Working with homeless patients in a clinical setting
Acknowledgements

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Executive summary

It has been recognised that there are unique challenges associated with treating patients who are homeless. The typical approach towards treating health issues is to undertake medical interventions to treat and prevent reoccurrence of disease, illness or injury.\(^1\) Although this response is vital, it does not address external, social issues that contribute to the development of poor health.\(^1\) To sustain health outcomes achieved by medical intervention, the environmental and socioeconomic factors that lead to health complications must be considered and addressed.\(^1,2\)

This paper aims to educate junior medical officers (JMOs) of the importance of considering a homeless patient’s social circumstances, along with the need for a collaborative approach to care and referral to community services. This paper also aims to enhance JMOs knowledge regarding the following:

- awareness of the issue of homelessness and the associated problems and comorbidities
- what to consider when treating or consulting with a person who is homeless
- local services available to assist the homeless and how to facilitate access to these.

People who are homeless experience serious health and socioeconomic inequities, which significantly reduce an individual’s quality and length of life.\(^2\) Compared to the general population, people who are homeless have higher rates and more severe cases of injury, illness and disease.\(^2\) People who are homeless also present more frequently to hospital and have a longer average length of stay.\(^2\) Further insights into the health of the Australian homeless population have been provided within this paper, along with the average cost to the health care system to treat homeless patients and barriers to health care.

Tools and practical recommendations that may assist JMOs during consultation and treatment of a homeless patient are provided within this document. Tools can be selected and adopted where deemed necessary to meet the needs of specific work places. It is up to the discretion of the reader to choose which resources and information they wish to use, it is not expected that all tools be adopted. Tools and recommendations for practice outlined within this paper include:

- trauma-informed care
- addressing patient resistance
- evaluation of living conditions
- development of a care plan
- referring a homeless patient.

A focus on a collaborative approach to care and referral aims to reduce homeless patient’s high re-admittance rates to hospital, by addressing the social factors impacting the patient’s health. The interconnectedness between medical and social factors must be acknowledged and addressed to sustain positive health outcomes.\(^2\)
Background

In November 2016 a Clinical Senate Debate covered the topic of *Homelessness – No fixed address – Can we still deliver care?* Discussions during the debate led to the development of eight recommendations to enhance the provision of homeless health care throughout Health Service Providers (HSPs) in Western Australia (WA). This paper has been developed in alignment with the Clinical Senate recommendation to invest in staff education that evaluates the social determinants of health and the linkages to homelessness.

This aim of this paper is to educate JMOs on the broad issue of homelessness and provide recommendations to facilitate holistic care to homeless patients throughout WA Health HSPs.

JMOs have been recognised as an influential group to receive education on homelessness according to the following factors:

- the cohort is large and includes people at a range of career stages
- JMOs come in contact with homeless patients
- JMOs work alongside a range of health professionals which may allow them opportunities to influence and educate colleagues
- JMOs are encouraged to take on educational training and opportunities.

To supplement this paper, an online education package has been developed in line with the *Take 5* concept, designed by Nick May from Royal Perth Hospital. The package includes five slides with links and references to access further information, and is currently available on the *Take 5* webpage (see link below).


A checklist resource for hospitals entitled ‘Consulting with a homeless patient?’ can also be found at Appendix C of this report or at the following webpage:


Both of these resources may be of relevance to a broad range of staff providing support to homeless patients.
1 Defining homelessness

There are a number of different definitions of homelessness, along with a range of methods that categorise the severity of homelessness. The definition of homelessness provided by the Australian Bureau of Statistics incorporates the intricacies of the meaning of a home and acknowledges the complexities associated with homelessness. Homelessness is defined according to the suitability of a person’s living arrangements. Suitability is associated with the adequacy, security, safety and privacy of the dwelling.

A standard definition has been identified across WA Health for Health Services to use and promote to ensure that this vulnerable group receives care appropriate to their needs and to improve the accuracy of data capture and reporting. The definition is:

A person is defined to be homeless if they do not have suitable accommodation alternatives and their current living arrangement:

- is in a dwelling that is inadequate;
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations

(Australian Bureau of Statistics, 2016)

This includes people who are

- without conventional accommodation and therefore sleep in public places,
- move frequently between temporary accommodation (a crisis service or staying with relatives or friends ie: ‘couch surfers’); or
- residing in boarding houses, hostels or caravans with no secure lease or private facilities.

Homelessness can be categorised to highlight the level of inadequacy and insecurity of a person’s current living arrangement.

- Primary homelessness - Rough sleepers: Refers to those who sleep in public places such as streets, parks, vehicles, vacant buildings or under bridges.
- Secondary homelessness - Couch surfing: People who live in temporary and unstable accommodation or those in need of emergency or supported accommodation. This also includes people who rely on relatives for a place to live or who live in caravans or shelters.
- Tertiary homelessness: People who rely on hostels or boarding houses for accommodation.

When defining homelessness for Aboriginal people, cultural variations in the definition of homelessness should be considered. Aboriginal people who are experiencing homelessness can be defined as public place dwellers, at risk of homelessness or spiritual homeless. The inclusion of spiritual homelessness acknowledges Aboriginal people’s connection to country. People can be spiritually homeless if they are away from their country of origin.
2 Homelessness in Western Australia

There are approximately 9,005 people experiencing homelessness in WA and over 116,000 nationwide.\(^7\) In WA this equates to 36.4 homeless persons per 10,000 people, compared to the national average of 49.8.\(^7\) Currently within hospital settings across WA, people who are homeless are identified as patients with no fixed address. The post code 6999 is often entered as the address details for patients with no fixed address.

Aboriginal and Torres Strait Islander (ATSI) people are disproportionately represented amongst WA’s homeless population.\(^7\) ATSI people make up 3.1% of the WA population, conversely, near 30% of homeless people in WA identified as being ATSI.\(^7,8\) In recognition of the high number of ATSI people who are homeless, the Clinical Senate recommendations state a need to develop culturally safe homeless health care in WA (see section 7.0 Practical recommendations).

People who are homeless experience major disparities in health outcomes compared to the broader population of WA.\(^9\) As a result of the poor quality of life that people who are homeless experience, the average life expectancy for this group is almost half that of the Western Australian general population.\(^10,23\) The average life expectancy for homeless people is between 40 and 42 years, whilst the average life expectancy for non-homeless people in WA is 82.5 years.\(^11,10,23\)

3 Health of the homeless

It is understandable that health care may not be a primary priority for a homeless individual, therefore, late presentation for medical treatment may occur (see section 5.2 Maslow’s Hierarchy of Needs).\(^2,12\) This often results in heightened complexity of health issues at presentation, increased risk of mortality and subsequent increase in costs to the health care system at a tertiary level.\(^2,13,14\)

Tri-morbidity describes the simultaneous occurrence of psychiatric illness, substance misuse disorder and a chronic medical condition.\(^12\) Research conducted in WA revealed an 80% prevalence of tri-morbidity amongst 110 formerly homeless clients undertaking the housing program 50 Lives 50 Homes.\(^12\) The results from this study are consistent with similar national and international studies based on people who are sleeping rough.\(^14,15\)

‘Because of these multiple needs, a multidisciplinary team approach is often effective for homeless patients.’\(^39\) p.8

The health outcomes of homeless people across Australia have been recorded amongst clients who accessed Specialist Homelessness Services (SHS).\(^16\) Over 288,000 people accessed SHS in Australia during 2016 and 2017.\(^16\) Within that group, over 25% of clients reported to be experiencing a mental health problem, a 7% increase from previous years.\(^16\) Studies from WA show that amongst a cohort of over 300 homeless people, 78% were experiencing at least one mental health problem, a 4% increase from previous years.\(^14\) Homeless people who have a
mental health problem may be at an increased risk of adopting unhealthy coping mechanisms including substance use. A study from 2005 reported that amongst 300 young people experiencing homelessness, over half stated that they became homeless as a direct or indirect result of personal drug use. A systematic review revealed that substance abuse was the most common risk factor for homelessness amongst veterans.

Over one in five SHS clients in Australia had accessed treatment for the misuse of multiple drugs; this prevalence is three times higher than in the general population. Amphetamines, heroin and pharmaceutical drugs are commonly used amongst the homeless population and are used at higher rates than the national average. Amongst the 50 Lives 50 Homes clients over 90% reported experiencing problematic use of alcohol and other drugs, compared to one in twenty people from the general population of Australia.

The prevalence of smoking is significantly higher amongst homeless people compared to people who are not homeless in WA. On average 10.7% of the WA population smoke cigarettes, whilst approximately 60-77% of the homeless population are known to smoke. High rates of smoking may be associated with increased risk of tobacco-related health concerns such as asthma, vascular disease and chronic conditions like emphysema and therefore homeless people may be more at risk of such conditions. Other common physical health problems amongst people who are homeless include heat stroke, cardiomyopathy, endocarditis, asthma, hepatitis C, diabetes, traumatic brain injury, poor dentition, skin infections and dehydration.

