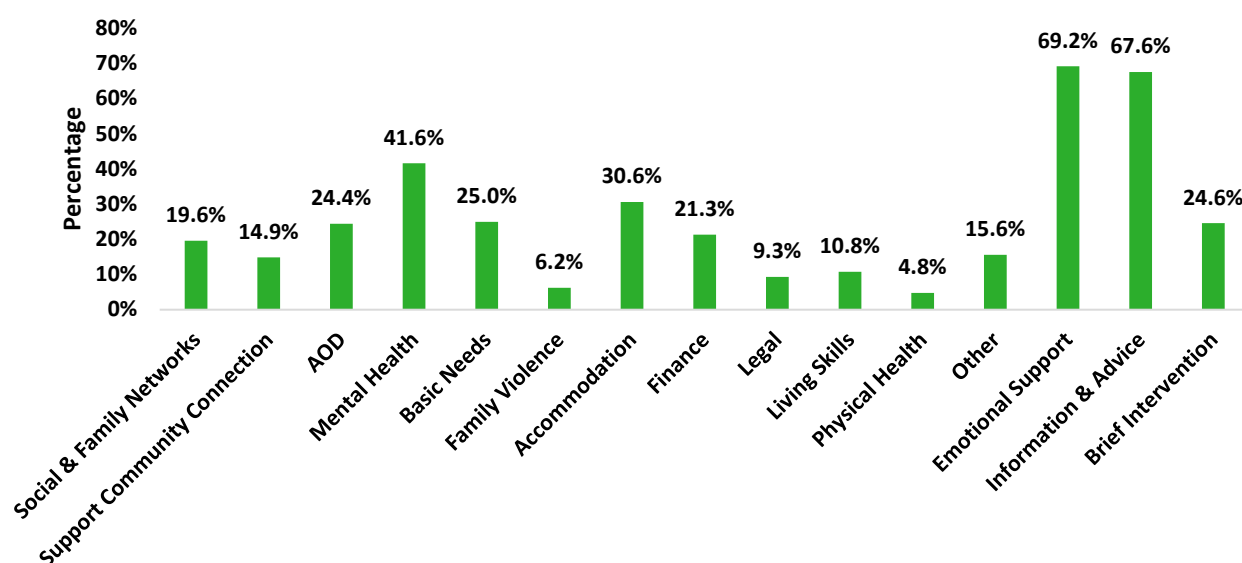


Figure 7: Instances of Support Provided to Choices Clients

2.6.2 REFERRALS TO EXTERNAL SERVICES

A core aim of Choices is to refer and link clients with community-based services and supports, both around health issues and social needs. Mental health, accommodation and AOD rehabilitation are the most common services that Choices clients are referred to (Figure 8 shows the main types and proportion of referrals to other services).

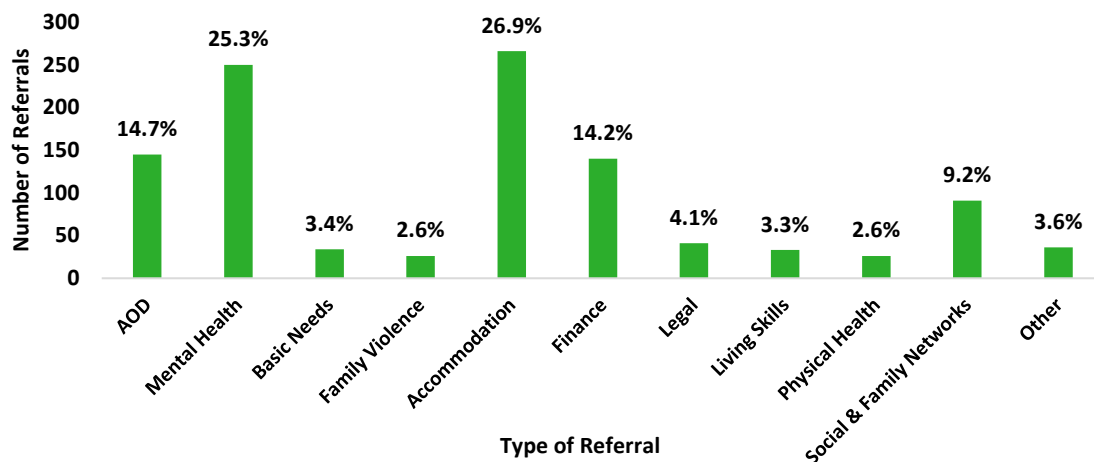


Figure 8: Referrals to External Services

Choices has connected clients to over 44 external support agencies; the majority of these were community, mental health or accommodation services (See Appendix 2). As many clients present with multiple issues, the support provided often spans multiple sectors and incorporates addressing direct and indirect factors of health as illustrated in the case study below.

Box 4: Case Study: Multi-Faceted Support

Background

Paul is a man in his mid-thirties who suffers from a degenerative back issue affecting his ability to work. He was living in a Housing Authority property with his partner and children until their relationship deteriorated. At the time of his first contact with Choices in September 2018 he had been sleeping in his car following a move-on notice from police. Paul had suicidal ideation when he presented to RGH ED and was referred to Choices.

Support Provided by Choices

The support provided by Choices related not only to Paul's immediate health issues, but to the housing situation; a major stressor contributing to his hospital presentations. Initially, Choices provided Paul with intense support including multiple appointments a week and daily phone calls. Over the course of three months, he had contact with the Choices team on 24 occasions. Choices connected Paul with a GP assisting him to access a Disability Support Pension. He was also connected with Ruah Mental Health and Wellness service. Choices helped Paul apply for public housing and he qualified for priority listing, but no house was immediately available. While waiting for a public housing property, Choices assisted him with looking for a private rental. They submitted over 20 unsuccessful applications. During this process it was discovered that he had been blacklisted for private tenancies due to an outstanding damages bill incurred seven years prior in another State. Paul was not aware of this. Choices was able to ascertain that his name should not have been blacklisted, and advocated on his behalf to have this rectified.

Current Situation

Paul is currently residing in a Housing Authority house, which has railings and supports to assist Paul with his bad back. He has regular appointments with Ruah and his GP.

3 DEMOGRAPHICS

This chapter presents demographic information for the subset of Choices clients (n=392) who received support up until March 2019 and for whom linked data was requested.

There is a broad spread in age of clients seen by Choices, with the majority (77%) aged between 21 - 50 years (Figure 9), with an average age of 39 years.

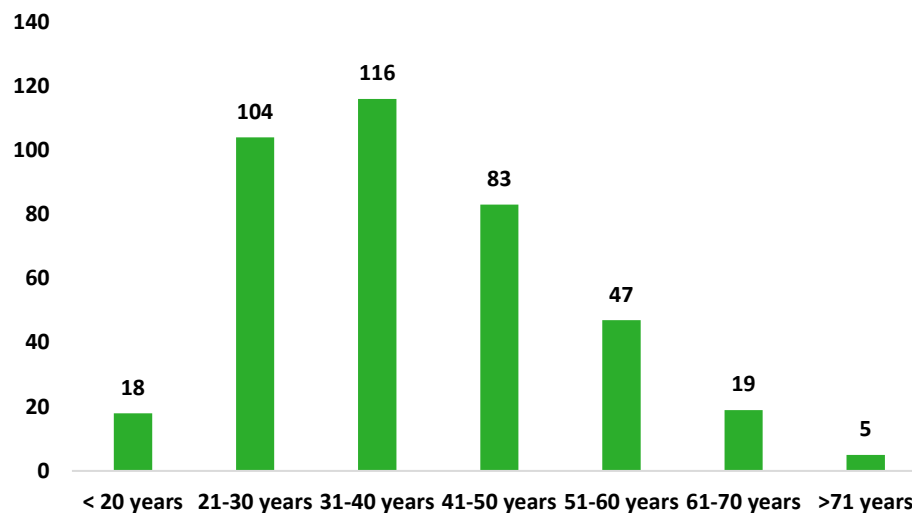


Figure 9: Age Range of Choices Clients

Overall, nearly one third (31%) of the people seen by Choices identified as Aboriginal and/or Torres Strait Islander, with the different proportions for this by setting (RPH, RGH and Justice) shown below in Table 1.

Table 1: Choices Client Demographics

	RPH (n=209)	RGH (n=100)	Justice (n=83)	Total (n=392)
Gender				
Male	112 (54)	49 (49)	49 (59)	210 (54)
Female	96 (46)	51 (51)	34 (41)	181 (46)
Transgender	1 (0)			1 (0)
Age				
Mean age	41	38	35	39
Range	16-93	18 - 67	19 - 61	16-93
Aboriginal and/or Torres Strait Islander				
Yes	64 (31)	27 (27)	29 (35)	120 (31)
No	129 (62)	67 (67)	49 (59)	245 (62)
Missing	16 (7)	6 (6)	5 (6)	27 (7)

Overall, there were some differences observed in the demographic pattern of clients between the three settings. Clients seen at RPH had a higher average age than clients at the other two sites (41 years compared to 38 at RGH and 35 at Justice) and there were a higher proportion of males in the

Justice settings (59% compared to 49% at RGH and 54% at RPH) (Table 1). Clients living circumstances differed between the three sites, with RGH seeing more people experiencing homelessness (39% compared to 26% at RPH and 27% for Justice clients) (Figure 10).

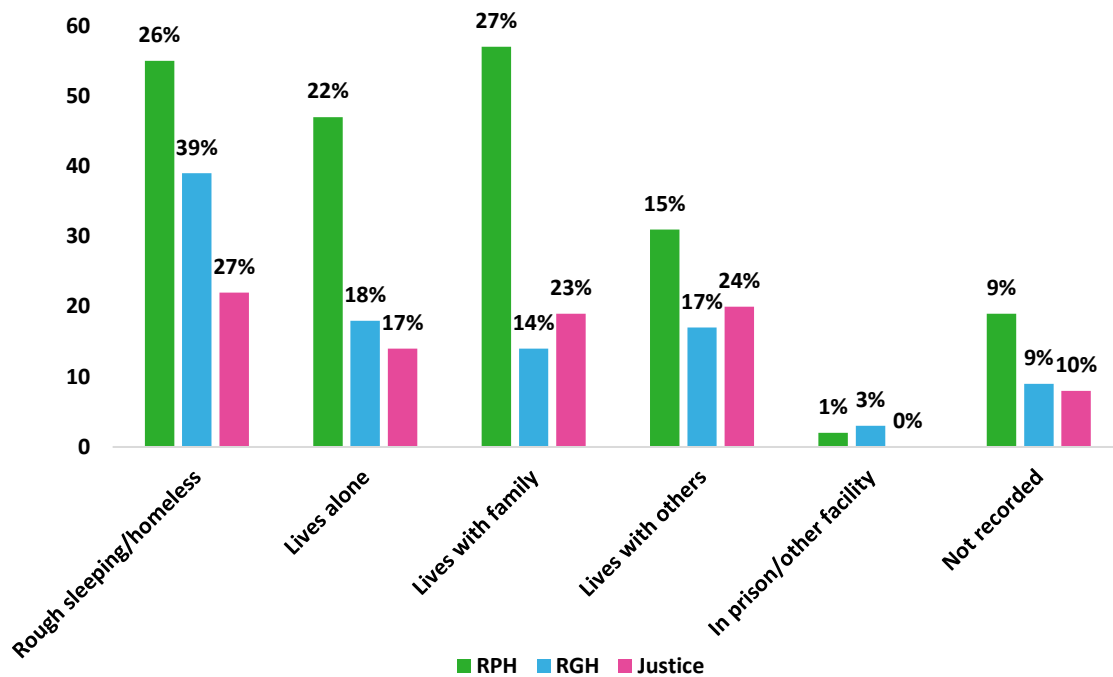


Figure 10: Clients' Living Circumstance Across Pilot Sites



Photo 5: Part of the Choices Team



Photo 6: Choices Poster at RGH

4 CLIENT HEALTH

Improving health and reducing unplanned hospital attendances lies at the heart of the rationale for the Choices program, but the imperative to identify and address underlying social drivers of poor health is very much embedded into the Choices ethos and service delivery model. Many social determinants of health (including addiction, trauma, homelessness, social isolation, financial hardship and family and domestic violence (FDV)) contribute to the poor physical and mental health outcomes observed.

This chapter explores the strategies used by Choices to connect clients to primary care and other health services, drawing on administrative hospital data to examine patterns of hospital use prior to and following client engagement with Choices.



Figure II: Socially Determined Factors Influencing Health

4.1 CONNECTING PEOPLE TO HEALTHCARE SERVICES AND SUPPORT

An important aspect of the Choices model of care is connecting people to other services in the community, both healthcare services, and services that can support people with other needs that are impacting adversely on their health (such as homelessness or addiction).

4.1.1 LINK TO PRIMARY CARE

One of the services key aims of Choices is to facilitate access to community based health services and primary care as a means of addressing clients underlying issues and diverting them away from ED.