WA data shows that 16 to 32% of homeless participants have a form of heart disease, whilst the rate of heart disease for the remainder of the WA population is 5.5%. Common cardiovascular morbidities in the homeless population include hypertension, peripheral vascular disease, and cardiac arrhythmias. Furthermore, the rate of diabetes is 12.7-17% amongst homeless people, compared to the WA average of 6.6%. The prevalence of asthma for the homeless is also 11% higher than the general population of Australia.
4 Cost of treating homeless patients

People who are homeless present more frequently to hospital Emergency Departments (ED) and have an average length of stay that is longer than patients who are not homeless.²,²⁸ As a result, providing health care to homeless patients costs the health care system more than what it does to treat a patient who is not homeless.²

People who are homeless are on average 5 times more likely to present to EDs and are between 4-8 times more likely to be admitted to hospital, compared to people who are not homeless.³,²⁷ In addition to the higher rates of admittance to hospital, it is known that people who are homeless stay in hospital for an average of 7.1 days when admitted, compared to 2.7 days for people who are not homeless.²⁸,²⁹

Data collaboratively interpreted by Royal Perth Hospital (RPH) and the 50 Lives 50 Homes project provided insight into the number of ED visits and hospital admissions of local homeless clients.¹² It has been calculated that at RPH alone, the average cost to the health care system to treat one person who is homeless and sleeping rough is approximately $93,000 for one year.¹² The average cost to the health care system in Australia for people who are not homeless is $7,096 per person per year.³⁰ Other case studies from WA have identified that within two and a half years, homeless patients cost RPH between $202,860 and $623,000 per person.²

Economic evaluation has shown that providing a homeless person with housing and support can result in substantial savings to the health care system.³¹ The National Partnership Agreement on Homelessness and the Australian Housing and Urban Research Institute identified that $5000 per person per year was saved through providing housing to homeless subjects.³¹ This equates to over $16 million saved annually within the state government health care system.³¹

Coupling housing with support services equated to a larger amount of financial benefits to the health care system, with over $13,000 per person per year being saved.³¹ The greatest savings to the health care system were seen amongst homeless clients who accessed housing and mental health support services, with over $84,000 saved per person per year.³¹ There is potential to reduce the cost that homelessness has on the health care system by directing homeless patients to housing and support services (see section 6.1 Housing first).³¹,⁵⁷
5 Important considerations when treating a homeless patient

5.1 The social determinants

‘What good does it do to treat people and send them back to the conditions that made them sick?’

The health of homeless people is strongly determined by social circumstances.\(^2,3\) Considering the social determinants of health is essential when delivering treatment to homeless patients.\(^1,2\) The social determinants of health outlined by the World Health Organisation (WHO) describe multiple factors that determine a person’s health outcomes.\(^1\) The social determinants of health occur beyond the medical setting and instead impact aspects of everyday life.\(^3\)

According to the WHO the social determinants can be defined as:

‘the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.’ [http://www.who.int/social_determinants/en/]

Social determinants of health encompass:\(^1,3\)

- **The social gradient:** This reflects the correlation between socioeconomic status and health outcomes. People high on the social ladder or gradient (the wealthy) have better health outcomes and live longer than people who are lower on the ladder (those experiencing poverty).\(^3\)
- **Social stressors:** Long-term stress is damaging to health and reduces length of life.\(^3\) Situations that cause stress include social isolation, financial difficulties, domestic violence, relationship problems, unstable housing, racism, discrimination and unemployment.\(^4\)
- **Childhood and teenage experiences:** Poor nutrition, lack of education, abuse, poverty and trauma during early life stages can harm growth and development.\(^3\) The consequences of this are carried into adulthood, increasing the risk of chronic disease, poor mental health and poverty.\(^3\)
- **Social isolation:** Groups who often experience social exclusion include refugees, people who have a disability, people who are homeless and other minority groups.\(^3\) Discrimination and racism can lead to social isolation. Social isolation a risk factor for increased morbidity and mortality.\(^3\)
- **Unemployment:** Homeless people experience high rates of underemployment.\(^4\) Unemployed individuals and their families are at an increased risk of poor physical health, mental health and premature death.\(^3\)

- **Social support:** The absence of supportive relationships results in a reduction of well-being and increased risk of disability, depression and chronic disease.\(^3\) Homeless
people may have been a part of an abusive relationship, leading to physical and mental health complications.\textsuperscript{33}

- **Substance use and addiction:** A high proportion of homeless people are known to use multiple drugs, smoke tobacco and drink unsafe amounts of alcohol.\textsuperscript{41} Substance use and addiction is associated with social isolation, poor health and overall decrease in quality and length of life.\textsuperscript{33}

- **Financial and food security:** Homeless people face extreme poverty and financial instability. As a result, the homeless aren’t often able to afford regular nutritious meals, clothes, hygiene products, transport or medication.\textsuperscript{39} Due to the inability to afford such necessities malnutrition and illness are more likely to occur.\textsuperscript{18, 33}

- **Transport:** People who are homeless may experience geographical isolation due to the inability to afford their own vehicle, fuel or public transport.\textsuperscript{39} This reduces their ability to attend appointments and access essential services.\textsuperscript{39} Overall, the inability to travel is known to increase the risk of poor health outcomes.\textsuperscript{33}

- **Housing:** The absence of adequate, affordable and stable accommodation directly increases the risk of poor physical and mental health outcomes.\textsuperscript{35} The quality of housing which allows people access to clean water, sanitation facilities and safety is a major contributor to health.\textsuperscript{35}

Recognising and anticipating the impact that social factors have on a homeless person’s health will assist in appropriate referral onto relevant social and community services (refer to sections 7.0 Practical recommendations and 8.0 Referring a homeless patient).\textsuperscript{13} For example, a homeless person may not be able to access outpatient appointments due to financial and transport limitations, or be able to receive notification of appointments due to the absence of a contact address or telephone.\textsuperscript{39} Engaging with social and community services will assist in overcoming such barriers through the development of an alternative treatment plan or transport arrangements (see section 7.2 Development of a care plan).\textsuperscript{44} Without addressing the social determinants, high readmission rates to hospital are likely to continue to occur for homeless patients.\textsuperscript{1, 2} Inquiry into a patient’s social determinants should take place if a patient continues to present regularly to hospital.\textsuperscript{39}

The relationship between homelessness and health is ‘bi-directional’, as poor health can lead to homelessness and homelessness can lead to poor health (see Figure 1).\textsuperscript{2} This is also true for homelessness and the social determinants. For example social isolation may lead to poor mental health, followed by homelessness.\textsuperscript{1} The reverse can also occur and homelessness can be the direct cause of social isolation and poor mental health.\textsuperscript{1}
Figure 1 Bi-directional relationship between health, social determinants and homelessness

The American Academy of Family Physicians (AAFP) adopted a screening tool for patients to assess the social determinants of health, allowing for holistic insight into social factors that influence a patient’s health (see Appendix 1). This tool is worded in a sensitive manner to ensure patients do not feel discriminated against, allowing for honest insight into what is impacting a person’s ability to acquire good health. Identifying the stability of a patient’s housing and social situation enables health care professionals to appropriately refer patients onto relevant services.

5.2 Maslow’s Hierarchy of Needs

‘If you’re hungry and cold and haven’t got anywhere to sleep, you’re going to deal with those things first, not health issues.’

Maslow’s Hierarchy of Needs acts as a useful model to enhance understanding of the difficulties homeless people experience when trying to prioritise health and overcome barriers to accessing health care.

Addressing health concerns for a homeless person is difficult to prioritise amongst the everyday challenges of sourcing basic necessities. Consequently there is likely to be a mismatch in treatment priorities between the patient and the health professional. For example a homeless patient may present to hospital with a range of health conditions such as skin infections, asthma, drug dependence and mental health issues. Yet, despite presenting with multiple health complications, it is likely that the patient feels they more urgently need something to eat to satisfy hunger or perhaps an extra jacket for warmth. It is important to acknowledge and
ask about where health concerns fit amongst the client’s priorities. Such acknowledgement will ensure any issues inhibiting the patient’s ability to prioritise health are addressed and the patient is ready and prepared to engage with treatment.

Maslow’s Hierarchy of Needs outlines categories of sequential needs that must be progressively obtained in order for a person to reach optimum quality of life. This Hierarchy supports the idea that for a person who is homeless to consider addressing and sustaining health, basic needs must be met first. Homeless individuals may struggle to meet basic physiological needs such as access to food, shelter, clothing and a safe and comfortable place to sleep. These unmet needs act as a barrier to the progressive acquirement of safety and security, further resulting in poor health outcomes (see Figure 2).

![Maslow's Hierarchy of Needs](image)

**Figure 2 Maslow’s Hierarchy of Needs**
5.3 Barriers to health care

‘A lot of patients reiterate the fact they don’t like to see doctors. This makes me mindful that building trust and rapport and creating a positive health experience is essential to ensure these patients are more likely to connect with the medical system again.’

Many people who are homeless have indicated they do not regularly obtain medical treatment when needed. There are numerous barriers to health care that exist for people who are homeless such as:

- absence of health insurance
- competing priorities such as sourcing basic needs
- financial insecurity
- fear of discrimination due to past negative experiences with health care
- mental health problems
- difficulty getting to appointments within strict business hours.