The acute nature of care provided in EDs is often not able to adequately address chronic health and psychosocial issues and individuals end up in a revolving cycle of frequent ED attendance and deteriorating health. - Dr Andrew Davies¹⁸

In a recent international review of barriers to primary care access, people with low income and those experiencing mental health issues faced the paradox of high primary care needs but were the least likely to access,¹⁹ and this resonates with the Choices clientele. In Australia, overall 83% of the population have a regular GP,²⁰ but it is well recognised that this masks disparities in GP access and engagement, and that people from more disadvantaged and at-risk groups face additional barriers to primary care.²¹ Over the course of the Choices pilot, it was evident that many Choices clients do not have a regular GP and/or were presenting to ED with health conditions that could be potentially be managed through primary care to avert recurrent hospital use.

In January 2019, Choices commenced routine data collection to record whether clients were linked to a GP, both at support commencement, and on exiting from Choices.ⁱⁱⁱ Of the 120 clients for whom this data was available, only 19% were linked with a GP when they started receiving support, compared with 33% of Choices clients linked with a GP at their latest data collection point.

The case study below illustrates the way in which Choices assisted a client to access a bulk-billing GP clinic, and how the regular support of this GP coupled with other support measures provided through Choices, have substantially improved his health and wellbeing.

Box 5: Case Study: Linking Clients to Primary Care

Background

Geoff, is a single, socially isolated male who suffers from terminal prostate cancer and numerous other health conditions which cause severe pain. He also has chronic anxiety and has attempted suicide on several occasions. Geoff has presented at RGH with suicidal ideation, homelessness and stomach pain on numerous occasions. He has also presented to other ED's in WA, and has had prior mental health admissions.

Support Provided by Choices

The Senior Community Worker and Peer Community Worker initially sat with Geoff, listening to his concerns and providing him with emotional support. Together, they developed an action plan, prioritising his needs. He expressed that his main goal was to be able to return to the country area where he used to live. His most urgent problem however was his lack of access to primary care. He had presented several times at RGH ED in pain, but had been informed he would need to see a GP to receive pain treatment and management. Choices was able to arrange an appointment with a bulk billing GP clinic, and accompanied him to the appointment to assist him with explaining his situation and to advocate on his behalf. Choices also assisted Geoff with Centrelink issues, food access and an application for accommodation in the country town he wished to relocate to. Choices liaised with regional assessment services and the social work department at the local hospital to ensure supports were in place once Geoff moved to their area. He was also linked to a GP in the new location and Choices arranged to have his medical records transferred.

Current Situation

Choices continued to support Geoff when he first moved to the country until local services began providing appropriate supports. At the four week exit follow up Geoff reported he had settled well and was enjoying living in a small remote community again. He reported feeling happy, well supported and part of the community, and that he has made friends. He sees a social worker once a week and she has referred him to a dietician to help him work out which foods to eat that won't aggravate his stomach problems. He is "delighted" with his GP and nurses at the local surgery who he says have gone out of their way to welcome and support him. His medication has been reviewed and his pain is being well managed.

4.1.2 MENTAL HEALTH AND AOD SUPPORT

The majority of Choices clients have mental health and/or AOD issues and, at the time of first contact with Choices, the Choices team often observed that clients were unaware of support services and treatments available to them. As shown later in this Chapter, mental health and AOD issues are among the most common diagnoses associated with ED presentations among the Choices cohort. The Choices

ⁱⁱⁱ Prior to January 2019, this was collected at exit and follow up, as a review of the clients community connection, including connection to supports for their mental health, physical health and other community agencies

team has supported clients to access a range of community based mental health and AOD supports, and have at times accompanied clients to initial appointments. The type of support provided includes linking clients with primary care providers to develop mental health treatments plans, assisting clients to source and engage with low cost psychologists, connecting clients to AOD counselling services, and supporting clients who are participating in a WA Drug Court program.²² The case study below illustrates an example of this.

Box 6: Case Study: Supporting Client with AOD Issues

Background

Caleb is a male in his late twenties who lives with his partner and one year old child. After losing his job his AOD use escalated, costing approximately \$1,000 per month. The loss of income and the costly AOD use meant his family were at risk of losing their private rental due to an inability to pay rent. In the seven months prior to contact with Choices Caleb had six ED presentations relating to AOD use or withdrawal.

Support Provided by Choices

Choices first engaged with Caleb in late 2018 during an admission at RPH. Whilst initially supported by the RPH case worker, he requested to work with one of the peer workers as they had shared experiences with anxiety. The Peer Community Worker began connecting him with a number of services. He was connected to an AOD counselling service for assistance with his AOD and mental health issues as well as a clinical psychologist who he now has appointments with twice a week. He independently obtained a referral to a Psychiatrist. As Caleb required legal assistance due to a drug related offence Choices connected him with the Mental Health Law Centre. The centre encouraged him to engage with the Drug Court Program; a therapeutic program that provides AOD counselling and support.

Current Situation

In January 2019 Caleb and his family were evicted from their private rental due to their inability to pay rent but acquired new accommodation through the Housing Authority. Caleb was very enthusiastic about engaging with the Drug Court program and has progressed to the second phase. The Choices Peer Community Worker then stepped back support but continued to phone him weekly to check in.

4.1.3 COLLABORATION WITH HOMELESSNESS SERVICES

Precarious housing and homelessness are pervasive among the clients seen by Choices to date. As reported in Chapter 2, more than a third of clients recruited to Choices at RGH were experiencing homelessness, and more than a quarter of those who signed up to Choices via RPH or Justice settings were homeless. This presents an enormous challenge for the Choices team, as it is not a homelessness service per se, but the lack of safe stable accommodation is often one of the most urgent needs, and invariably impacts on health and service engagement if not addressed.

Health and housing are inextricably linked, with mounting evidence conveying that stable and secure housing is, in fact, the most effective intervention to improve the health of people experiencing homelessness.¹⁸

Collaboration with homelessness services is thus an important pillar of the work of the Choices team. This includes not only community-based homelessness services, but at RPH incorporates collaboration and cross-referrals with the RPH Homeless Team. Through the RPH Homeless Team, patients experiencing homelessness can be seen by one of the Homeless Healthcare GPs who conduct ward rounds each weekday morning, and a number of Choices clients have received follow up primary care support from Homeless Healthcare. The RPH Homeless Team also has an expansive network of connections with accommodation providers and homelessness services, and is able to work with the Choices team to identify suitable accommodation options for clients. Choices can provide a valuable complement to the work of the RPH Homeless Team as it is able to provide community-based case management for clients once discharged, and assist clients to access support for social needs.



Photo 7: RPH Homeless Team Clinical Lead Dr Stafford with Choices Peer Worker.

The case study below illustrates collaboration between Choices, the RPH Homeless Team and Safe as Houses (SASH), a program that supports women and children at risk of homelessness as a consequence of FDV.

Box 7: Case Study Collaboration between Choices, RPH Homeless Team and Safe as Houses

Background

Sharon is a female in her early forties who has been sleeping rough as a consequence of leaving a FDV situation, and traumatic experiences of sexual and physical assault. Health issues include Post-Traumatic Stress Disorder, anxiety and drug dependency. She had been presenting with increasing frequency to ED since mid 2018, including occasions where medical care was required following assault.

Collaboration between Choices, RPH Homeless Team and Sash

Sharon was referred to Choices by the RPH Homeless Team, and the support she received over a three month period was a collaboration between RPH, Choices and SASH, a pilot collaboration project between Tenancy WA, Street Law Centre WA and Women's Legal Service WA who provide integrated legal and support services to women at risk of homelessness as a consequence of FDV. Choices provided emotional support, a referral pathway to trauma counselling and information on other community services. The RPH Homeless Team advocated for Sharon to be able to access stable refuge accommodation, and worked with Choices to facilitate this. SASH assisted Sharon with legal issues arising from her experiences of FDV. Further assistance was provided by Choices to fund Sharon's relocation to a women's refuge in another State, due to concerns about her safety when her partner is released from prison. Choices exited the client when she was relocated.

4.2 HOSPITAL USE PRE AND POST CHOICES ENGAGEMENT

For the cohort of 392 clients whom linked hospital administrative data was available for, analysis was undertaken to examine:

- overall hospital use (ED and inpatient admissions) in the six-months and one year prior to engagement with Choices;
- changes in hospital use among those with a minimum of six months of data post commencement of support from Choices; and,

- estimated costs to the health system based on costs per ED presentation and costs per inpatient day in WA hospitals as reported in the most recent National Hospital Cost Data Collection.²³

It should be noted that the hospital use data relates only to client attendances at RPH and RGH as these are the two Choices hospital intervention sites and clients were recruited as a result of ED presentations to these hospitals. Where clients presented at both RPH and RGH, this is captured, but it was beyond the scope of this evaluation to access data from all other Perth hospitals, hence the data presented is likely to under-estimate the total burden of hospital use across this cohort. Based on our prior evaluations of 50 Lives 50 Homes^{24, 25} with a not dissimilar target group, it is estimated that between 20 - 30% of clients may also have had some ED presentations or admissions at other hospitals.

4.2.1 PRIMARY DIAGNOSES ASSOCIATED WITH HOSPITAL ATTENDANCE

The most common primary diagnoses associated with hospital use for this cohort of Choices clients in the year prior to enrolment AOD, injury/poisoning, and mental health (Figure 12, Figure 13). It is pertinent to note that the injury/poisoning diagnosis category includes self-harm, and as observed by the Choices team, suicidal ideation and self-harm are common among clients they have seen to date. Brief definitions for the most common diagnoses seen among Choices clients are provided in Table 2. A high percentage of hospital and ED events had a diagnosis of 'other' (25% inpatient, 37% ED). This category was largely comprised of events without a formal diagnosis is (e.g. symptoms, signs and abnormal clinical and laboratory findings, and scheduled procedures that were not able to be carried out).

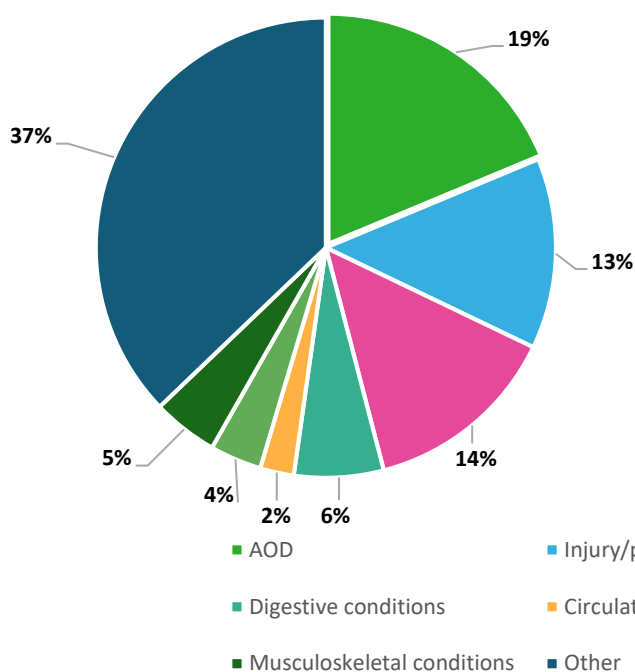


Figure 12: Primary ED Diagnoses in Year Prior to Choices

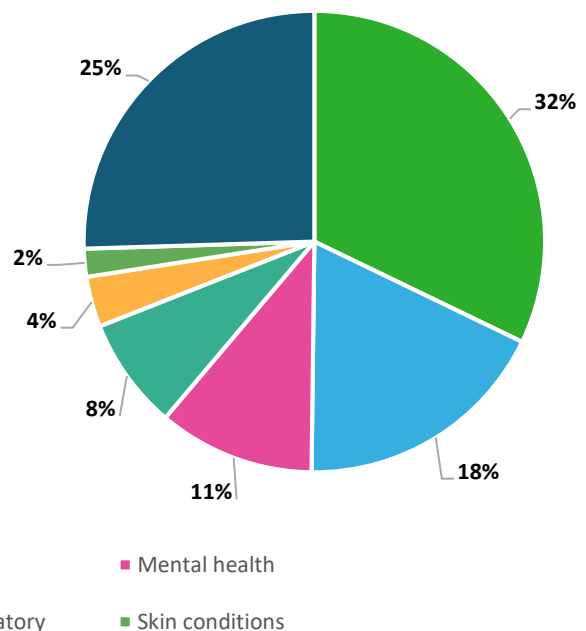


Figure 13: Primary Inpatient Diagnoses in Year Prior to Choices

Table 2 below provides definitions and common examples for the diagnoses categories shown in the preceding two figures.

Table 2: Diagnoses Definitions and Examples

Diagnoses	Definition ²⁶
AOD	Alcohol and/or Other Drug related issues e.g. dependence, withdrawal, and includes issues relating to a range of illicit drugs, as well health issues relating to dependency on pharmaceuticals such as benzodiazepine.
Mental Health	Disturbances of mood or thought that can affect behaviour and distress the person or those around them, so that the person has trouble functioning normally e.g. depression, anxiety.
Circulatory/Respiratory	Conditions affecting the airway or cardiovascular system (eg. asthma, chronic obstructive pulmonary disease, angina, heart attack, stroke).
Musculoskeletal condition	Conditions of the bones, muscles and connective tissues, including various forms of arthritis, back pain, osteoporosis and gout ²⁶
Injury/poisoning	Conditions relating to injury and poisoning including self-harm.
Digestive Conditions	Conditions affecting the gastrointestinal system causing illness such as pain, vomiting, diarrhoea and other symptoms.
Skin Conditions	Includes conditions such as cellulitis, dermatitis and eczema.

As Choices has a strong focus on supporting clients with mental health issues, the main types of mental health diagnoses were further disaggregated, as the inpatient and ED mental health primary diagnoses shown in the preceding Figure 12 and Figure 13 (11% and 14% respectively) comprised multiple different conditions. The most common mental health conditions recorded as primary diagnoses for inpatient admissions and ED presentations in the year prior to Choices are shown below (Figure 14 and Figure 15).

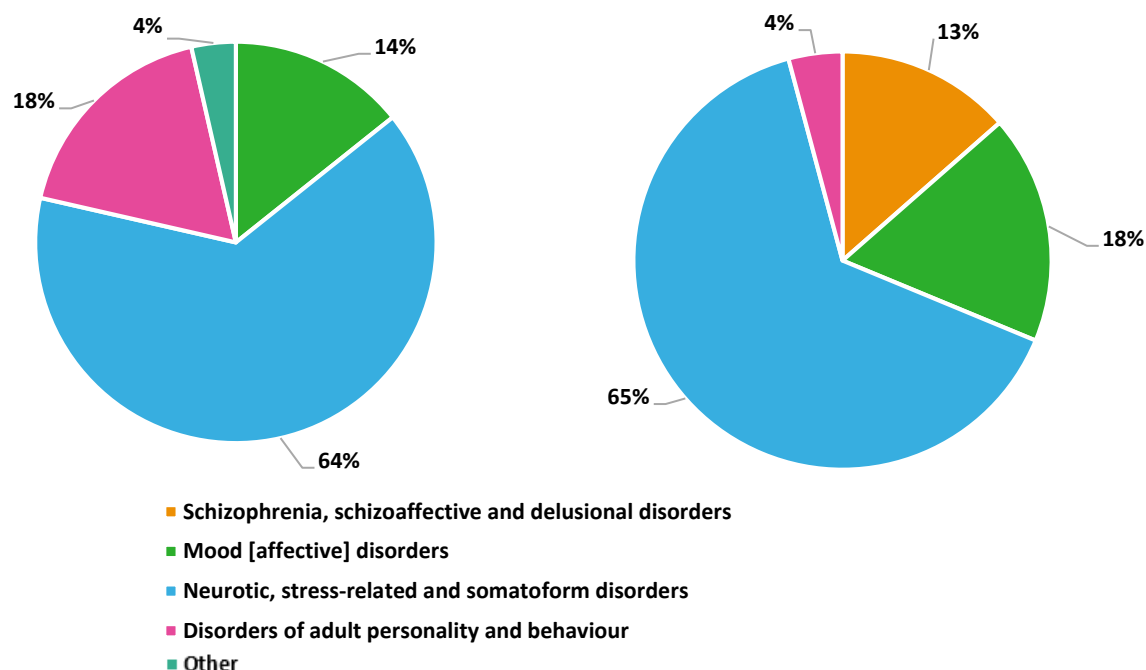


Figure 14: Inpatient Mental Health Diagnoses Year Prior to Choices Figure 15: ED Mental Health Diagnoses Year Prior to Choices

The most commonly observed mental health diagnoses are defined in Table 3 below.

Table 3: Mental Health Diagnoses Definitions and Examples

Diagnoses	Definition ²⁷
Schizophrenia, Schizoaffective and delusional disorders	Significant impairments in reality testing and alterations in behaviour manifest characterised by persistent delusions, hallucinations and disorganised thinking.
Mood [affective] Disorders	Disorders resulting in a change in affect or mood including conditions such as depression and bipolar disorder.
Neurotic, stress-related and somatoform disorders	Includes phobic anxiety disorders, obsessive-compulsive disorder, somatoform disorders, post traumatic stress disorder and acute stress reaction.
Disorders of adult personality and behaviour	A variety of conditions and behaviour patterns of clinical significance which tend to be persistent and involve pervasive difficulties with navigating interpersonal relationships and with individual social and professional functioning, often presenting with difficulties in self expression and emotional regulation. Includes personality disorders e.g. antisocial personality disorder and emotionally unstable personality disorder.

4.2.2 PRE-CHOICES ED PRESENTATIONS

In the year prior to being enrolled in Choices, over 70% (n=277) of Choices clients had presented to ED. It is pertinent to note that this was not limited to those clients first seen at RPH or RGH, but also included some clients seen by Choices in the Justice settings. Of the 277 clients with one or more ED presentations in the year prior, there was an enormous range, with one client presenting to ED 49 times within the one year period. In total, there were 1,443 ED presentations for this cohort in the year prior to enrolment in Choices (see Table 4).

Table 4: ED Presentations for all Clients Prior to Choices

N=392	Six-months prior	12-months prior
Total people (%*)	274 (69.9)	277 (70.7)
Total presentations	1,038	1,443
Mean (SD)	2.6 (4.5)	3.7 (6.5)
Range	0-34	0-49

*% calculated for whole cohort including those who did not present in this period

4.2.3 PRE-CHOICES INPATIENT ADMISSIONS

In the year prior to receiving support from Choices 184 clients were admitted to RPH and/or RGH, with a total of 469 admissions for the client cohort (Table 5). As with the ED presentations, there was substantial variability, with one client having 17 admissions within the year. The 469 admissions equated to a total of 1,691 inpatient bed days in the 12 month period prior to Choices for this cohort.

Table 5: Inpatient Admissions for all Clients Prior to Choices

N=392	Six-months prior	12-months prior
<i>Inpatient Admissions</i>		
Total people (%)	163 (41.6)	184 (46.9)
Total admissions	348	469
Mean (SD)	3.6 (5.2)	3.6 (5.1)
Range	0-13	0-17
<i>Length of Stay</i>		
Total days	1,237	1,691
Mean (SD)	3.2 (7.2)	4.3 (9.4)
Range	0 -62	0 - 62

4.2.4 PRE-CHOICES ASSOCIATED ECONOMIC COST

Using the average cost per ED presentation and per inpatient day in a WA public hospital from the National Hospital Cost Data Collection,²³ the crude costings based on the aggregate ED and inpatient data for these 392 clients equated to a total of nearly \$6,128,352 in health service usage in the year prior to Choices (Table 6).

Table 6: Aggregate Cost of Health Service Use in the Year Prior to Choices

	Presentations / Days [^]	Unit Price [*]	Aggregate Cost	Cost Per Person (n=392)
Aggregate ED Presentations	1,443	\$838 per presentation	\$1,209,234	\$3,085
Aggregate Inpatient Days	1,691	\$2,909 per day admitted	\$4,919,119	\$12,549
TOTAL			\$6,128,353	\$15,634

[^]Hospital data RPH and RGH

^{*}Costs based on the latest IHPA (Round 21) figures for the 2016-17 financial year for WA.²³

4.3 CHANGES IN HEALTH SERVICE USAGE ONCE ENGAGED WITH CHOICES

The preceding analysis was based on a cohort of Choices clients who had enrolled between June 2017 and March 2019, hence there were varying periods of follow-time for the Choices clients for whom hospital data is available. The following sections of the report examine changes in hospital service utilisation for the subset of 333 clients who had six-month follow-up data after receiving support from Choices, and examines changes in hospital use for the subset of 228 clients who had at least 12-months follow-up data. These longer term follow-up periods are important as Choices itself provides support for up to three months only in most instances, hence examination of patterns of hospital use following the end of the support period is critical.

As a caveat to this analysis, there is a need for a cautionary approach to simplistic pre-post intervention comparisons of hospital use for population groups with multi-morbidities and support needs.²⁸ The Choices clientele are a cohort where multiple health and social challenges cluster with mental health and/or alcohol and drug use, and these intersect with complex health and justice systems, leading to frequent ED presentations and unplanned hospital admissions.²⁸

Hence no single short-term intervention (even if multi-faceted as is the case with Choices), can realistically expect to dramatically curtail hospital use for all clients, for a number of reasons identified in the literature and evident in the data examined for this evaluation:

- Some individuals are already too sick or on a downward health trajectory, and will require further acute medical care⁷
- Interventions that connect people to primary care and other health services may lead to previously undiagnosed or untreated health issues being addressed, which in some cases can require hospitalisation²⁸
- Social determinants of health beyond the scope of the intervention to address may continue to drive hospital use (such as homelessness, FDV, social isolation, poverty)
- Prior adverse life experiences, particularly trauma, have enormous impact on people's trust and engagement with healthcare services²⁹ and their capacity to modify behaviours or situations that contribute to poor health
- Duration of support influences the likelihood of longer-term outcomes; for people with multiple needs, a shorter term intervention is not able to address all of the factors that contribute to poor health and hospital use.

By its very nature, Choices is engaging with clients in a period of health or social crisis, either in the ED, the Watch House or Magistrates Court. As 79% of the Choices clients for whom we had hospital data were recruited through the ED at either RPH or RGH, the data inevitably shows a sharp increase in the overall level of hospital service utilisation in the period immediately before enrolment into Choices. This steep increase has the potential to skew the pre/post analysis of changes in service utilisation.²⁸ To address this, we examined pre and post-enrolment service utilisation including all ED presentations and inpatient admissions and then conducted a second analysis of changes in health service utilisation excluding a two week period before and after enrolment into Choices. The two-week period also recognises that the Choices teams follow up all potential clients within a two-week period of being seen at the hospital, hence hospital use may have continued to occur between first contact with Choices and actual commencement of support. It is important to note that at the individual client level, changes in patterns of hospital use were mixed. Whilst some clients experienced substantial reductions in hospital use, others had similar patterns of use pre and post and for some hospital use increased. The latter finding is congruent with other literature, that shows that tailored support can lead to people accessing primary care or other healthcare that then identifies undiagnosed or untreated issues that require hospitalisation.²⁸

4.3.1 CHANGES IN ED PRESENTATIONS

Overall, there was a reduction in both the number of clients presenting to ED, and the total number of presentations for the client cohort. Specifically, for the subgroup with six months data pre and post Choices enrolment (n=333), there was a 43% reduction overall in the number of clients presenting to ED, whilst for the subset with 12 months pre and post data, it was 35%. The number of ED presentations in the year following support from Choices declined by 37% for those with six months pre/post data, and by 18% for the subgroup with 12 months pre/post data (Table 7).

Table 7: ED Presentations Six and 12 Months Pre/Post Choices

	6 Months (n=333)			12 Months (n=228)		
	Pre	Post	% Change	Pre	Post	% Change
Total people (%)^	222 (67)	127 (38)	-43	144 (63)	93 (41)	-35
Total presentations	798	502	-37	716	586	-18
Mean (SD)	2.0 (4.2)	1.3 (3.2)	-35	1.8 (4.9)	1.5 (5.2)	-17
Range	0-34	0-21		0-49	0-70	

^ % of total clients including those that did not present

As the majority of Choices clients were recruited within the hospital setting following an ED presentation, not surprisingly, there was a spike in ED presentations around the time of enrolment in Choices, as shown in Figure 16.

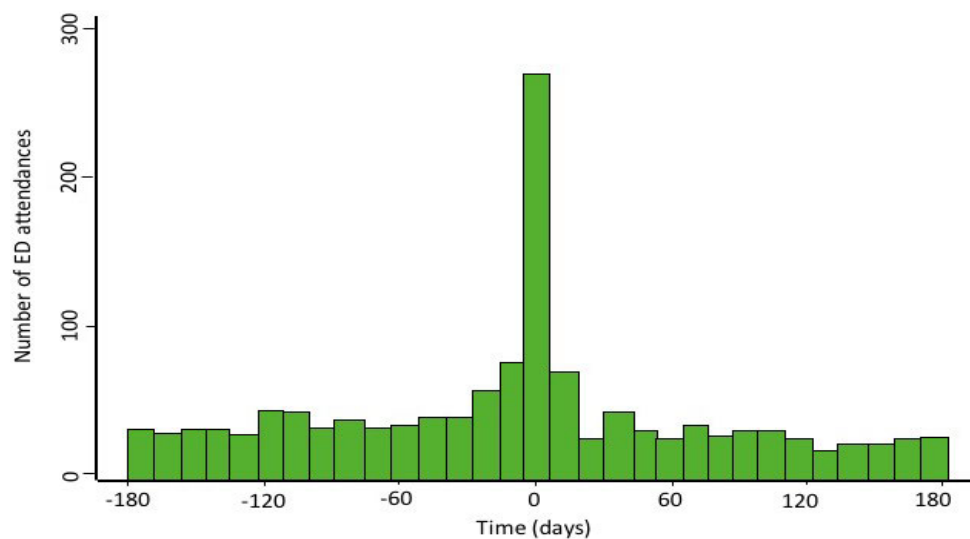


Figure 16: Histogram of ED Presentations at Time of Choices Enrolment

The below table (Table 8) presents changes in ED presentations for Choices clients excluding the two week period pre/post enrolment, to account for the spike in presentations around the time of enrolment into Choices. Even with this exclusion, there was a reduction in both the number of people presenting to ED and a 20% decrease in the total number of presentations.