The high prevalence of psychiatric problems amongst homeless patients is one of the most common barriers to accessing health care. Depression, anxiety, schizophrenia, bipolar disorder and other personality disorders are common amongst homeless people. Each psychiatric problem can uniquely impede upon a person’s ability to interact with others and undertake self-care. Booking and attending a doctor’s appointment can be confronting task that acts as a barrier to care for a homeless person with poor mental health.

Health Service’s business hours, appointment times, forms requiring adequate literacy skills and the location of services may reduce accessibility to health care for a homeless person. The absence of basic needs such as those outlined in section 5.2 Maslow’s Hierarchy of Needs can also act as barriers to homeless people accessing health care.

Drop in Clinics and Street Doctor services are designed to reduce barriers for homeless patients (see section 5.3 Barriers to health care). Such services also work to provide patients with basic necessities such as food, clothes and comfort to ensure the patient is more able to focus on their health.
Evidence based interventions

6.1 Housing first

As stated in section 5.2 Maslow’s Hierarchy of Needs, a person must have adequate access to housing, safety and physiological necessities before being able to address and maintain health.\(^{13,50}\) The housing first approach acknowledges the sequence of such needs and considers housing as an essential human right.\(^{50}\) Housing first ensures a person is housed before they are expected to fulfil any responsibilities or behaviour change.\(^{51}\) The housing first approach has demonstrated effectiveness in transitioning people who are homeless into stable housing.\(^{12}\)

Adoption of the housing first approach has occurred in response to poor tenant retention rates demonstrated by traditional housing ready programs.\(^{51}\) The housing ready approach is structured so that homeless clients are required to recover from any addictions or other social and health problems prior to being considered eligible to be housed.\(^{52}\) The housing ready approach does not take into account that people who are homeless do not have the resources or support available to undertake such drastic changes.\(^{53}\) Such expectations are recognised as being unrealistic without providing adequate assistance in the form of resources, security, stability and support.\(^{52}\)

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**Case Study: Homeless Healthcare ‘Elderly man’**

“An elderly Aboriginal man walked away from the soup van, he had no shoes and a very dirty bandage on his left foot. We asked if he would like his bandage changed, he agreed. This delightful man, Ian, was in Perth from Cotton Creek for a funeral. He had stepped on glass and had it removed and sutured 2 weeks prior. It was difficult to get a lot of information from Ian as his English was limited (he speaks 6 Aboriginal languages) and he was very shy. On examination his foot was in a terrible state, the odour was putrid, skin had broken down and ulcerated, the sutures were still in but had torn open.

Ian is a diabetic; he has neuropathy to his feet (no sensation) and very poor blood supply. He also just wanted to go back to Cotton Creek so his foot was very low on his priority. After cutting dressings off Ian’s’ foot, removing sutures and dressing the foot as best we could we supplied him with clean socks (donated by Rotary) and he was given a pair of thongs by the soup van staff. An appointment was set up with Homeless Healthcare for further treatment at the Ruah centre immediately. The Crossroads Outreach workers were also in attendance at the soup van and they transported Ian to Ruah.

He was seen by a doctor, linked up with a case worker to help with accommodation or transport back to Cotton Creek. This man was definitely at risk of losing his foot and may still be, but he would not have presented at Royal Perth Hospital for fear of being admitted.”

Sourced from Homeless Healthcare on 20/04/2018 via link below

Homeless services traditionally worked like a reward system: Kick an addiction, get a home. Take some medication, get counselling.\textsuperscript{54 p.1}

50 Lives 50 Homes is a housing first project currently in progress in Perth WA, which aims to provide housing and support to 50 homeless people.\textsuperscript{12} The project utilises a collaborative approach that encompasses the importance of housing and health, and recognises that clients are at risk of returning to homelessness and may come in contact with the justice system.\textsuperscript{12} Currently the project has housed 42 individuals and 8 families.\textsuperscript{12} Since being housed, Perth clients have reduced the frequency of ED presentations and shown an improvement in their overall health.\textsuperscript{12} Furthermore a subsequent decrease in costs to the health care system has also resulted.\textsuperscript{2,12}

The 50 Lives 50 Homes project is being implemented in a number of states across Australia. Evaluation of the project in other states has revealed a tenant retention rate of 84\% for at least one year.\textsuperscript{2,12} In comparison, the housing ready approach has demonstrated a much lower average for tenant retention rates, with less than 47\% retention.\textsuperscript{2,55} These findings are consistent with results from other international studies, indicating that the uptake of a housing first approach offers more sustainable benefits for both the client and government resources compared to the housing ready approach.\textsuperscript{31,55,56}

6.2 Pathway Homeless Healthcare

‘Our hospital teams build relationships with homeless patients who have complex needs, support them as individuals through their time in hospital, and coordinate their care and their discharge from hospital with the many different professional teams who may be working with our patients beyond the confines of the hospital.’\textsuperscript{58 p.3}

The Pathway Homeless Healthcare Program in the United Kingdom has demonstrated success in reducing the hospital ED attendance rates of homeless patients.\textsuperscript{57} As a result of Pathway, one hospital reported the number of homeless ED attendees reduced from 195 to 68 over a two month period.\textsuperscript{57} Other hospitals reported a 30-66\% reduction in length of stay for homeless patients, 43\% reduction in ED presentations and saved hundreds of days in length of stay.\textsuperscript{57} These results came after a 12 month Pathway intervention.\textsuperscript{57}

The model of care adopted by Pathway is informed by principles of Inclusion Health.\textsuperscript{58} Inclusion Health aims to prevent and restore health and social inequities among vulnerable and marginalised groups.\textsuperscript{58} The Pathway model was developed to improve the standard of care provided to homeless patients in hospital.\textsuperscript{58} The following project aims were outlined:\textsuperscript{58}

- transform the quality of patient/staff relationships, through changing staff behaviours, attitudes and practice
- test, enhance and prove the Pathway model is both replicable and transferable to other hospitals that see a high number of homeless patients
• improve connections between primary and secondary care, to reduce admissions to hospital demonstrating compassion and commitment to homeless healthcare, advocate for patients and put in place care navigation programs.

The success of Pathway can be attributed to methods that ensure homeless patients are identified and connected to relevant health, social and community services. The program enables a systematic approach to addressing the health vulnerabilities of people who are homeless. Pathway acknowledges it is not the responsibility of the doctor or the hospital staff to solve homelessness, however, doctors and hospital staff can play a key role in connecting homeless patients to specialist services.

Pathway encourages all hospital staff to be mindful of the need to prioritise tailored care to homeless patients. This approach aims to increase the likelihood that homeless people will seek medical intervention at earlier stages of illness or injury. Early intervention may work to prevent health issues from progressing to more severe stages.

Pathway acknowledges that a multidisciplinary team is essential to efficiently and thoroughly address the multiple issues that people who are homeless face. For example, working collaboratively with social workers in hospitals can provide valuable contribution when creating a care plan and referring patients onto social services. Social workers may also play a key role in advocating for homeless patients, ensuring that their needs are prioritised in a busy hospital setting.
7 Practical recommendations

7.1 Care during consultation

The Standards for Working with Homelessness developed by Pathway may act as a useful guide to assist JMOs in providing health care to the homeless.64 A number of points from Pathway standards are outlined below.64

- if a patient reveals they are homeless, assist them in accessing any type of healthcare they need
- try to ensure that housing status of “No Fixed Address” is recorded on forms and records
  - encourage other clinicians to record and update housing status for all patients
  - ask patient for contact numbers or the address of a GP, transitional housing, case manager, or other service that they regularly attend
- ask for next of kin details, but be mindful that this may be a sensitive question, as the person may have lost touch with their family
  - if the patient does not wish to give next of kin details, ask them if there is a friend or support worker who could be contacted in an emergency
- allow longer appointment times for patients with multiple problems and those facing addiction, mental health issues or cognitive difficulties
  - where possible provide other staff with an alert or a reminder to consider this when booking appointments
  - identify the best method of reminding the patient of their upcoming appointments
  - where possible allow for some flexibility for homeless patients in keeping and attending appointments on time
  - if appropriate allow patients the option of bringing their support or case worker to appointments, as this may assist the patient with remembering appointment details
- seek an interpreter, translator or someone who can communicate through sign language if additional communication support is needed
  - record any communication support used, to ensure the services can be booked in advance for future appointments
- if the patient is required to complete paper work, be sure to ask if the patient needs assistance
  - be prepared to provide the assistance or have contacts on standby that can help
- ensure cultural competency is prioritised throughout all areas of care
  - be aware of common cultural practices and adapt practice accordingly
  - be mindful of cultural practices that relate to gender
- provide specialised support for victims of domestic violence
  - this may involve recording preference of clinician gender
- ensure a list of social and community services is easily accessible for referral
  - provide patients with information on the services
7.2 Evaluation of living conditions

It is recommended that health professionals have an understanding of the factors that lead to and exacerbate homelessness. Through gaining knowledge of the social determinants, Maslow’s Hierarchy of Needs and barriers to health, health professionals are more equipped to adapt their practice to meet the needs of the homeless. The translation of such knowledge into practice is vital to improve the health and health care experiences of homeless patients.