Table 8: ED Presentations Six and 12 Months Pre/Post Choices Excluding Two Week Period

	6 Months (n=333)			12 Months (n=228)		
	Pre	Post	% Change	Pre	Post	% Change
Total people (%)^	134 (40)	115 (35)	-14	100 (44)	91 (40)	-9
Total presentations	518	413	-20	547	539	-1.5
Mean (SD)	1.3 (3.7)	1.1 (2.8)	-15	1.4 (4.4)	1.4 (5.0)	0
Range	0-41	0-103		0-45	0-69	

^ % of total clients including those that did not present

4.3.2 CHANGES IN INPATIENT ADMISSIONS

Overall, both the proportion of clients being admitted to hospital and the total number of inpatient admissions for Choices clients decreased in the six and 12-months after clients commenced receiving support from Choices (Table 9). In the six months post enrolment, compared to six-months prior, 31%

of Choices clients had a decrease in the number of inpatient admissions, 11% had an increase in the number of admissions and 58% had no change. There was a substantial decrease in the proportion being admitted as an inpatient at either RPH or RGH, with a 44% decrease among those with six months pre and post data, and a decrease of 35% among those with 12 months follow up data.

When changes in total inpatient days admitted were examined, this had decreased substantially among the cohort with six months pre-post data (by 31%). However, the observed decrease attenuated in the subgroup with 12 months follow up data, but it is pertinent to note that the 12 months post period included 14 clients who had admissions over 30 days, including one who was admitted for 162 days.

Table 9: Hospital Inpatient Admissions Pre/Post Support from Choices

	6 Months (n=333)			12 Months (n=228)		
	Pre	Post	% Change	Pre	Post	% Change
<i>Inpatient Admissions</i>						
Total people (%)^	137 (41)	77 (23)	-44	102 (45)	66 (29)	-35
Total admissions	280	173	-38	255	237	-7
Mean (SD)	0.7 (1.5)	0.4 (1.4)	-43	0.7(1.5)	0.6 (2.5)	-14
Range	0-13	0-13		0-17	0-37	
<i>Length of Stay</i>						
Total days	1,012	701	-31	888	878	-1
Mean (SD)	2.6 (6.7)	1.8 (7.5)	-31	2.3(6.9)	2.2 (10.5)	-4
Range	0-62	0-103		0-62	0-162	

^ % of total clients including those that were not admitted

Given that the ED presentation that first led to contact with Choices resulted for some patients in an unplanned inpatient admissions, not surprisingly (and similar to the pattern observed with ED presentations), there was a spike in inpatient admissions around the time of enrolment in Choices (Figure 17).

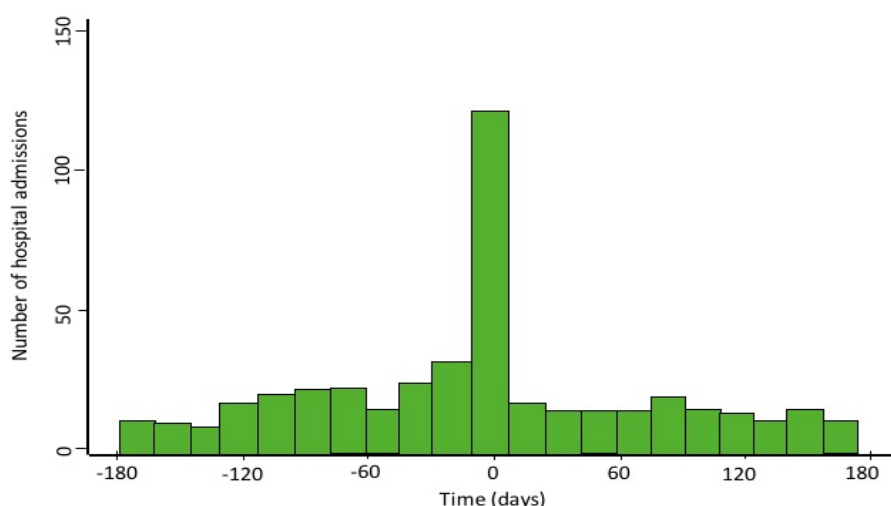


Figure 17: Histogram of Inpatient Admissions at time of Choices Enrolment

As with ED presentations, inpatient admissions were analysed excluding the two weeks pre/post Choices enrolment to account for the increase in health service utilisation around the time of enrolment. The changes in inpatient admissions with the two-week excluded period are shown in Table 10 below. Pre/Post changes in inpatient admission are similar to the data not excluding the two

weeks pre/post admission. A key difference is the slight increase in inpatient admissions and length of stay in the year post Choices.

Table 10: Hospital Inpatient Admissions Pre/Post Choices Excluding Two Week Period

	6 Months (n=333)			12 Months (n=228)		
	Pre	Post	% Change	Pre	Post	% Change
Inpatient Admissions						
Total people (%)^	78 (23)	69 (21)	-12	66 (29)	62 (27)	-6
Total admissions	171	146	-15	181	220	+21
Mean (SD)	0.4 (1.3)	0.4 (1.2)	-0	0.5 (1.7)	0.6 (2.4)	+20
Range	0-12	0-12		0-16	0-37	
Length of Stay						
Total days	620	548	-12	605	769	+27
Mean (SD)	1.6 (5.1)	1.4 (7.0)	-13	1.5 (5.5)	2.0 (10.2)	+33
Range	0-41	0-103		0-46	0-162	

^ % of total clients including those who were not admitted

The 27% increase in length of stay 12 months post Choices is partially explained by one client who was admitted for 162 days.

4.3.3 CHANGES IN BOTH ED PRESENTATIONS AND INPATIENT ADMISSIONS

While Choices has a particular focus on reducing recurrent ED presentations, it is clear that ED presentations often lead to unplanned inpatient admissions among this cohort. Thus in seeking to support clients to address mental health, AOD issues and social factors that contribute to hospital use, it plausible that changes in both ED and inpatient admissions will be observed in some clients. This is reflected in the two case studies below.

Box 8: RPH Case Study

Background

Marcus is a man in his mid-twenties who has a history of anxiety and depression and lacks family or community supports. Within a three day period his partner left him and he lost his job. This led to a sudden increase in ED presentations and hospital admissions at RPH between April and October 2018.

Support Provided by Choices

Choices first engaged with Marcus in early October 2018 and provided him with immediate relief through Woolworth's vouchers. Choices assisted him by liaising with Centrelink, advocated on his behalf to property agency to have rent arrears wiped and provided emotional support.

"The people have been great – everyone is really nice – friendly and they understand – don't judge – they will do anything they can to help you. I can call – and after the call I can feel comfortable – even just being able to come in and have a chat."

Health Service Utilisation and Cost*

In 2018, prior to Choices support, Marcus presented at RPH ED on 11 occasions and accumulated 15 inpatient days, equating to a cost of \$52,853. Since engagement with Choices he has not attended hospital.

Current Situation

Marcus reports being inspired by the Choices Peer Community Workers. He has started a Certificate IV in Mental Health and Peer Work, improved his diet and is focussing on self-care. He has reported making new friends who provide him with support.

*Average cost per ED presentation WA hospital \$838, per inpatient day \$2,909 based on the IHPA (Round 21) figures for the 2016–17 financial year.²³

The case study below also provides an example of the challenges faced by clients and that some need to re-engage with Choices when their situation deteriorates.

Box 9: RGH Case Study

Background

Daniela is a woman in her mid-fifties who was living in a poor quality private rental with her daughter and grandchildren. It was a precarious housing situation as her daughter had been in an abusive relationship, and her ex-partner would often come to the house despite a VRO being in place. Daniela was using alcohol to cope with the violent situation and presented at RPH ED regularly for safety and treatment of depression and alcoholism.

Support Provided by Choices

Daniela was first engaged by a peer worker at RPH ED in February 2018. The Choices Senior Community Worker met with her every 1-2 weeks to establish goals and helped her reconnect with her GP. Through the GP she was able to get a Mental Health Care Plan and was linked to a bulk billing Psychologist. The Choices case worker helped Daniela and her family move into new accommodation and connected her to local services. In August 2018 she was exited from the Choices program with supports in place.

However, several months later, Daniela's situation went downhill due to family stressors. She relapsed into alcohol addiction and was struggling with mental health issues including suicidality. She began presenting at RGH ED in October. She was reconnected with the Choices Senior Community Worker and re-entered the program. Choices helped Daniela access AOD counselling and through RGH she was connected to a psychiatrist for regular appointments. She participated in a self-esteem workshops for women experience FDV and developed employment goals with the Choices worker. Daniela exited Choices in March 2019.

Health Service Utilisation and Cost*

In 2018 Daniela had seven ED presentations, six inpatient admissions and a seven day psychiatric admission resulting in a cost to the health system of \$33,645. In 2019, this reduced substantially, and she has only had one ED presentation and a one day inpatient admission.

Current Situation

Daniela is currently completing an online retail course with the goal of getting employment in a supermarket. She recounted in an interview with Ruah that she feels like a stronger person for being heard and supported.

"The service is absolutely wonderful and goes above & beyond, it has not just impacted me, but also my grandchildren are much happier in [suburb]. There's the beach, parks, we are away from the previous stress that little children shouldn't have to endure."

*Average cost per ED presentation WA hospital \$838, per inpatient day \$2,909 based on the IHPA (Round 21) figures for the 2016-17 financial year for WA.²³ Average cost per psychiatric admission \$1,475 based on AIHW Mental Health Services in Australia 2019 Report.³⁰

As noted earlier in this Chapter, one of the service aims of Choices is to facilitate access to community based health services and primary care as a means of addressing clients underlying health and psycho-social issues that can help to reduce recurrent ED use. The following case study illustrates the way in which GP support and primary care coupled with housing has contributed to changes in ED presentations and inpatient admissions. In this case study (Box 10), many of the presentations to hospital related to health issues that can be addressed in a primary care setting, but were exacerbated by his homelessness, and not having a regular GP prior to Choices commencement.

Box 10: Choices Support with Health Needs Case Study

Background

Sam is a man in his mid-fifties who had been experiencing homelessness for over a decade. He was in foster care as a child and has a number of health and social issues including impaired cognitive and social development, AOD issues and chronic kidney failure. Without stable accommodation, Sam struggled to manage his health as he was unable to appropriately store his medications or attend dialysis outpatient appointments. His mental health issues were also exacerbated by homelessness resulting in several prolonged psychiatric admissions in 2018.

Support Provided by Choices

Sam was referred to Choices by the RPH Homeless Team. They were able to find him supported transitional accommodation at St. Bartholomew's House. They connected him to a Homeless Healthcare GP for ongoing care and medication management and assisted him with an application for a Disability Support Pension.

Health Service Utilisation and Cost*

In 2018, Sam had nine ED presentations, three inpatient admissions and 44 psychiatric days, equating to a cost of \$81,169 to the health system. So far in 2019 he has only presented to ED on one occasion, costing \$838.

Current Situation

Sam is still residing at St. Bartholomew's and receiving support from staff to develop healthy living routines. He continues to engage with his GP and is attending his dialysis appointments.

*Average cost per ED presentation WA hospital \$838, per inpatient day \$2,909 based on the IHPA (Round 21) figures for the 2016-17 financial year for WA.²³ Average cost per psychiatric admission \$1,475 based on AIHW Mental Health Services in Australia 2019 Report.³⁰

4.3.4 CHANGES IN ECONOMIC COST ASSOCIATED WITH HOSPITAL USE

Economic analyses can examine whether the cost of service provision can at least, in part, be offset by cost decreases associated with a reduction in use of high-cost health services when health issues are appropriately managed through less frequent and intense use of health services and/or by clients accessing lower cost health services. In the case of Choices, there is particular interest in whether supports to address social needs and linking clients to primary care and other community based health services can reduce the cost burden associated with ED presentations and inpatient admissions.

It is sometimes argued that 'cost savings' associated with reductions in hospital use are not literally savings that accrue to the bank balance of the health sector, and we acknowledge this upfront. However, there is increasing scrutiny on individual hospitals and on area health services to deliver their services 'on budget' and reducing demand on ED and/or inpatient bed days is a critical metric in this regard. As evidenced in previous research, there are also a significant number of ED presentations that reflect needs that could have been met through primary care or community based services, thus efforts to encourage people to access lower cost healthcare options outside of the ED, frees up available resources (staff and beds) to meet the needs of other patients.^{5, 7}

In Section 4.2, it was noted that in this cohort of 332 people, the estimated cost associated with ED presentations and inpatient days in the year prior to enrollment with Choices was a staggering \$6,128,352, equating to an average cost of approximately \$15,634 per person. To compute estimated cost savings associated with observed reductions in hospital use, we used the larger cohort of clients with six months pre and post data, as shown in Table 11.

For the cohort of 333 people with six months pre and post Choices hospital data, the observed reduction in ED presentations and hospital inpatient days equated to a cost reduction of \$1,152,747. As there were fewer people with 12 months follow up data, and some of the changes were confounded by a couple of clients with lengthy hospital admissions in the post period, the data was not considered robust enough for economic analysis.

Table II: Changes in Economic Cost Over Six Months Pre/Post Choices

Six-months pre/post (n=333)	Change in Presentations / Days^	Unit Price*	Change in Aggregate Cost	Change in Cost Per Person
Change in ED Presentations	-296 Presentations	\$838 per presentation	-\$248,048	-\$745
Change in Inpatient Days	-311 Days	\$2,909 per day admitted	-\$904,699	-\$2,717
TOTAL			-\$1,152,747	-\$3,462

A full cost-benefit analysis is beyond the scope of this evaluation, and would require longer term follow up data for a larger cohort of Choices clients. Future evaluations could incorporate a more in-depth economic analysis accounting for the cost of service provision.

5 CLIENT INTERACTIONS WITH JUSTICE SYSTEM

Complexity of healthcare needs is often the norm for people in contact with the criminal justice system, a notion which has clear implications for the development of effective and appropriate interventions...^{13 p. 13}

The overlap between mental health and AOD issues and contact with the justice system in Australia is well recognised.³¹ Moreover, social factors and adverse life events often precede the observed clustering of mental health and AOD issues with justice system interactions. It is this interface between health, social factors and justice that precipitated the rationale for the Choices program being piloted in both an ED and justice setting.

As illustrated in Figure 18, mental health and/or AOD issues are over-represented across the justice continuum, from the likelihood of contact with police, committing of offences and imprisonment. Moreover, people with mental health issues are far more likely than the general population to be victims of crime, with AOD issues and homelessness increasing their risk of victimisation.³²

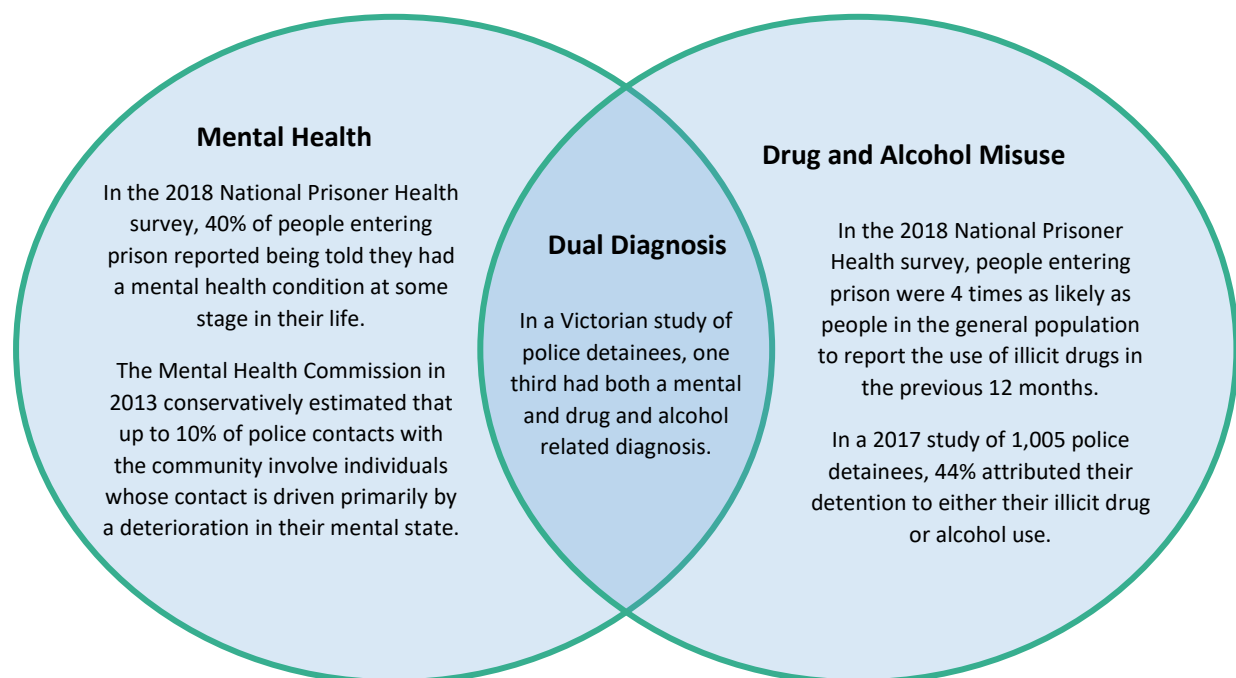


Figure 18: Mental Health, AOD Misuse and Dual Diagnosis Among People in Contact with the Justice System

References: ^{13, 31, 33, 34}

From a social determinants of health perspective, many of the underlying factors that contribute to addiction and mental health challenges, such as childhood trauma, FDV and homelessness, are also over-represented among people in contact with the justice system.³⁵ Thus the social determinants approach taken by the Choices program is critical in supporting clients to address both mental health and AOD issues, and also underlying and exacerbating factors relating to contact with the justice system, as well as homelessness, poverty, FDV and trauma. The vignette in Box 11, is one of many examples of the trajectories of Choices clients in which justice, health and homelessness intersect.

Box II: Experiences of a Choices Client

Hannah was in her early 20's when she met a Choices worker at the Watch House. She had been in custody for breaching a move on notice from the police as she was sleeping rough in Northbridge. Hannah had an extremely troubled childhood, spending time in foster care before running away and becoming homeless at age 17. She has been using illicit drugs since becoming homeless and had spent four months in prison before the age of 20. Whilst wanting to get off drugs because she was pregnant, she noted to Choices that this was nearly impossible without stable accommodation. At one point Hannah was subjected to FDV while couch surfing, further exacerbating her stressors and mental health issues.

5.1 POLICE INTERACTIONS PRIOR TO CHOICES SUPPORT

Using the police data available for 381 clients, patterns of offending and victimisation before and after support from the Choices program was examined.

5.1.1 OFFENDING BEHAVIOUR

Overall, just under half the Choices client cohort (49%, n=192) had been charged with an offence in the 12 months prior to receiving support from Choices. Unsurprisingly, this was far higher among those recruited through the Justice settings (96%, n=77). However, the overlap between health and justice system interactions is evident in the fact that 41% (n=85) of Choices clients recruited through RPH and 30% (n=30) recruited through RGH had been charged with offences in the 12 months prior to receiving support from Choices (see Figure 19).

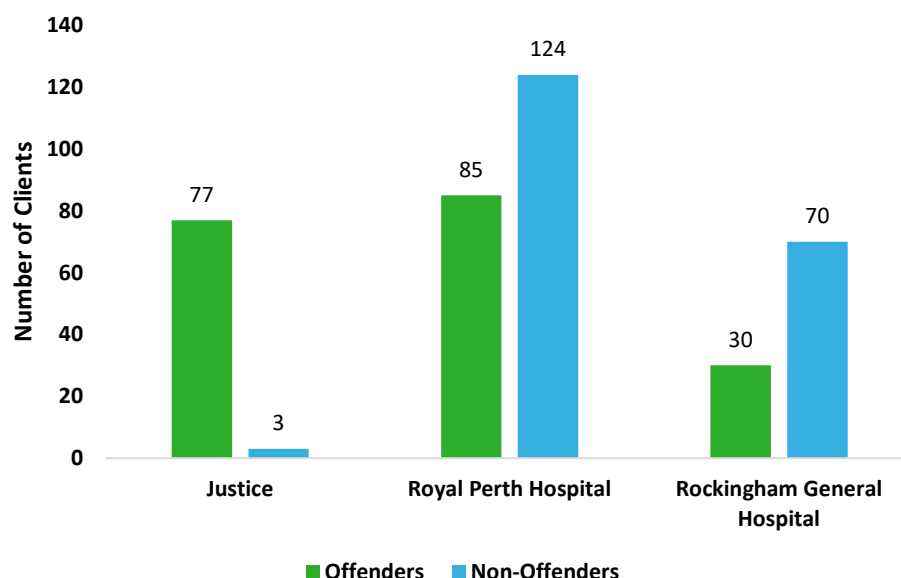


Figure 19: Offenders and Non-Offenders by Recruitment Site

Number and Types of Offences Committed Pre-Choices

In the year prior to receiving support, there were 1,342 charged offences across the Choices client cohort (n=381) for whom police data was available. In Table 12, the number of offences in each major category of offences for the Choices client cohort is shown for periods six and 12 months before clients commenced receiving support from Choices. The three most common offences related to theft/stealing, drug-related crime, and breach of bail or VROs.

Table 12: Offences Six and 12 Months Pre Choices

Offence Group	6 Months	12 Months
Offences against the person (e.g. assault)	68	96
Sexual assault and related offences	80	80
<i>Property related offences</i>		
Burglary/break and enter	17	28
Property damage	43	65
Theft/stealing	253	360
Fraud/deception	65	95
Illicit drugs	171	239
Offences against justice procedures (e.g breach VRO, bail etc.)	143	209
Public order offences	72	115
Traffic/vehicle regulatory offences	18	30
Weapons/explosives	13	24
Miscellaneous	1	1
TOTAL	944	1,342

5.1.2 VICTIMISATION

Whilst mental health and AOD issues are often associated with criminal offending, a growing body of evidence highlights the vulnerability of people living in disadvantaged circumstances to being victims of crime.^{25, 36, 37} This was evident in the police data for Choices clients, with more than two thirds (39%) of the overall cohort being a victim of crime in the 12 months prior to contact with Choices. Clients recruited in the Justice setting were more likely to have been victims of offences (46%), compared to clients recruited from RPH (39%) or RGH (33%) (Figure 20).

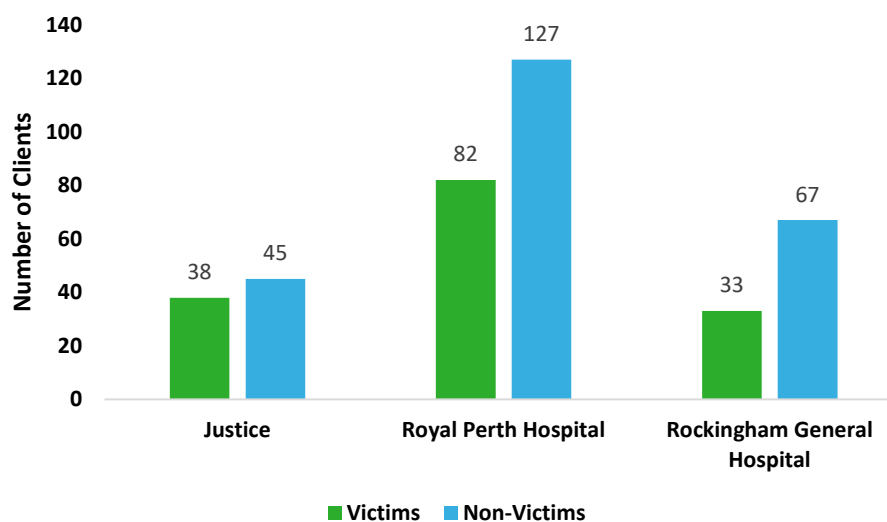


Figure 20: Victims and Non-Victims by Recruitment Site

Overall, looking at the people who were victims of crime and people who committed offences, there was 47% overlap that were both (Figure 21). Meaning that those who commit offences, are also likely to be the victim of crimes.

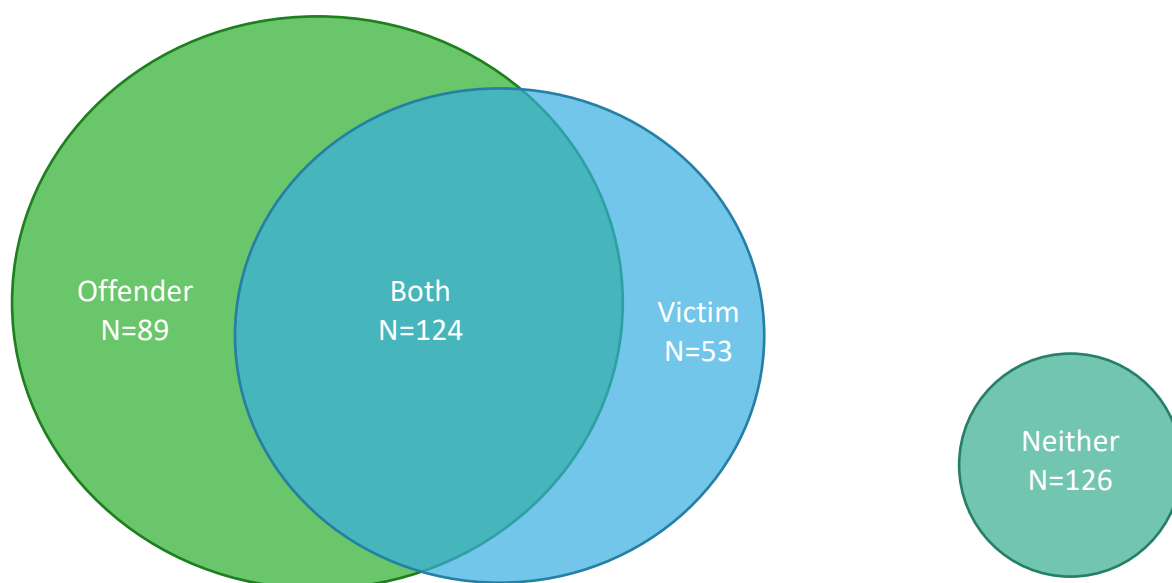


Figure 21: Overlap Between Offending and Victimization of Choices Clients

Overall, there were 395 instances of victimisation in the year prior to support from Choices across the cohort of 392 clients for whom police data was available (see Table 13). The most common offences perpetrated against Choices clients in the year prior to support were offences against the person, theft and offences against justice procedures.