It has been acknowledged that there can be challenges associated with treating a homeless patient and unique difficulties can arise when trying to identify and confirm if a person is homeless. If a patient regularly presents to ED or other health services and are suspected to be homeless, it is recommended that health professionals ask the patient about their living conditions and history of homelessness. To evaluate the quality of a patient’s living conditions and the social circumstances impacting their health, questions regarding the following can be useful:

**Living conditions**

- ask the patient where they are staying and if they feel their health and safety are threatened
- questions regarding access to food, water, a bathroom and a safe place to store medication help to identify the patient’s immediate needs

**Past and current homelessness**

- identifying a patient’s past and current experiences of homelessness can assist in refining which services are appropriate for referral
- ask if the patient has been homeless before and if homelessness has been chronic or episodic
- identifying what lead to the person becoming homeless can also assist in understanding the patient’s needs
  - for example, if a patient is has been in an abusive relationship it may be best suited to refer the individual onto support services specialising in domestic violence
  - it is important to remember that the patient may not wish to discuss such details as they may be afraid of judgment or retelling the circumstances may be too traumatic. If that is the case, reassure the patient that they are in a safe environment and they are welcome to discuss such matters when they feel comfortable.
**Social determinants** (see section 5.1 The social determinants)

- assessing the social needs of a patient is essential for the development of a care plan that will assist the patient in achieving sustainable health outcomes
- The Social Needs Screening Tool contains multiple choice questions that assess housing, food, safety and transportation (see Appendix A: Social Needs Screening Tool)
- evaluating the social factors impacting a patient’s health will assist in guiding referral and enrich understanding of the patient’s health concerns and risks.

### 7.3 Development of a care plan

Developing a detailed care plan is known to be an effective tool when treating homeless patients. A quality care plan generally will integrate the following:

- a social worker and/or case worker
- a range of health care specialists
- social and community services
- appropriate medication
- patient’s basic needs and priorities

A care plan should be developed using a patient centred approach to ensure the plan is achievable and relevant to the individual. A patient centred approach has been defined by the Institute of Medicine as care that is compassionate, empathetic and responsive to the needs, values and preferences of each patient and patients should be informed decision-makers in their care.

The principles outlined in Maslow’s Hierarchy of Needs play an important role in the development of a care plan. Displaying an understanding that health cannot be fully obtained until basic physiological needs are met is vital when developing a care plan for a homeless patient.

Collaboratively develop strategies with the patient to meet basic needs such as food, shelter and clothing. This process aims to enhance both the patient’s health outcomes and their sense of stability.

The development of a care plan using a patient centred approach will highlight priorities and goals identified by the patient. Asking the patient about their short and long term health goals and priorities will help to gain patient trust and enhance their engagement in treatment. Once priorities have been discussed it is advised that the most immediate health concerns are addressed first.
7.4 Action plan

An action plan can act as a useful tool to keep both practitioner and patient well informed.\cite{85} The action plan should be easy for the patient to understand and it can include the following:\cite{85}

- contact details of referred services
- places to contact for support and health care after hours
- patient goals
- appointment details
- transport assistance
- information about dosage and storage of medications
- support services for reading and completing forms if the patient is unable to adequately do so alone.

Homeless outpatients may be challenging to contact due to a range of factors such as; no fixed address, mobile numbers may change regularly, no next of kin and limited access to internet.\cite{72,69,70} As advised above in section 7.0 Practical recommendations, multiple contact details should ideally be collected from the patient.\cite{85} Details may include; the location of where the patient usually sleeps, a facility that the patient regularly gets food from, transitional housing, boarding house or a shelter.\cite{85} Emergency contact details may include a GP, case manager or a friend or family member that has a stable address.\cite{85}

People who are homeless may not have reliable access to a secure or appropriate place to store medication and paperwork.\cite{47,85} This should be considered when prescribing medication and dosages to homeless patients.\cite{71,85} The inability to afford medication may also act as a barrier to adhering to a medication regime, social workers and case workers may be able to reduce this barrier by assisting the patient with their finances.\cite{86} The potential for misuse of medications should also be thoroughly evaluated.\cite{85} Where possible it is recommended to prescribe a simple medication regime, along with daily dispensing of medication from a health care site or a pharmacy.\cite{85} These strategies may reduce barriers to adherence.\cite{85}
7.5 Trauma-informed care

"we will be unable to solve the issue of homelessness without addressing the underlying trauma that is so intricately interwoven with the experience of homelessness."^{75} p.81

It is important to be aware of models of care that may assist in managing a homeless patient who appears mentally unstable during consultation. Poor mental health and drug dependent coping mechanisms may be a result of past traumatic experiences. The instability of a homeless patient’s mental health can result in hypersensitivity, paranoia and subsequent difficulties during consultations. Adopting methods outlined in the principles of trauma-informed care (TIC) can assist in enhancing JMOs understanding and management of episodes of anxiety, aggression or fear presented by a patient.

For people who have experienced trauma and are mentally unstable, their perception of a situation and interaction can be significantly distorted. Such perceptions result from ongoing post-traumatic stress, which impacts the way a person functions, interacts with others and further complicates how they perceive themselves.

The impact of past traumatic experiences can act as a barrier to accessing health care services. The mental instability of homeless people who have experienced trauma may result in distrust and fear when interacting with health professionals. Additionally, some trauma affected patients have experienced mistreatment from health professionals who did not have the knowledge to appropriately address such situations. As a result, such patients may be
reluctant to seek health care again out of fear of being mistreated.\textsuperscript{75} This reluctance can result in an increase in late presentation for medical treatment, a subsequent decrease in health and an increase in costs to the health care system.\textsuperscript{13}

To deliver effective health care to people who have experienced trauma, it is recommended that methods of caution are adopted to ensure patients feel comforted and understood. Application of the principles of TIC works to create a safe and sensitive consultation environment.\textsuperscript{74,75} This will assist in reducing any distress that homeless patients exhibit in a health care setting.\textsuperscript{74,75} See Table 1.\textsuperscript{75}
## Table 1 Principles of trauma-informed care

<table>
<thead>
<tr>
<th>Principle</th>
<th>Recommendation</th>
<th>Relevant resources</th>
</tr>
</thead>
</table>
| Understand trauma and its impact       | JMOs are advised to acknowledge that if a homeless patient behaves aggressively or fearfully, it is likely that such behaviour may have been adopted by the individual as a coping and safety mechanism in response to past traumatic experiences. | Utilise professionals such as:  
- mental health nurse  
- psychologist or psychiatrist  
- social worker  
- alcohol and drug worker  
- Aboriginal health worker.  
Drawing on lessons learned from any mental health education may also assist in forming strategies to assist the patient. |
| Promote safety                         | JMOs should provide consistent, predictable and respectful services to ensure a safe physical and emotional environment is established. JMOs are recommended to consult with patients to highlight expectations around what a safe and consistent environment entails for the patient. | Strategies to create a safe environment may involve:  
- allow patients to bring a friend or family member to appointments  
- mental health professionals (as listed above)  
- if JMOs feel their safety or the patient’s safety is at risk, hospital security can be called upon. |
| Ensure cultural competence             | Cultural awareness online training is a mandatory course across WA Health and HSPs. Gaining cultural competency will assist in understanding the diversity of responses to trauma and allow for the uptake of appropriate cultural practices and referral to services. |  
- Aboriginal health workers and translators may assist  
- professionals who specialise in delivering culturally safe services will help to inform appropriate practice  
- complete cultural training as soon as possible and take on any additional opportunities to learn about cultural awareness, respect and sensitivity. |
| Support patient control, choice and autonomy | It is advised that JMOs keep the patient well informed of all decisions and processes, to assist in gaining trust and encourage participation. As previously stated in section 7.3 Development of a care plan, prioritising a patient centred approach is a key recommendation for JMOs. |  
- A case worker or social worker may assist by supporting the patient in obtaining relevant services  
- Case workers may assist in managing barriers the patient has such as the absence of health insurance. |
| Integrated care                        | As discussed, maintaining a holistic and collaborative approach to health care will assist in addressing both social and medical factors impacting health.                                                                 | See section 7 Practical recommendations and 8.1 Considerations when making a referral to assist in providing integrated care.                                                                                       |
7.5 Addressing patient resistance

Rolling with resistance is a method that can be used to motivate healthy behaviour change. It is used to assist patients that are experiencing problems with the misuse of substances such as alcohol, tobacco and other drugs.

Adopting the process of rolling with resistance and motivational interviewing has shown to enhance engagement during consultations with homeless patients. Addressing the causes of resistance and empowering the patient to take control of their health may increase appointment attendance and commitment to improving health and health related behaviours.

Rolling with resistance encompasses strategies that enable a patient to reflect and feel in control of their treatment plan, rather than feeling they are being forced to make change. It is known that telling a person to do something often results in increased resistance and defensiveness; in comparison to a person voluntarily committing to undertake change. Rolling with resistance encourages patient engagement and ownership of their health through participation in reflection and patient centred discussion. Rolling with resistance encourages consultants to acknowledge a patient’s reasoning for being resistant and recognise that such reasons are important to the individual. Following such acknowledgment, it is recommended that consultants provide subtle enquiries during discussion that initiate patient self-reflection regarding their resistance to change. This process works to enhance patient self-awareness whilst also avoiding arguments and disputes.