Table 13: Victimization Six and 12 months Pre-Choices

Offence Group	6-Months	12-Months
Offences against the person (e.g. assault)	118	200
Sexual assault and related offences	5	10
<i>Property related offences</i>		
Burglary/break and enter	15	25
Property damage	18	34
Theft/stealing	53	85
Fraud/deception	7	9
Offences against justice procedures (e.g. breach VRO, bail etc.)	11	28
Public order offences	2	4
TOTAL	229	395

As reflected in the preceding data, offences against the person accounted for a substantial proportion of the victimisation. This category of offence includes FDV offences and reflects the vulnerability of people surviving without stable and safe housing to assault. Choices case and peer workers reported that many of the clients seen at both of the Choices hospital sites have been victims of FDV and the capacity of the Choices team to sensitively identify this and then connect clients to appropriate supports (ranging from refuge accommodation to counselling to domestic violence support agencies)

is an important element of the work of the Choices team. As reflected in the following case study (Box 12), this support is not confined to women, and extends also to male clients who have been victims of FDV.

Box 12: Support for Choices Client Experiencing Family and Domestic Violence

Background

Liam was in an emotionally and physically abusive relationship. As a male, Choices was the only service available to him to provide FDV support. The Peer Community Worker assisted Liam with creating and maintaining boundaries, as well as advocating to the police on his behalf regarding the ongoing situation. Due to the support he received through Choices he has not returned to this relationship for approximately six months and as a result has had decreased involvement with the police.

Health Service Utilisation and Cost*

In 2018, prior to support from Choices, Liam had eight ED presentations and six psychiatric inpatient days totaling \$17,230. In 2019, after receiving support from Choices, he has had only three inpatient days, equating to a cost of \$8,727.

*Average cost per ED presentation WA hospital \$838, per inpatient day \$2,909 based on the IHPA (Round 21) figures for the 2016–17 financial year for WA.²³ Average cost per psychiatric admission \$1,475 based on AIHW Mental Health Services in Australia 2019 Report.³⁰

5.1.3 ESCORTED BY POLICE INTO ED

As Choices is a program that spans the health and justice systems and recognises the intersection of these in the lives of people with multiple needs, this evaluation looked at the extent to which Choices clients were brought into the hospital by police. This not only illustrates the overlap in health and justice interaction among people who are vulnerable, but is also pertinent to the appraisal of the costs to the public purse associated with people who are over-represented in both health and police data.

In the 12 months prior to receiving Choices support, 125 clients were brought into RPH or RGH ED by police. In the six months prior, there were 67 accompanied to ED, compared to 27 in the six-month period post Choices intervention. This represents a 60% decrease.

*Sometimes we can spend a whole shift waiting with someone to be seen by a doctor in ED. On average it is easily 2-3 hours for two of our officers to wait there with someone we have brought in to ED. There have been times when half the police cars in the district are in the hospital car park. It takes a lot of our resources off the street - **Acting Sergeant WA Police***

5.1.4 CHANGES IN POLICE INTERACTION FOLLOWING SUPPORT FROM CHOICES

Overall, there was a significant reduction in both offending and the frequency of victimisation amongst the Choices client cohort when police data was compared for the periods six months pre and post Choices support, and also when data 12 months pre and post was compared.

Comparing police interactions 1 year pre/post-Choices



- 18% decrease in number of people offending
- 44% decrease in victims of offences
- 33% of clients had a decrease in number of offending charges
- 30% of clients had a reduction in instances of victimisation
- 60% decrease in clients brought to ED by police

Specifically, in the 12 months post Choices, 154 clients had committed offences, a reduction of 18% compared to the year prior to Choices. The number of clients who were victims of offences decreased by 44% from 153 in the year prior to Choices to 85 the year after.

The below case study illustrates the link between homelessness, contact with the health and justice sectors and the impact of Choices support (Box 13).

Box 13: Link between Justice System, Homelessness and Health

A 21-year-old female who suffers from long term chronic homelessness met a Choices Community Worker at the Watch House. She had been in custody for breaching a move on notice from the police as she was sleeping rough in Northbridge. She has had a troubled life, including foster care, imprisonment, AOD issues and severe mental health problems. Between January 2016 and July 2018, she presented to ED on 14 occasions and had a one day inpatient stay, costing a total of \$14,193.* She was in prison for four months during 2017, costing the Department of Justice \$38,308.³⁸

Choices Support Provided

Her Choices Community Worker accompanied her to her Priority Housing interview and she is now on the waitlist. Since then she has moved into private accommodation. She was connected with a mental health service and a service for pregnant women with AOD issues. She was allocated a Ruah Mental Health Community Worker and 50 Lives 50 Homes Lead Worker for ongoing support and discharged from Choices in July 2018.

*Average cost per ED presentation WA hospital \$838, per inpatient day \$2,909 based on the IHPA (Round 21) figures for the 2016-17 financial year.²³

5.1.5 CHANGES IN OFFENCES COMMITTED

The total number of offences committed across the client cohort in the six months after Choices support was 651, a 31% reduction from the 944 offences that occurred in the six months prior to support. Offences in the 12 months after support from Choices reduced from 1,342 the year prior to 994, a reduction of 26% over the twelve-month period (Figure 22).



Figure 22: Changes in Offences Committed Six and 12 Months Pre/Post Choices Support

5.1.6 CHANGES IN VICTIMISATION

There were substantial reductions in the number of victimisation offences experienced by Choices clients when data 12 and six months pre and post Choices support was compared (Figure 23). In the year after support Choices clients fell victim to 216 offences, a reduction of 45% compared to the 395 offences the year prior. Victimisation also decreased from 229 offences in the six months prior to Choices to 104 six months post support, a reduction of 55% (Figure 23).

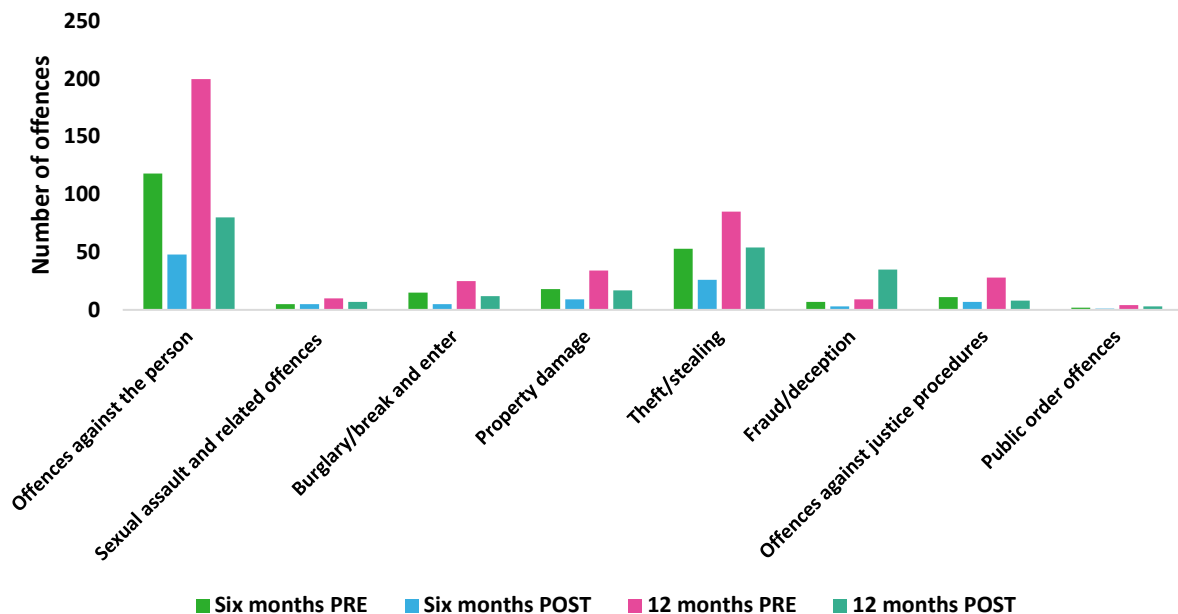


Figure 23: Changes in Victimisation Six- and 12-Months Pre/Post Choices Support

Engagement with Choices is associated with positive trends in terms of a reduction in offences and victimisation amongst Choices clients. After receiving support from Choices there were reductions in both the number of offences and proportion of clients charged with offences, potentially reflecting the provision of appropriate support through Choices. In many cases, offences were related to drug and alcohol dependence and mental health issues and Choices provided an important role in linking clients with support services for these issues.

6 CRITICAL SUCCESS FACTORS AND CHALLENGES

As Choices originated as a pilot project, it is helpful to reflect on the critical success factors and challenges encountered, not only to refine the operation of Choices in its current settings going forward but to provide learnings for potential adaption to other sites. This has been informed by focus groups and staff interviews with the Choices team and hospital staff interacting with the team and from observational data collated by the UWA evaluation team.

6.1 FACILITATORS AND CRITICAL SUCCESS FACTORS

Over the course of the evaluation, a number of factors emerged as critical to the capacity of Choices to engage with clients and to achieve its intended service aims. These are depicted in Figure 24, and discussed throughout this section.

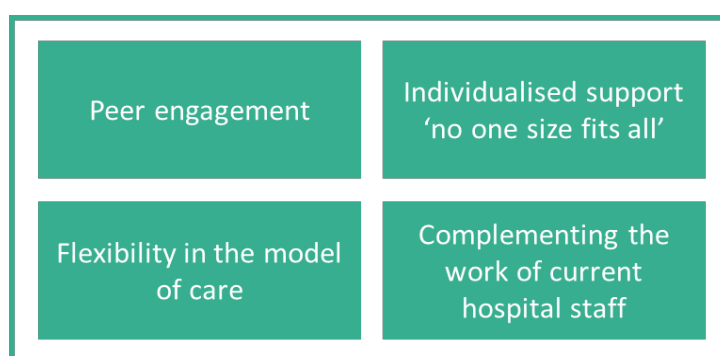


Figure 24: Critical Success Factors of the Choices Model of Care

6.1.1 PEER ENGAGEMENT

One of the unique aspects of Choices is the integral role of people with a lived experience of mental health and/or AOD issues as peer support workers. Studies have shown that peer workers in hospital settings can improve outpatient appointment attendance and decrease ED presentations,⁵ but this is in its relative infancy in WA compared to some other States and other countries. Implementation of a peer support model in a Justice setting to identify and address underlying social determinants of health is unique to the Choices program.

Peer workers can offer understanding and support based on their own experiences and interactions with the system in which they work as well as acting as a caring and sympathetic advocate for the client.² This was evident in feedback both from peers themselves, the Choices caseworkers, Ruah and hospital staff.