Rolling with resistance aims to build patient self-efficacy and enhance their trust towards health care professionals. Empathy from doctors and health professionals may help to reduce patient resistance and subsequently enhance the patient’s willingness to discuss health concerns.

JMOs can use rolling with resistance at times when they recognise a patient is becoming defensive towards a proposed change. Further insight into resistance and methods to manage it are provided below in Table 2 Rolling with resistance. It is recommended that JMOs adopt the following strategies to effectively manage a patient’s resistance:

- ask open-ended questions: this requires the patient to elaborate rather than provide simple yes or no answers
- listen reflectively: reflecting back what the patient has said can reassure the client that they are being understood and heard
- provide client with affirmation: support and comment on the client’s strengths, motivation and progress
- prompt the patient to be self-motivated: allow the patient to voice their concerns and goals opposed to trying to convince the patient to undertake change.
Table 2 Rolling with resistance81

<table>
<thead>
<tr>
<th>What is resistance?</th>
<th>Reasons for resistance</th>
<th>Recommendations for action</th>
</tr>
</thead>
</table>
| Occurs if a health professional expects a patient to undertake behaviour change prior to the patient being ready to change patient will subsequently become defensive and less likely to consider or undertake any change | Displaying resistance is often a natural response to unexpected change the reason for resistance should be considered important. Discussing the reasons for resistance with the patient is essential to overcoming it | Issue related resistance:  
- empathise with any concerns the patient has and collaboratively explore options for going forward  
- adopt a non-judgemental approach and ensure the patient feels their concerns are being recognised  
- develop discrepancy to highlight the difference between the patient’s goals and their current behaviour - this will assist the patient in becoming more willing to change  
- promote self-belief and self-efficacy by adopting a strengths based approach towards the patient  
- adopt ‘change talk’ that motivates and moves the client in the direction of undertaking change rather than maintaining ‘status quo’. |

Types of resistance

**Issue related:** the patient’s resistance to change is associated with the specific behaviour; for example quitting smoking

**Relationship related:** the patient has an issue with the consultant or the healthcare setting.

<table>
<thead>
<tr>
<th>Issue related resistance:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relationship related resistance:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Types of resistance</th>
<th>Reasoning for resistance should not be neglected or disregarded it is important to identify the type of resistance to tailor the most appropriate response</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient's reasoning for resistance should not be neglected or disregarded it is important to identify the type of resistance to tailor the most appropriate response</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25
7.6 Providing care at discharge

International homeless health care research has indicated that homeless patients are often discharged prior to their health needs being fully met.\textsuperscript{27,82} Many homeless patients are also being discharged without staff considering the patient has nowhere to go and are at high risk of readmission.\textsuperscript{82} Both the patient’s health and their place to stay outside the hospital should be considered when determining if a patient is fit for discharge.\textsuperscript{82} For a homeless person that may not have a place to rest or a refrigerator to store medication, it may be necessary to keep them in hospital for a longer period of time to assist in preventing readmission.\textsuperscript{82}

\begin{quote}
Many clients linked their early discharge to worsening health and readmission to hospital.\textsuperscript{82} p.18
\end{quote}

Self-discharge has also been recognised as an issue when providing homeless patients with adequate care.\textsuperscript{82} Patients may self-discharge for a number of reasons related to mistreatment and drug and alcohol dependence.\textsuperscript{82,83} Other reasons why patients self-discharge may include:

- family responsibility
- feeling isolated or afraid
- miscommunication or poor relationship with hospital staff
- concerns related to housing and property
- loneliness
- language and cultural barriers
- Aboriginal patient wishes to die on their country
- perception it is ‘okay to go’. \textsuperscript{83}

In order to prevent patients from self-discharging, JMOs are recommended to make sure services are culturally safe (see Table 1 Trauma-informed care). It is important to check in with the patient to ask if there is any way that practices can be adjusted to help make the patient’s stay easier.\textsuperscript{82,83} Transferring and referring a patient to services that are closer to their home and family may beneficial to the patient’s health.\textsuperscript{83}
8 Referring a homeless patient

8.1 Considerations when making a referral

There is a need for a collaborative and a multidisciplinary approach when providing care to a homeless patient. There may be a need for numerous referrals to a range of services and specialists. It is important to ensure the patient understands the reason for each referral and that consent to be referred is obtained. See Appendix D: Example referral forms as a guide of what services may require in a referral.

A referral can be made in a range of ways including; a verbal referral, a written referral to one service, or a written referral to multiple services. For those making referrals, awareness of the specific service each agency offers is a key factor in ensuring a homeless patient receives relevant support. It is important to find out what the service or specialist requires in a referral to prevent complications for the patient.

The following guidelines provide useful points to consider before writing a referral for a homeless patient. Consider the following factors when referring a homeless patient to other services:

- identify any issues that may prevent the patient from attending appointments and devise plans to reduce the impact of those issues
- thoroughly explain what the service does and discuss any expectations the patient may have regarding the service
- obtain the patient’s consent to directly make the referral if they are unable to do so themselves
- ask the patient for feedback on the referred services and discuss if there is any need for alternative or additional referrals.
- look into any protocols the service may have for priority of access
- assess if it is possible for the patient to attend without an appointment
- find a contact person from the agency who can provide assistance if needed
- provide adequate information on the patient to the service to prevent duplication of questions.
8.2 Freo Street Doctor

‘Our services are accessible, physically in terms of being set up in central metropolitan or suburban community centres with the vans set up in a simple, non-ostentatious way; and financially, as our service is free.’\(^3\)\(^9\) p.\(^7\)

Homeless patients may face multiple barriers in accessing health care, as do health professionals in delivering health care to the homeless.\(^8\)\(^5\) A number of services in WA aim to assist people at various stages of homelessness by providing care in a range of settings.\(^3\)\(^9\),\(^8\)\(^6\)

Freo Street Doctor is a mobile primary health service that works to reduce the barriers people who are homeless encounter when accessing health care.\(^8\)\(^7\) The service provides a range of essential services which address issues that homeless people commonly present with such as:

- mental health problems
- chronic disease
- injuries
- addiction
- social and emotional concerns
- blood borne viruses
- diabetes

The service operates in a range of locations which works to reduce the barrier of travel and the Freo Street Doctor does not require patients to obtain a referral or book an appointment time.\(^8\)\(^7\) To overcome barriers related to financial insecurity, the Freo Street Doctor bulk bills all procedures, however, patients are required to have a Medicare card.\(^8\)\(^7\)

The Freo Street Doctor works collaboratively with a range of health care professionals and community services to ensure patients receive thorough medical and social assistance.\(^8\)\(^7\) Detailed information on Freo Street Doctor’s services, location and times can be found on their website (see link below).


8.3 Homeless Healthcare

Homeless Healthcare is a mobile GP service that operates throughout the Perth metropolitan area\(^8\)\(^6\). Homeless Healthcare has prevented near 2500 presentations to ED since 2016 as a result of just one program alone.\(^8\)\(^8\) A summary of the services provided by Homeless Healthcare are outlined in Table 3 below.\(^8\)\(^6\) Further information on the operating times and location of Homeless Healthcare can be found on their website (see link below).

https://homelesshealthcare.org.au
**Table 3 Homeless Healthcare services**

<table>
<thead>
<tr>
<th>Mobile Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and Alcohol Therapeutic Communities</td>
<td>As a large majority of homeless people present with problematic use of alcohol and other drugs, the Communities’ service provides tailored programs to reduce use and dependence.</td>
</tr>
<tr>
<td>Shelter</td>
<td>The Homeless Healthcare team set up clinics in a number of housing support services and temporary housing facilities. This service is targeted at homeless people whose current living situation is unstable or in temporary housing.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Many homeless people experience mental health problems. In the Homeless Healthcare mobile GP clinic, a Community Health Nurse provides specialised care to assist with the mental health of patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transitions Clinic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It is acknowledged that formerly homeless people remain vulnerable whilst transitioning into a home. The Transitions Clinic aims to assist formerly homeless people as they adjust to new living situations. This service works to prevent the reoccurrence of homelessness and assist formerly homeless people to enter mainstream health services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Health</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This service assists people sleeping rough who are unable to access health services. The Homeless Healthcare team travel to places where rough sleepers commonly reside such as parks, streets and other public places, along with soup kitchens.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Afterhours Support Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This service is offered to clients of the 50 Lives 50 Homes project, providing extended hours of support every day of the week. This service aims to increase tenant retention.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Royal Perth Hospital In-Reach Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This program works to address the high rates of homeless people who attend ED. The program ensures that homeless hospital patients are assisted by the Homeless Healthcare team and directed to specialist services.</td>
</tr>
</tbody>
</table>

**8.4 Local services**

The WA Department of Communities Child Protection and Family Support (DCCPFS) have developed a comprehensive list of community services located across the state. The list is categorised by location and type, with a range of services specialising in the social determinants related to homelessness. A summary of the DCCPFS resource lists has been provided in the Appendices. The information provided in the Appendices outlines services that are relevant to homelessness, a full list can be accessed on their website (see link below). [https://www.dcp.wa.gov.au/servicescommunity/Pages/Services%20by%20type.aspx](https://www.dcp.wa.gov.au/servicescommunity/Pages/Services%20by%20type.aspx)

Entrypoint Perth is a free service providing assessment and referrals for homeless and people at risk of homelessness. It is the first point of contact for families and individuals who require access to Specialist Homelessness Services (SHS) and other accommodation and/or support services in the Perth metropolitan area. Entrypoint Perth works with other agencies to streamline the referral process for people who may need crisis accommodation, referrals to short or long term accommodation, or assistance with sustaining current tenancies.