...being able to say, I was in hospital 10 years ago, or, I can relate to what you're going through from feeling this way. As soon as I say that to people, specifically that thing, that I was in hospital...the look on their face changes. It's like, oh, right, so this is actually real, this is to help...You understand. - Peer Worker

I think people really respond to that, because you've got that in-built empathy because you've gone through it yourself. I think that's a huge thing for people, they don't feel like there's those barriers there that there might be with nurses or doctors. – Peer Worker

As noted by one of the RGH staff, peers have a unique capacity to directly relate to patients and this can provide benefits to the clinical hospital staff:

The ability to build rapport with people who are difficult to build rapport with, [that lived experience] is pertinent to the relationship... Choices are really good at that sort of stuff. That's huge. That's the key to it. – Hospital Staff

Advocacy on behalf of clients is another hallmark of the peer roles within Choices:

I think advocating for them [clients], because we've had a fair few at the moment where they've re-presented with mental health. The doctors are wanting to discharge them, but clearly, they could do with a hospital stay, and the peers advocating for that. We've had three recently where they've been referred on to mental health hospitals or wards for that additional support. - Senior Community Worker

The capacity for peer workers to engage with clients and explain concepts in ways that clients can relate to is a key strength of Choices. This also builds capacity amongst hospital staff:

I think that peer-to-peer is absolutely incredible as far as the value that it can bring to the table. We need more of it in a medical driven system. ... -Hospital Staff

....that peer-to-peer, human perspective when they come into a place where they don't necessarily mesh well with the mainstream healthcare system then they get somebody [a peer worker] who can say we can look at doing these things, can explain things – Hospital Staff

One of the Choices Senior Community Workers also noted that the peers undertake valuable groundwork and rapport building with clients that adds value and efficiency to the case management aspect of Choices:

...it helps me build rapport quite easily. Because when I meet people, instead of trying to build rapport, I have a peer who has already engaged them, they've already built rapport. So I'm coming into a comfortable environment, saying, oh, this is <name>, he's one of the workers, so they trust the peer. Coming in with that peer, they automatically trust me, so it's easy for me to kick-start with what I need to do. – Senior Community Worker

6.1.2 INDIVIDUALISED SUPPORT - 'NO ONE SIZE FITS ALL'

As conveyed by the naming of Choices, from the outset the need to tailor support to the presenting needs and priorities of clients is critical. This has included acknowledgement of the fact that some clients may not be ready for the more intensive support Choices can offer, but that brief interventions can start them on a path to change:

...one of the clients that I did it for, he did end up back in hospital because the realisation was that he wasn't ready for the support that we could provide. But because of the small engagement that I did have with him, he did start going into counselling and things like that... So it plants that seed, even if we don't have the outcome of him - he's still come back to hospital. But at least he's doing those small things that could long-term prevent him from continuously coming back. – Peer Worker

The system often is basing their support on rigid engagement that might not fit clients' chaotic lifestyles, so having the brief intervention and one-off support, can still have a significant impact on the clients' lives, because we offer support in a less restrictive way.– Senior Community Worker

One community worker observed their capacity to support clients immediately, even with relatively small issues, enables the client to feel supported and may prevent further crisis situations.

...sometimes the crisis may simply be, the taxi didn't get there on time to get them somewhere. It can be just a simple thing, but we get the calls, and it's just about talking them down and saying, okay, what can we do? Right, let's ring and change the appointment, and set this up. – Senior Community Worker

Because there were times even through the three-month support, where she said, oh, I don't feel like attending today. We've had a conversation, and at the end of the conversation, she changes her mind and attends. I think to expect them to be independent sometimes takes a little bit of time and encouragement.... Just putting some positivity back in their life that day and reminding them how far they've come and what the rewards and benefits are going to be for them if they do attend. You know, saying it's your choice, but it would really be good if you went [to the appointment]. Mostly they go, yeah, I'm going to go, you were right. – Senior Community Worker

6.1.3 FLEXIBILITY IN THE MODEL OF CARE

The flexibility within the role of a Choices worker to provide their client autonomy and slowly exit is important, as clients build and regain capacity the intensity of support provided can be reduced:

At the start you might do a lot of work for the client, but you need to give them the autonomy to start doing it for themselves so that by the time you get to that three month mark they're already making most of the appointments by themselves and doing things like that, so that they're not having to rely on you. – Peer Worker

Flexibility with regard to the duration and intensity of support has been critical. The Choices team often note that for some clients just a small brief intervention can be invaluable, while others need multi-pronged or more intense support. In some instances a client has been doing well and exited, but their circumstances change and they have re-engaged with Choices, and the residual trust and rapport established has proven beneficial.

6.1.4 FILLING A GAP THAT HOSPITALS DO NOT HAVE CAPACITY TO ADDRESS

Hospital stakeholders noted the link with Choices enabled them to access additional resources and/or refer onto other services and that this helped to maximise the efficiency of limited resources.

There are limited resources to refer out into the community. To have a community worker that's linked to the hospital and linked to a peer, I think the structure of that works really quite well because it gives options to refer out to. – Hospital Staff

...the [peer] role is actually really pertinent because it can access people that I can't access and build relationships with sometimes people I can't build relationships with... – Hospital Staff

6.2 CURRENT CHALLENGES

As a pilot project, a number of challenges have evolved and been addressed over the course of Choices to date. Hence only challenges and suggestions for strengthening the program identified through the most recent round of interviews with Choices staff or observed in recent interviews with staff from the two hospitals are included here, see Figure 25.



Figure 25: Current Challenges and Barriers to the Choices Model of Care

6.2.1 PHYSICAL ENVIRONMENT WHERE CHOICES OPERATES

Lack of a Quiet Private Space to Meet with Clients within the Hospital Setting

Neither hospital has a room or private area free to set aside where Choices peers can meet with clients when they come for appointments. Often the meeting takes place in the café area, which has implications for client privacy and capacity to discuss sensitive issues. Some clients are also noise sensitive and principles of trauma informed practice support the need ideally for a more private quiet location in each of the Choices settings.

Especially again who we're working with, they have so much trauma and just - the triggers can be noise, sounds, anything. - Senior Community Worker

I've just finished supporting a gentleman that just really struggled to tolerate noises around him. He was physically very unwell. He's got terminal cancer and a whole lot of other issues, so we were going upstairs and trying to find an area... For me, I don't think it's ideal to do an initial risk assessment with a client in the cafeteria – Senior Community Worker

Visibility and Co-location of the Choices Team

Where the Choices team is physically located also makes a difference. At RGH, the team is co-located with social work, right next to the Psychiatric Liaison Nurse (PLN) office and in close proximity to the ED. This was noted as a strength by RGH staff and the Choices peers working at RGH.

...where we're located at RGH makes a difference, because the PLNs are right there. The ED is right there. That's where the social work is. So we're sharing the same area. So other hospital staff are walking up and down here all the time... they might be heading through that door, then they'll stop suddenly and it's like, oh hi there... and come talk to us about a patient – Senior Community Worker

By contrast, at RPH the Choices office is much further away from ED and not near hospital staff who are likely to make referrals. At both sites, the team undertakes daily ward rounds, and otherwise respond to referrals or requests to come see a patient. Several staff at RPH suggested that greater visibility of Choices in the hospital setting would raise awareness of their role and presence and bolster referrals.

Choices are simply not visible in the hospital setting. I see them once in the morning and rarely do I see them for the rest of the day. – Hospital Staff

...you've got to build relationships in the hospital and I think that's the most pertinent component. If you're up in your office not engaging when you should be on the floor that's where the distance lies. – Hospital Staff

Awareness of Choices Impacted by Frequency of Staff Turnover

Awareness and understanding of 'what Choices is there for' has increased over time, and the team has worked hard to build rapport and referral pathways at all of the sites. However, inevitably there is staff turnover, particularly at RPH as a large teaching hospital with many staff on rotations, and this impacts on the continuity of staff awareness of Choices and referrals to the program.

So just as you start to get a good rapport with a social worker, you come in one day and you find out that they've moved– Peer Worker

6.2.2 NATURE OF CLIENT NEEDS

There are often multiple underlying needs related to frequent contact with the health and justice sectors and Choices staff work to identify these and support clients to engage with longer-term services to address issues that require ongoing support. Choices Staff have an important role to play in assisting clients to navigate the exceptionally complex health and justice systems. The high prevalence of mental health and AOD issues for example can have implications for scheduled client appointments, and Choices recognises the need to be understanding and flexible in relation to this:

...sometimes clients rock up when they don't have an appointment, and that's a logistical thing that happens a lot. But it means that they don't get the service - we - yes, we are there at the hospital, but we don't have an appointment with them, we may be dealing with other clients or engaging with someone in the ED. So that's the kind of logistical thing that comes under non-engagement, but actually its they are showing up, but we don't have the capacity to see them at that time. Because of their chaotic lifestyle, they don't know how to keep appointments sometimes... Sometimes it's even like we'll get people show up four hours early to an appointment. It's like well, I have two appointments before your appointment. Then it's but I'm here now, then it's like how often do you compromise and drop what you're doing to go and see a person. - Peer Worker

6.2.3 DISTRICT OR PRIOR NEGATIVE EXPERIENCES OF HEALTH SYSTEM

The time it can take to build rapport and trust with clients, particularly those who have had prior negative experiences of the health system, was a recurrent theme in discussions with both Choices team members and hospital staff. This is not unique to Choices and has been the experience also of Homeless Healthcare¹⁸ and in its current pilot of Homeless Outreach Dual Diagnosis Services (HODDS).³⁹ It also mirrors the observations of Fleming et al (2017) from their US ethnographic study of hospital staff perspectives on patient engagement, concluding that many “*marginalised patients had sufficient warrant to distrust the health care system due to histories of exclusion and poor treatment. This distrust in turn manifested in behaviours or in-actions that gave the appearance of low engagement*”.⁴⁰

6.2.4 LACK OF SOCIAL HOUSING AND CRISIS ACCOMMODATION

It is difficult to work with someone to address their health issues when they do not have a safe place to sleep or store their belongings. Referring or assisting clients to access homelessness or housing services thus consumes a lot of time for the Choices team, and this is particularly exacerbated in the Rockingham area where there is a paucity of available social housing or crisis/temporary accommodations available.

...one of the challenges is always trying to find accommodation for clients. – Senior Community Worker

...it's the same with women's refuges. They're all mainly in the city or Fremantle as well... There is one down there, but that's full mostly – Senior Community Worker

Hospital staff also noted how they sometimes are left without a choice but to discharge clients to homelessness which only perpetuates the cycle of risky behaviour, homelessness and high health services use:

Once again the patient is discharged, we don't have any immediate crisis accommodation, they go back on the street. I would be doing the same thing. I'd be hitting the drugs, I'd be doing whatever I've got to do to make my life feel a bit better and then straight back into hospital again. We can't reach into that next tier of accommodation and that's the issue – Stakeholder

6.2.5 LACK OF AVAILABILITY OF SERVICES SOME CLIENTS NEED

Lack of availability and long waiting periods for services, including AOD and mental health services, were key gaps for Choices clients. Choices staff identified a need and willingness among their clients to access these services, but this wasn't possible due to lack of availability.

I mean things like rehab...they have to attend that open meeting to hear what it's all about. Then they have their assessment, then if they're accepted, they've got to wait for a place. Then they've got to go to Northbridge one night a week or one day a week to attend the programs... So if they're in Rockingham they've got to travel all the way to Northbridge one day a week and do that for - it can be up to six, seven weeks 'til the place becomes available – Senior Community Worker

But a lot of the meetings are on at like five to seven or whatever on an evening, so we're not working at that point...So you've really got to want to be committed to that - I mean the one lady I had, she'd be having a drink at four o'clock... If it was in the morning, she maybe could have got there. – Senior Community Worker

The problem is when they're homeless and need rehab, because you don't want to be applying for rehab and housing ... But then they've got nowhere in between, waiting for rehab, they're on the street. – Peer Worker

6.2.6 FIXED TIMEFRAME FOR SERVICE DELIVERY

The fixed time-frame for service delivery was perceived as too short for some clients, particularly when they took a long time to engage. Community workers noted that it can be frustrating having to exit clients at the three-month mark, especially when they are trying to link them in with other services (i.e. AOD rehab) as sometimes there are waitlists with those services.

When you think about it, considering that a lot of things have a waitlist, so it takes you maybe a month or two before services start actively supporting the person. Then a month later, you exit them, and expect them to thrive on their own... That's why they keep coming back, not because they didn't have services... So losing them at that three months when, yes, they're doing well [is challenging]. - Senior Community Worker

Many clients do not have photo IDs, which prevents them from being able to apply for services such as Centrelink or public housing.

*I mean just this client I'm working with now, his ex binned and burned all his stuff when they split. So he was here on a temporary visa and so wasn't eligible for Centrelink - anyway when he'd eventually done his 152 week or however long he had to do, he then didn't have photo ID - so then we had to go and do all of that. So now his Centrelink money is coming in. Now we want to do the housing application. But he has to get a letter about his residency status. But in order to do that he has to have a valid passport. He hasn't got a passport. So we've got to apply for a UK passport. So we're how many weeks in and we haven't even started to put the housing application in yet. - **Senior Community Worker***

Clients have also reported back to the community worker that they sometimes feel the support period is too short:

*I must say on a lot of the exit questions that I've done with clients, a lot of them have said that they feel the support period is too short. I understand that we are just a service to point them to and link them up, but sometimes there might be a week or two or three, before we've got the initial risk assessment done because they're still unwell or there's something going on there. - **Senior Community Worker***

On the contrary, some of the peers noted that by having a strict timeframe to work with clients assisted with setting boundaries and letting clients know that it wasn't "forever" support. However, clients tend to want more support the closer you get to the three-month mark which again can be difficult in trying to support them with the time they have left.