9 Conclusion

JMO’s providing health care for homeless people can use a range of models and tools to assist in gaining a better understanding of their patients. A holistic approach is required to adequately address the interconnectedness between the medical and social factors that influence the health and wellbeing of homeless people. A greater understanding of these factors can result in better health outcomes for the patient and can also improve the clinical experience that JMOs have when supporting a homeless patient.

Many of the tools provided throughout this report offer strategies to better communicate with patients about their individual needs. It is not intended that a JMO should use all tools as a combined treatment approach, instead a range of options have been included which can be adapted and incorporated into care plans according to both the clinician and patient circumstances.

As the report has demonstrated there are many agencies who have significant experience in working with homeless people. It is these groups who can also provide expert advice and support to JMOs as they build their skills in working with homeless people. Through collaborating with a range of health professionals and providing specialised care, homeless patients are more likely to sustain positive outcomes and show a reduction in hospital presentations.²

Providing health care for homeless people is complex and requires patience, perseverance and flexibility to find the best solutions for each individual. The simple act of being respectful and listening to the patient needs can go a long way in providing support to this very vulnerable group.

“The many health issues of homeless individuals cluster with, and are exacerbated by, other social determinants of health such as psychological trauma, poverty, unemployment, domestic violence and social disconnection… Awareness and understanding of these underlying issues is critical to effective healthcare.”²
Appendices

Appendix A: Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING
1. What is your housing situation today?
   - [ ] I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a bench, in a car, abandoned building, bus or train station, or in a park)
   - [ ] I have housing today, but I am worried about losing housing in the future
   - [ ] I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - [ ] Bug infestation
   - [ ] Mold
   - [ ] Leaky paint or pipes
   - [ ] Inadequate heat
   - [ ] Oven or stove not working
   - [ ] No or not working smoke detectors
   - [ ] Water leaks
   - [ ] None of the above

FOOD
3. Within the last 12 months, you worried that your food would run out before you got money to buy more.
   - [ ] Often true
   - [ ] Sometimes true
   - [ ] Never true

4. Within the last 12 months, the food you bought just didn’t last and you didn’t have money to get more.
   - [ ] Often true
   - [ ] Sometimes true
   - [ ] Never true

TRANSPORTATION
5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)
   - [ ] Yes, it has kept me from medical appointments or getting medications
   - [ ] Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - [ ] No

UTILITIES
6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   - [ ] Yes
   - [ ] No
   - [ ] Already shut off

PERSONAL SAFETY
7. How often does anyone, including family, physically hurt you?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Fairly often
   - [ ] Frequently

8. How often does anyone, including family, insult or talk down to you?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Fairly often
   - [ ] Frequently

9. How often does anyone, including family, threaten you with harm?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Fairly often
   - [ ] Frequently
10. How often does anyone, including family, scream or curse at you?
- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

ASSISTANCE

11. Would you like help with any of those needs?
- Yes
- No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

## Appendix B: WA local services

### Table 4 Homelessness accommodation support workers

<table>
<thead>
<tr>
<th>Where is the service? Metropolitan area (MA)</th>
<th>What is the name of the service?</th>
<th>What are their contact details?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2302-2308 Albany Hwy, Gosnells 6110</td>
<td>Centrecare Inc</td>
<td><a href="mailto:gosnells@centrecare.com.au">gosnells@centrecare.com.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(08) 9498 9200</td>
</tr>
<tr>
<td>40 Orr Street, Maddington 6109</td>
<td>Mission Australia</td>
<td><a href="mailto:mills@missionaustralia.com.au">mills@missionaustralia.com.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(08) 9262 4200</td>
</tr>
<tr>
<td>241-243 High Street, Fremantle 6160</td>
<td>Fremantle Multicultural Centre Inc</td>
<td><a href="mailto:Administration@fmcwa.com.au">Administration@fmcwa.com.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9336 8282</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fremantle Multicultural Centre</td>
</tr>
<tr>
<td>85 Boas Avenue, Joondalup 6027</td>
<td>Centrecare Inc</td>
<td><a href="mailto:joondalup@centrecare.com.au">joondalup@centrecare.com.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CentreCare</td>
</tr>
<tr>
<td>1/70 Davidson Terrace, Joondalup 6027</td>
<td>Youth Futures WA Inc</td>
<td><a href="mailto:youthfutureswa@youthfutureswa.org.au">youthfutureswa@youthfutureswa.org.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>08 9300 2677</td>
</tr>
<tr>
<td>Joondalup</td>
<td>Patricia Giles Centre Inc (for women only)</td>
<td><a href="mailto:pgc-housing@iinet.net.au">pgc-housing@iinet.net.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For women's counselling: 08 9300 1022</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For refuge: 08 9300 0340</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://patgilescentre.org.au/">http://patgilescentre.org.au/</a></td>
</tr>
<tr>
<td>Midland</td>
<td>Indigo Junction</td>
<td><a href="mailto:youth@indigojunction.org.au">youth@indigojunction.org.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>08 9274 1611</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://indigojunction.org.au/">https://indigojunction.org.au/</a></td>
</tr>
<tr>
<td>Suite 3, 7 Anzac Place, Mandurah 6210</td>
<td>Westaus Crisis and Welfare Service Inc</td>
<td><a href="mailto:admin@westauscrisis.com.au">admin@westauscrisis.com.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9582 9920</td>
</tr>
<tr>
<td>14 Council Ave, Rockingham 6189</td>
<td>Anglicare WA Inc</td>
<td><a href="mailto:housing@anglicarewa.org.au">housing@anglicarewa.org.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(08) 9528 0702</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://www.anglicarewa.org.au">https://www.anglicarewa.org.au</a></td>
</tr>
<tr>
<td>Where is the service?</td>
<td>What is the service?</td>
<td>What are their contact details?</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>1917 –1923 Albany Hwy, Maddington</td>
<td>Ruah Community Services – Ruah Tenancy Support</td>
<td><a href="mailto:connecting@ruah.org.au">connecting@ruah.org.au</a> 9493 5021 <a href="https://www.ruah.org.au/">https://www.ruah.org.au/</a></td>
</tr>
<tr>
<td>40 Orr Street, Maddington 6109</td>
<td>Mission Australia - Wattle House</td>
<td><a href="mailto:wattlehouse@missionaustralia.com.au">wattlehouse@missionaustralia.com.au</a> 9493 2447 <a href="https://www.missionaustralia.com.au/">https://www.missionaustralia.com.au/</a></td>
</tr>
<tr>
<td>2117 Albany Highway, Gosnells 6109</td>
<td>Moorditch Gurlongga Association Inc – Coolabaroo Housing Service</td>
<td>9490 4333 <a href="mailto:housing@coolabaroo.com.au">housing@coolabaroo.com.au</a> <a href="http://coolabaroo.com.au/">http://coolabaroo.com.au/</a></td>
</tr>
<tr>
<td>12 Queen Victoria St Fremantle 6160</td>
<td>St Patrick’s Community Support Centre Ltd</td>
<td><a href="mailto:admin@stpats.com.au">admin@stpats.com.au</a> 9430 4159 <a href="http://stpats.com.au/services/housing/">http://stpats.com.au/services/housing/</a></td>
</tr>
<tr>
<td>Unit 5/5 Aberdeen Street, East Perth 6004</td>
<td>UnitingCare West – Accommodation Service</td>
<td><a href="mailto:residential@unitingcarewest.org.au">residential@unitingcarewest.org.au</a> 9220 1288 <a href="http://www.unitingcarewest.org.au/">http://www.unitingcarewest.org.au/</a></td>
</tr>
<tr>
<td>241-243 High Street (Corner of Ord Street), Fremantle 6160</td>
<td>Fremantle Multicultural Centre Inc – Crisis Accommodation for Refugees and Migrants</td>
<td><a href="mailto:Administration@fmcwa.com.au">Administration@fmcwa.com.au</a> 9336 8282 <a href="http://www.fmcwa.com.au/">http://www.fmcwa.com.au/</a></td>
</tr>
<tr>
<td>456 Hay Street Perth 6000</td>
<td>Centrecare Inc – Centrecare Family Accommodation Service – CFAS</td>
<td><a href="mailto:enquiries@centrecare.com.au">enquiries@centrecare.com.au</a> (08) 9325 6644 <a href="https://www.centrecare.com.au/">https://www.centrecare.com.au/</a></td>
</tr>
<tr>
<td>Where is the service?</td>
<td>What is the service?</td>
<td>What are their contact details?</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>255 Hay Street, Subiaco</td>
<td>Ruah Community Services – Ruah Centre</td>
<td><a href="mailto:connecting@ruah.org.au">connecting@ruah.org.au</a> 9328 7682 <a href="https://www.ruah.org.au/">https://www.ruah.org.au/</a></td>
</tr>
<tr>
<td>Unit 6 / 5 Aberdeen Street, East Perth 6004</td>
<td>UnitingCare West – Tranby Day Centre</td>
<td><a href="mailto:tranby@unitingcarewest.org.au">tranby@unitingcarewest.org.au</a> 9220 1200 <a href="http://www.unitingcarewest.org.au/">http://www.unitingcarewest.org.au/</a></td>
</tr>
<tr>
<td>2 Midland Square, Midland 6056</td>
<td>Swan Emergency Accommodation</td>
<td>9274 1611</td>
</tr>
<tr>
<td>10/18 Lavant Way Balga 6061</td>
<td>Salvation Army (WA) Property Trust – Balga Family Accommodation Service</td>
<td>9349 7488 <a href="http://www.salvationarmy.org.au/wa">http://www.salvationarmy.org.au/wa</a></td>
</tr>
<tr>
<td>61 Woodrow Ave Yokine 6060</td>
<td>Jewish Care WA (Inc) – Rae Lenny Shalom House</td>
<td><a href="mailto:office@jewishcarewa.com.au">office@jewishcarewa.com.au</a> 9275 6743 <a href="mailto:socialworker@jewishcarewa.com.au">socialworker@jewishcarewa.com.au</a></td>
</tr>
<tr>
<td>Peel</td>
<td>Westaus Crisis and Welfare Service Inc – Westaus Accommodation Advocacy and Support Peel – WAASP</td>
<td>9582 9920 <a href="http://www.westauscrisis.org.au/">http://www.westauscrisis.org.au/</a></td>
</tr>
<tr>
<td>Perth</td>
<td>Perth Asian Community Centre Inc – Perth Asian Community Centre</td>
<td>9328 2237 <a href="mailto:pacc@optusnet.com.au">pacc@optusnet.com.au</a></td>
</tr>
<tr>
<td>Perth</td>
<td>Salvation Army (WA) Property Trust – Bridge House</td>
<td>9227 8086 <a href="http://www.salvationarmy.org.au/wa">http://www.salvationarmy.org.au/wa</a></td>
</tr>
<tr>
<td>Location</td>
<td>Service Provider</td>
<td>Contact Details</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Perth</td>
<td>St Bartholomew’s House Inc – Barts Plus</td>
<td>9323 5179 <a href="http://www.stbarts.org.au/">http://www.stbarts.org.au/</a></td>
</tr>
<tr>
<td>Perth</td>
<td>St Bartholomew’s House Homeless and Transitional Support Services</td>
<td>9323 5179 <a href="http://www.stbarts.org.au/">http://www.stbarts.org.au/</a></td>
</tr>
<tr>
<td>Perth</td>
<td>55 Central Inc – 55 Central</td>
<td>9227 1333 <a href="http://55central.asn.au/">http://55central.asn.au/</a></td>
</tr>
<tr>
<td>Perth</td>
<td>Salvation Army (WA) Property Trust – Salvation Army Men’s Homelessness Service</td>
<td>9313 2727 <a href="http://www.salvationarmy.org.au/">www.salvationarmy.org.au</a> <a href="mailto:allan.gould@aus.salvationarmy.org">allan.gould@aus.salvationarmy.org</a></td>
</tr>
<tr>
<td>Perth</td>
<td>Multicultural Housing Services Program</td>
<td>9328 1544 <a href="http://mscwa.com.au/">http://mscwa.com.au/</a></td>
</tr>
<tr>
<td>Rockingham</td>
<td>Communicare Inc – Communicare Breathing Space</td>
<td>9439 5707 <a href="https://www.communicare.org.au/">https://www.communicare.org.au/</a> <a href="mailto:breathingspace@communicare.org.au">breathingspace@communicare.org.au</a></td>
</tr>
<tr>
<td>Rockingham</td>
<td>Communicare Inc – Safe at Home Perpetrator Response</td>
<td>Specialist referral only <a href="https://www.communicare.org.au/">https://www.communicare.org.au/</a> <a href="mailto:breathingspace@communicare.org.au">breathingspace@communicare.org.au</a></td>
</tr>
</tbody>
</table>
### Table 6 Specialist homelessness services family and domestic violence accommodation and support

<table>
<thead>
<tr>
<th>Where is the service?</th>
<th>What is the service?</th>
<th>What are their contact details?</th>
<th>Who can access the service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armadale</td>
<td>The Centre for Safety and Wellbeing – Starick Services Inc</td>
<td>9478 5300</td>
<td>Women with/without accompanying children who are homeless due to family domestic violence or other crisis.</td>
</tr>
<tr>
<td>Cannington</td>
<td>Nardine Wimmin’s Refuge</td>
<td>9470 3628 <a href="mailto:admin@nardine.org.au">admin@nardine.org.au</a></td>
<td>Women with/without accompanying children who are homeless due to family domestic violence or other crisis.</td>
</tr>
<tr>
<td>Fremantle</td>
<td>UnitingCare West – Wyn Carr House – 37ncorp Fremantle Regional Indigenous Family Violence Service</td>
<td>9430 5756 <a href="mailto:admin@unitingcarewest.org.au">admin@unitingcarewest.org.au</a> <a href="http://www.unitingcarewest.org.au">www.unitingcarewest.org.au</a></td>
<td>Single women who are homeless due to family domestic violence or other crisis.</td>
</tr>
<tr>
<td>Fremantle</td>
<td>City of Fremantle – Warrawee Women’s Refuge</td>
<td>9432 9819</td>
<td>Women with/without accompanying children who are homeless due to family domestic violence or other crisis.</td>
</tr>
<tr>
<td>Joondalup</td>
<td>Patricia Giles Centre 37ncorp. Damara House</td>
<td>Pat Giles Centre: 9300 0304 <a href="mailto:pgc1@iinet.net.au">pgc1@iinet.net.au</a> patgilescentre.org.au Damara House: 9304 3832 <a href="mailto:damarahouse@iinet.net.au">damarahouse@iinet.net.au</a></td>
<td>Women with/without accompanying children who are homeless due to family domestic violence or other crisis.</td>
</tr>
<tr>
<td>Mirrabooka</td>
<td>City of Stirling – Stirling Women’s Centre</td>
<td>9205 7375 <a href="mailto:womensr@stirling.wa.gov.au">womensr@stirling.wa.gov.au</a> <a href="https://www.stirling.wa.gov.au/">https://www.stirling.wa.gov.au/</a></td>
<td>Women with/without accompanying children who are homeless due to family domestic violence or other crisis.</td>
</tr>
</tbody>
</table>
Appendix C: Resource for hospitals Consulting with a homeless patient?

Consulting with a homeless patient?

Definition of homelessness
The WA health system defines a person to be homeless if they do not have suitable accommodation alternatives and their current living arrangement:
- is in a dwelling that is inadequate;
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations (Australian Bureau of Statistics, 2016)
This includes people who:
- are without conventional accommodation and therefore sleep in public places;
- move frequently between temporary accommodation (a crisis service or staying with relatives or friends i.e: 'couch surfers'); or
- reside in boarding houses, hostels or caravans with no secure lease or private facilities.

When consulting with a homeless patient

☐ allow longer, flexible appointment times for patients with multiple problems and those facing addiction, mental health issues or cognitive difficulties
☐ provide specialised support for victims of domestic violence
  - this may involve recording preference of clinician gender
☐ ensure cultural competency is prioritised throughout all areas of care
  - be aware of common cultural practices and adapt practice accordingly
☐ seek an interpreter, translator or someone who can communicate through sign language if additional communication support is needed
☐ ensure a list of social and community services is easily accessible for referrals and information
☐ ask for secondary contact details, but be mindful that this may be a sensitive question
☐ ask if there is a friend, support worker, or GP who may help remind the patient of upcoming appointments or be contacted in an emergency
☐ consider prioritising the patient’s location and transport options when scheduling follow-up or outpatient appointments
☐ upon discharge, give consideration to patient safety, medication storage and affordability, treatment compliance, and where the patient will be living.

Other resources
An online education package on Homelessness is currently available on the Take 5 webpage https://rph.healthpoint.hdwa.health.wa.gov.au/directory/safety-and-learning/Pages/Take-5.aspx


better health = better care = better value
# Social and community services

A range of local social and community services are outlined in the table below. A list of all services available in Western Australia can be found on the Department of Communities Child Protection and Family Support website via the following link: [https://www.dcp.wa.gov.au/servicescommunity/Pages/Services%20by%20Type.aspx](https://www.dcp.wa.gov.au/servicescommunity/Pages/Services%20by%20Type.aspx)

<table>
<thead>
<tr>
<th>The service</th>
<th>Where?</th>
<th>When?</th>
<th>What do they do?</th>
<th>Who can access?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Entrypoint Perth</strong></td>
<td>Phone service only: #6496 0001 or #1800 124 684</td>
<td>9am-7pm Monday to Friday &amp; 9am-5pm Saturday</td>
<td>Free assessment and referral service providing access to Specialist Homelessness Services (SHS)</td>
<td>People who are homeless, or at risk of becoming homeless</td>
</tr>
<tr>
<td><strong>Freo Street Doctor</strong></td>
<td>Fremantle, Cockburn &amp; Melville</td>
<td>3 hours at weekly clinics</td>
<td>Primary health care – range of bulk billed services</td>
<td>Anyone with a Medicare card – no referral needed</td>
</tr>
<tr>
<td><strong>Homeless Healthcare</strong></td>
<td>Royal Perth Hospital, Ruah, Tranby, Street Clinics and other drop in centres</td>
<td>A range of times each weekday</td>
<td>Primary health care – range of bulk billed services</td>
<td>Anyone – some services do not require an appointment or referral</td>
</tr>
<tr>
<td><strong>Ruah</strong></td>
<td>Main centre in Northbridge and tenancy assistance in Maddington, Fremantle, Mandurah, Rockingham, Stirling.</td>
<td>Clinics open weekdays and provide after-hours support</td>
<td>Free services assisting with: housing, Centrelink, sourcing basic needs</td>
<td>People who are homeless, or at risk of becoming homeless – referral may be required</td>
</tr>
<tr>
<td><strong>Tranby Drop-in Centre</strong></td>
<td>Unit 8 No 5, Aberdeen Street, East Perth</td>
<td>7am – 12pm Monday to Friday</td>
<td>Affordable food, showers and personal hygiene needs, medical and GP services, Centrelink, Case Managers, street outreach support, Street Lawyer, Disability Advocate, Mail collection point</td>
<td>People aged 18 and over who are experiencing homelessness or at risk of becoming homeless</td>
</tr>
<tr>
<td><strong>Mission Australia</strong></td>
<td>Drug and alcohol housing support in East Perth, Balcatta and Maddington. Support for homeless youth in Northbridge</td>
<td>8:30am – 4:30pm Monday to Friday</td>
<td>Support people whose alcohol and/or other drug use is a factor in their ability to secure and maintain long-term stable accommodation</td>
<td>Adults and young people who are homeless or at risk of being homeless</td>
</tr>
<tr>
<td><strong>Coolabaroo Housing Service</strong></td>
<td>2117 Albany Highway, Gosnells</td>
<td>8:30am – 4:30pm Monday to Friday</td>
<td>Provide accommodation for up to 12 months and support such as Case Workers, referrals and advocacy</td>
<td>Aboriginal families who are homeless or at risk of homelessness</td>
</tr>
</tbody>
</table>

This document can be made available in alternative formats on request for a person with a disability.

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[health.wa.gov.au](http://health.wa.gov.au)
Appendix D: Example referral form from Ruah

<table>
<thead>
<tr>
<th>Which services are most applicable to the client?</th>
<th>(Tick all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Housing and Homelessness</td>
<td>□ Family Services (Women Only)</td>
</tr>
<tr>
<td>□ Justice Support (Women Only)</td>
<td>□ Mental Health and Wellness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Name</td>
</tr>
<tr>
<td>DOB</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of Birth</td>
</tr>
<tr>
<td>Aboriginal</td>
</tr>
<tr>
<td>Torres Strait Islander</td>
</tr>
<tr>
<td>Main Language</td>
</tr>
<tr>
<td>Interpreter Required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visa Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the person received a Ruah Service in the past?</td>
</tr>
<tr>
<td>If Yes – What Service did they receive?</td>
</tr>
<tr>
<td>Do you have ambulance cover</td>
</tr>
<tr>
<td>Centrelink Number</td>
</tr>
<tr>
<td>Is this a hospital referral?</td>
</tr>
<tr>
<td>Referring Dr’s details</td>
</tr>
</tbody>
</table>

If Yes BRA, discharge summary and crisis action plan to be attached

<table>
<thead>
<tr>
<th>Current Living Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need help with hoarding or clutter at your property?</td>
</tr>
<tr>
<td>Your accommodation is:</td>
</tr>
<tr>
<td>Community Housing Authority/Transitional/Private Rental/other</td>
</tr>
</tbody>
</table>

| Do you have any current debts that you know of? |

<table>
<thead>
<tr>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you a parent?</td>
</tr>
<tr>
<td>If yes, No of dependent Children</td>
</tr>
</tbody>
</table>

For more information call 13 RUAH (13 7024) or email connecting@ruah.org.au
Current Treating Doctor/Medical Professionals

Name
Postal Address
Phone
Email

Is your Dr/Medical practitioner willing to work with Rush?  □ YES □ NO
If they are not currently seeing a medical practitioner, are they willing to be supported in finding one?  □ YES □ NO

Mental Health and Well Being

Current Diagnosed Mental Illness
If no formal diagnosis, describe symptoms.

Dates and reasons for any recent hospital admissions

Is there a Community Treatment Order in place?  □ YES □ NO

Current Medications (List name and dose)

Social and Support Network

Who is currently part of your social and support network?

Reason for Referral

Referral Source
If referred by another party, please include:

Who and name of organisation

Contact Details
Physical Health/Disabilities
List Below

<table>
<thead>
<tr>
<th>Physical Health/Disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>List Below</td>
</tr>
</tbody>
</table>

Safety
(Required for Duty of Care - Will be treated in confidence)
Do you have a history of harming self or others?  □ YES □ NO
Are you aware of any psoriatic alerts?  □ YES □ NO

Substance Use
List any significant substance abuse, either current or past

<table>
<thead>
<tr>
<th>Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>List any significant substance abuse, either current or past</td>
</tr>
</tbody>
</table>

Is client currently engaged with or willing to engage with ADD supports:  □ YES □ NO

How would you describe your current situation?

<table>
<thead>
<tr>
<th>How would you describe your current situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

What are your strengths and weaknesses?
Strengths

<table>
<thead>
<tr>
<th>What are your strengths and weaknesses?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths</td>
</tr>
</tbody>
</table>

Weaknesses

<table>
<thead>
<tr>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

How would we know we have worked with you successfully?

<table>
<thead>
<tr>
<th>How would we know we have worked with you successfully?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
What, if any, other agencies are currently providing services?

Agency
Service Provided
Contact Person
Contact details

Have you accessed Crisis Services?
☐ YES ☐ NO
Provide details

Guardianship
Is there an Enduring Power of Guardianship in place?  ☐ YES ☐ NO
Is there a Guardianship Order with the Public Trustee?  ☐ YES ☐ NO
Is there an Administration Order with the Public Trustee?  ☐ YES ☐ NO

Consent
I am willing to work with Ruah  ☐ YES ☐ NO
I consent to Ruah contacting the refer detailed below  ☐ YES ☐ NO
I consent to the detail provided in this form being kept as a permanent record  ☐ YES ☐ NO

Emergency Contact Details
Name  Phone
Name  Phone
Name  Phone

Family/Significant other/Support persons Contact Details
Name  Phone
Name  Phone
Name  Phone

This form has been completed by
☐ Client themselves  ☐ Other – (includes Worker)
☐ Agency (if applicable)
Postal Address
Phone  Email
If not the client, State relationship to the client
Frequency of contact with the person
Appendix E: St. Bartholomew’s House consent section of referral form

**SECTION 8: CONSENT & DISCLOSURE**

I, (Client Name) ____________________________ GIVE MY PERMISSION TO ALLOW ST BARTHOLOMEW’S HOUSE TO OBTAIN ANY INFORMATION FROM THE FOLLOWING SERVICES TO ASSIST MY APPLICATION FOR SHORT TO MEDIUM TERM ACCOMODATION.

I, (Client Name) ____________________________ UNDERSTAND THAT SHOULD THE INFORMATION THAT I HAVE PROVIDED BE FOUND TO BE INCOMPLETE, FALSE OR MISLEADING IT MAY RESULT IN ACCOMMODATION BEING WITHDRAWN.

<table>
<thead>
<tr>
<th>SERVICE PROVIDER</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>CENTRELINK</td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH SERVICES</td>
<td></td>
</tr>
<tr>
<td>MEDICAL PRACTITIONER / HEALTH or TREATMENT CENTRES (incl. AOD services)</td>
<td></td>
</tr>
<tr>
<td>DEPARTMENT OF COMMUNITIES (Housing Authority, Department of Child Protection and Family Support and Disability Services Commission).</td>
<td></td>
</tr>
<tr>
<td>PREVIOUS HOUSING PROVIDER (e.g. Foundation Housing)</td>
<td></td>
</tr>
<tr>
<td>WESTERN AUSTRALIA POLICE SERVICE, DEPARTMENT OF COMMUNITY CORRECTIONS and OUTCARE</td>
<td></td>
</tr>
</tbody>
</table>
| OTHER SERVICES
Please list any other agencies/ support the client is linked with.          |         |

CLIENT SIGNATURE ____________________________ DATE ___________

(This form must be signed for the referral to be assessed.)
10 References


Wright NM, Tompkins CN. How can health care systems effectively deal with the major health care needs of homeless people. World Health Organisation Regional Office for Europe, Copenhagen Cases. 2005.


Wood, L., Flatau, P., Zaretzky, K., Foster, S., Vallesi, S. and Miscenko, D., 2016. What are the health, social and economic benefits of providing public housing and support to formerly homeless people. Australian Housing and Urban Research Institute at The University of Western Australia.


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