*I've found that's been something that's helped me with clients getting attached is putting it out there from the start that we are a three-month program. I found that without that, the closer you creep to that three-month mark the more they're wanting your support. If they haven't really been made aware that it's three months, then suddenly it would feel like to them oh, you don't - you're not there for me suddenly. - **Peer Worker***

*I think, as well, for a lot of the clients that we have come through the hospital, if they're engaging in mental health supports, a lot of them haven't known how to do that previously. When you're someone that's kind of coming in and being like I can show you how to be connected to these, it's easy for them to then become attached to that kind of support. Which is, I guess, why it's good at the hospital to have that clear boundary of the three months. - **Peer Worker***

7 CONCLUSION

Internationally and within Australia, there is growing recognition of the need for different approaches to patient engagement, continuity of care and to address underlying drivers of poor health for people whose life circumstances contribute to more frequent emergency or unplanned hospital use.^{25, 28} As articulated in a recent paper by Fleming et al (2017), the “super-utilisers” of the health care system are those who often face challenges related to socioeconomic marginalisation including poverty, housing insecurity, exposure to violence and trauma, cognitive and mental health issues and substance use.^{40p.11} This astutely sums up the challenges faced by Choices clients and by traditional medical models of healthcare in seeking to improve health outcomes for this population group.

Given the recent evidence that about a fifth of ED presentations in WA could have been treated in primary care or community care, the Choices pilot, and this evaluation of it, is timely.⁹

A substantial challenge for a program such as Choices which supports clients with multiple needs, is to adequately do justice to the breadth of work undertaken with clients using quantifiable data alone. Choices clients tend to have multiple health and social needs that cluster with mental health and/or AOD use, and as noted in a recent paper by Field et al (2019), frequent ED presentations and unplanned hospital admissions mark a threshold in deteriorating health,²⁸ often characterised by multiple morbidities. Hence no single short-term intervention (even if multi-faceted as is the case with Choices) can realistically expect to dramatically curtail hospital use for all clients for a number of reasons identified in the literature and evident in the data examined for this evaluation:

Caveats to comparing pre and post hospital use for interventions with clients who have multiple health and social support needs

- Where health has deteriorated, further acute medical care may be unavoidable⁷
- Previously undiagnosed or untreated health issues being addressed, which in some cases can require hospitalisation²⁸
- Social determinants of health may continue to drive hospital use (such as homelessness, family and domestic violence, social isolation, poverty)
- Prior adverse life experiences and trauma can impact on service engagement²⁹ and capacity to modify factors that contribute to poor health.
- Duration and ‘dose’ of support influences the likelihood of longer term outcomes.

Notwithstanding these caveats and the short term duration of Choices support (typically up to three months), this evaluation did nonetheless indicate some reductions in both ED presentations and inpatient days, as well as reductions in clients contacts with police both from an offending and victim perspective. In the six-months following support from Choices there was a 37% reduction in ED presentations across the cohort and a 38% reduction in the number of inpatient admissions. The number of offences committed, number of offenders and instances of victimisation amongst the Choices client cohort all decreased in the six-months after receiving support.

The use of administrative hospital and police data in an evaluation of this kind, and the linking of this to Choices program level and client data has had its challenges, and there are learnings for this for future research of this kind:

Congruency of different sources of data. When using real world data, the way in which different data is defined, collected, recorded and able to be extracted can vary considerably. Many health and community service organisations have databases set up for case management, and outcomes

measurement has often been shaped by the requirements of funders and organisational governance. Hence, the data ideally needed may not be readily extractable in a format that can be linked for example to hospital data.

Time required to obtain administrative data. Administrative health and justice data yields valuable insight into changes in service utilisation pre and post program support. However, the ethics and governance approvals process required to access this data can be lengthy.

Absence of a control/comparison group. Whilst a randomised control trial is often not ethical nor feasible for an intervention of this kind, there are many confounding factors that can affect hospital or police interactions prior to or following service engagement, and this impedes conclusions that can be drawn from pre/post data alone. As suggested by Field et al (2019) from a recent evaluation of Pathway teams in National Health Service hospitals, by the time people with multiple health and social needs present to hospital, they may already be on a downward trajectory with regard to their health which can confound pre/post service engagement comparisons of hospital use.²⁸ Field et al (2019) and others have suggested the merits of such evaluations including a comparison group, and this could be done for a program like Choices via including data for a cohort of ED presenters with similar demographics and presenting needs who did not receive support.²⁸

There are a wide range of factors which can influence reporting and recording of offences. For example, those who are living rough are more 'visible' and vulnerable to repeated engagement with Police; particularly for public-order type offences and 'detected' offences such as drug possession. Engagement with support services can alter factors such as level of supervision and interaction with government agencies (may increase the likelihood of offences being identified and reported); or may improve confidence to report victimisation; and may alter relative vulnerability to property and personal crime. Entrenched offending behaviour linked to drug addiction and lack of legitimate means of support, and involvement with justice-involved families, can be hard to influence via such engagement. Basically, offending can be an entrenched way of life, and without a control/comparison group we cannot tell whether the recorded changes are remarkable, represent a return to the mean, or represent more routine fluctuations in antisocial behaviour. (WA Police Force, Personal Communication, 25 November 2019)

Impact of duration and dose of support not able to be determined. Among the clients supported by Choices to date, there are people who have received very brief intervention or support on just a few occasions, through to clients supported intensively for three months. Data on duration and amount of support per client was not available in a format that could be included into the analysis, but warrants consideration in any future evaluations.

Given the broader health equity imperative to better meet the needs of those with the poorest health,⁴¹ there is inevitably a discomfort in discussing the benefits of an intervention or service in purely economic terms. However, as recent evidence shows,⁹ the current demand on hospitals is not sustainable fiscally for the health system and this evaluation of the Choices pilot is timely in its demonstration of the way in which an innovative non-clinical service can help to break the cycle of revolving hospital use associated with the confluence of mental health and/or AOD issues and social needs. The impact of high hospital service utilisation of the health system is evident in the estimated \$6 million cost of Choices clients in the year prior to them receiving support. The potential savings when clients are linked with community supports is demonstrated through the overall \$1.1 million reduction in hospital costs equating to a \$3,462 reduction per person for Choices clients in the six-months after receiving support.

As with any pilot project there are learnings to be found and the potential to strengthen the program for future service delivery as discussed particularly in Chapter 6.

Social isolation, addiction, family breakdown, homelessness, trauma and FDV are common across Choices clients in both hospital and justice settings. Critical to program is the 'no one size fits all' ethos that allows support to vary according to client needs and the critical role of the Peer Community Workers. The importance of this approach is evidence in the adaptations made to Choices over the course of the pilot and in the three contrasting settings in which it operates. As a short-term case management and peer support program, it is recognised that Choices 'can only do so much' with the time and resources it has available for each client. Its impact is amplified by the emphasis on collaborating with and connecting clients to existing health and other services within the community.

Across Australia, EDs and hospitals are increasingly contending with health issues driven or compounded by a raft of social issues that are beyond the scope of immediate clinical care. To this end, programs such as Choices are seeking to address a critical void and present an innovative way to improve access to primary and community health service access and supports to reduce recurrent hospital attendances.

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APPENDIX 1 : AUSTRALIAN AND NEW ZEALAND STANDARD OFFENCE CLASSIFICATION

The ANZOC is used by the ABS as a framework for analysing criminal and justice statistics. Below is a brief summary of the offence categories.⁴²

Offence Category	Description
Assaults against the person including: • Abduction/harassment • Assault/acts intended to injure • Dangerous/negligent endangering persons • Robbery/extortion • Family and domestic Violence	Actions that harass or are intended to harass, threaten or invade the privacy of an individual, not amounting to an assault, sexual assault, stalking, blackmail or extortion. The action can be face-to-face, written, or by phone, computer etc. • Harassment and private nuisance • Threatening behaviour Acts intended to threaten or harass, or acts that unlawfully deprive another person of their freedom of movement. The unlawful confinement of a person against that person's will, or against the will of any parent, guardian or other person having lawful custody or care of that person. Acts, excluding attempted murder and those resulting in death which are intended to cause non-fatal injury or harm to another person and where there is no sexual or acquisitive element. The direct (and immediate/confrontational) infliction of force, injury or violence upon a person or persons resulting in an injury. Includes, but is not limited to: • Grievous bodily harm • Actual bodily harm • Wounding • Severe mental behavioural disturbance or disorder or • Loss of a foetus As well as the direct (and immediate/confrontational) infliction of force or violence upon a person or persons not resulting in an injury. Also includes acts such as • Stalking • Robbery • Blackmail and extortion
Burglary/break and enter	The unlawful entry of a structure with the intent to commit an offence, where the entry is either forced or unforced. • Break, enter and steal/burglary • Unlawful entry to a structure with intent • Ram raid • Smash and grab • Home invasion (not involving an assault)
Fraud/deception	Offences involving a dishonest act or omission carried out with the purpose of deceiving to obtain a benefit. • Obtain benefit by deception • Forgery and counterfeiting • Deceptive business/government practices • Other fraud and deception offence
Illicit drugs	The possessing, selling, dealing or trafficking, importing or exporting, manufacturing or cultivating of drugs or other substances prohibited under legislation. The term drug is used to describe narcotics, opiates, hallucinogens and any other substance prohibited under legal control. • Import, export, deal or traffic in illicit drugs • Manufacture or cultivate illicit drugs • Possess and/or use illicit drugs • Other illicit drug offences
Justice/govt security/govt ops/ breaching VRO's	An act or omission that is deemed to be prejudicial to the effective carrying out of justice procedures or any government operations. This includes general government operations as well as those specifically concerned with maintaining government security.

	• Breach of custodial order offences • Breach of community-based orders • Breach of violence and non-violence orders • Offences against government operations • Offences against government security • Offences against justice procedures
Property damage/environmental pollution	The wilful and unlawful destruction, damage or defacement of public or private property, or the pollution of property or a definable entity held in common by the community. The wilful and unlawful destruction, damage or defacement of property excluding pollution. • Property damage by fire or explosion • Graffiti • Damage or kill flora/fauna • Property damage caused by a riot • Tamper with a motor vehicle
Public order offences	Offences relating to personal conduct that involves, or may lead to, a breach of public order or decency, or that is indicative of criminal intent, or that is otherwise regulated or prohibited on moral or ethical grounds • Disorderly conduct • Regulated public order offences • Offensive conduct • Trespass • Criminal intent • Riot and affray Offences involving behaviour that is regulated or prohibited on moral or ethical grounds; • Betting and gambling offences • Liquor and tobacco offences • Censorship offences • Prostitution offences • Offences against public order sexual standards • Consumption of legal substances in regulated spaces
Sex assault and related offences	Acts, or intent of acts, of a sexual nature against another person, which are non-consensual or where consent is proscribed. Physical contact, or intent of contact, of a sexual nature directed toward another person where that person does not give consent, gives consent as a result of intimidation or deception, or consent is proscribed (i.e. the person is legally deemed incapable of giving consent because of youth, temporary/permanent (mental) incapacity or there is a familial relationship).
Theft/stealing	The unlawful taking or obtaining of money or goods, not involving the use of force, threat of force or violence, coercion or deception, with the intent to permanently or temporarily deprive the owner or possessor of the use of the money or goods, or the receiving or handling of money or goods obtained unlawfully. • Motor vehicle theft and related offences • Theft (except motor vehicles) • Receive or handle proceeds of crime • Illegal use of property (except motor vehicles) Theft of goods for sale, other than motor vehicles, by avoiding payment for those goods. Receive, handle, process or possess money or goods taken or obtained illegally.
Traffic/vehicle regulatory offences	Offences relating to vehicles and most forms of traffic, including offences pertaining to the licensing, registration, roadworthiness or use of vehicles, bicycle offences and pedestrian offences; • Driver license offences • Vehicle registration and roadworthiness offences • Regulatory driving offences • Pedestrian offences
Weapons/explosives	Offences involving prohibited or regulated weapons and explosives. Offences relating to weapons or explosives that are prohibited under legislation.

APPENDIX 2: CHOICES STAKEHOLDERS

Accommodation Services

- Bethanie Accommodation
- Entry Point
- Foundation Housing
- Housing Authority
- St Bartholomew's House
- Tom Fisher House
- Urban Fabric Accommodation

Alcohol and Drug Services

- AA Fellowship in WA
- Cyrenian House
- Next Step
- Women and Newborn Drug and Alcohol Service

Community Services

- Aboriginal Liaison Officer at St Johns, Midland
- Anglicare
- Christian's Against Poverty
- Mandurah Muscateers
- People Who Care
- Red Cross
- Ruah
- Salvation Army
- St Vincent de Paul
- St. Patrick's Community Support Centre
- The Esther Foundation
- United Care
- Uniting Care West

Health Services

- Joondalup Health Campus
- Midland Women's Health Centre

Hospital Services

- Fiona Stanley Hospital
- Hollywood Hospital Inpatient

Legal Services

- Legal Aid

Mental Health Services

- 360/ Partners in Recovery
- Cygnet Clinic
- Headspace
- Lorikeet Centre
- Midland Mental Health clinic
- Midland Psych Unit
- Richmond Fellowship

Relationship Support Services

- Relationships Australia
- Centrecare

Temporary/Crisis Accommodation Services

- Croft Crisis Accommodation
- Exclusive Backpackers
- The Beacon
- Zonta House – Positive Pathways

Trauma Support Services

- Angel Hands

