



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

Executive Summary Report and Recommendations

Homelessness

No fixed address – Can we still deliver care?

Clinical Senate of Western Australia

11 November 2016

Executive Summary

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

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

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

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

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

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

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

The opening session

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

Professor Julie Quinlivan, Chair of the Clinical Senate, introduced the topic for debate calling on senators and invited experts to consider how best we can ensure homeless Western Australians can access our health services, and how we can ensure they complete their care. The aim was to develop policy recommendations designed to improve access to care and co-ordination of care within and between WA Health facilities and community services.

Professor Quinlivan provided the following definition of homelessness:

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

¹ Australian Bureau of Statistics, Census of Population and Housing: Estimating Homelessness, 2012 Australian Institute of Health and Welfare, Specialist Homelessness Services 2012-13, 2013. Homelessness Australia, Homelessness in Western Australia (2014) (accessed 10 November 2016)
http://www.homelessnessaustralia.org.au/images/publications/Infographics/WA_-_updated_Jan_2014.pdf

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

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

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

Dr Russell-Weisz called on senators to consider practical solutions that both the system manager and health service providers could implement over time. He cautioned one size does not fit all and there is the need for strategies that can be adopted to each areas needs i.e. North metro, South metro etc. with consideration given to the different demographics/needs.

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

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

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

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

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

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

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

He emphasised the point that those in overcrowded dwellings are defined as homeless in the ABS definition but not in the cultural definition. Prof Flatau stated there is also a disconnect between the definition of homelessness and hospital definition of 'no fixed address'. Homelessness can be episodic, first entry and chronic and there are strong links between chronic homelessness and poor health outcomes.

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

WA Health must modify 'traditional' episodic care and shift to a collaborative approach towards continued care that included primary care and outreach. He stated there is opportunity for high cost saving for health systems to improve interventions through the creation of efficient models of care for these populations.

The significance of data linkage was evidenced when reporting on the impact of the National Partnerships Agreement on Homelessness (NPAH) programs on health costs. Outlined was the significant cost saving to government associated with reduced health service use. He reported: Reductions in health service use after entering a public housing tenancy (for the 3383 people in the study) was calculated as \$16,394,449 in one year or \$4,846 per person per year. Costs on average \$6462 per person/year to provide support via NPAH program, For NPAH clients, health system cost savings were \$13,273 per person/year and for NPAH clients receiving support upon exiting a mental health unit the cost savings equalled \$84,135 per person/year. Therefore, the greatest health savings when housing is coupled with support.

Professor Elizabeth Geelhoed reported on work undertaken in the United Kingdom by Sheffield University on mortality amongst homeless people². She reported on the causes of death and mortality rates for the general population versus the homeless population. The mean age of death for the general population (males) was 74 compared to 48 for homeless men. The mean age of death for general population (females) was 80 compared to 43 for homeless women.

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

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

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

Dr Michael Wright, Professor, Division of Health Sciences, Curtin University and Curtin University National Drug Research Institute spoke next presenting on Aboriginal people and homelessness.

²Thomas, B. (2011). Homelessness: A silent killer. A research briefing on mortality amongst homeless people, Report commissioned by Crisis.

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

Citing data from Homelessness Australia Dr Wright reported there are currently 105,237 people in Australia who are homeless and 25% (or 26,744) are Aboriginal and Torres Strait Islander Australians. In WA there are currently 9,595 people who are homeless³. The likely reasons for homelessness are: racism/discrimination in relation to access to housing be it private or public-unwilling to rent to Aboriginal people. Aboriginal women experience family violence and are 35 times more likely to become homeless; and there is a lack of cultural education leading to poorly designed housing that is unable to accommodate extended families.

Dr Wright stated there is a lack of understanding of how aboriginal people live-kin based societies. Housing for aboriginals is made up of generations living together and poorly designed public housing leads to overcrowding. Other contributing factors include poverty, mental health, substance abuse and economic barriers in relation to cost. Policies enable homelessness to happen due to this lack of understanding.

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

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

The study by Memcott et al (2003)⁴ defined three different categories that define Aboriginal homelessness:

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

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

In the second study by Barker J et al⁵ concluded there has been little attention given to the plight of Aboriginal people who are homeless despite the disproportionate number who are homeless. The main themes from the study indicated the existence of relationships are central to any meaningful engagement between service users and workers; services should be tailored to the individual needs and when flexible, have less restrictive rules. Importantly, all of these and the need for them to not require disclosure of personal information was critical to

³ Homelessness Australia
<http://www.homelessnessaustralia.org.au/index.php/about-homelessness/homeless-statistics>
(accessed 10 November 2016)

⁴ Memcott, P., Long, S., Chambers, C., Spring, F. (2003) Categories of Indigenous 'homeless' people and good practice responses to their needs, AHURI Final Report No. 49, Australian Housing and Urban Research Institute Limited, Melbourne.

⁵ Barker, J., Humphries, P., McArthur, M., & Thomson, L. (2012). Literature Review: Effective interventions for young people who are homeless or at risk of homelessness. Canberra: Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

engagement. Finally, greater consumer choice and control will more likely produce positive outcomes for clients.

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

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

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

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

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

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

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

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

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

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

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

Dr Stafford described that in Perth, the number of chronic high acuity street homeless is approximately 300; many are trimorbid having physical, mental health and alcohol and drug issues. She stated there are huge costs to healthcare, justice, welfare benefits and child protection. Using an example of 94 people from the Mobile Clinical Outreach Team (MCOT) Street Homeless Psychiatric patients there is an average of 47 days per year in hospital (90%

psych). A simple bed cost is \$58,750 per person/per year. This cohort cost is \$5.5 million on 94 people = \$1130/week or \$4150 per month. Another example shared in a subgroup of schizophrenic patients >90 inpatient days per year – 14 patients had 177 bed days per year. The bed costs equal \$3.3 million with per patient costs of \$236,250 per year /\$4500 per week or \$18,173 per month.

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

Poster presentations

During the morning tea break, eight poster presentations from academics, clinicians and community organisations showcased programs and research in the delivery of healthcare to people with no fixed address. Presentation titles are listed as an appendix to this document.

Plenary

The plenary session "Caring for the homeless" was opened with a presentation by Ms Bernadette Harrison who shared her lived experience. This was followed by a debate on the delivery of healthcare to homeless West Australians.

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

I stand here today to tell you that these are some of the most heartbreaking and soul shattering days I faced – society treated me as rubbish. I was looked down on, treated cruelly and it was as if everyone thought I was a second class citizen, yet no one knew the horror I faced daily trying to find shelter. I was starving, my physical health was deteriorating, and I was sick, scared and alone. Bernadette stated that it got to the point where she was so physically unwell that she presented to triage at Royal Perth Hospital (RPH). It all seemed to be going ok until a doctor found out I was homeless. He suddenly looked at me differently and his whole attitude changed. He spoke down to me. I was so embarrassed and ashamed that I left without treatment.

Bernadette recalled

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

She stated that prejudices lead to delays in seeking care. It was easier to ignore an infection or illness rather than deal with the feelings of worthlessness – this meant that when she did present for care, her illness or infection was severe.

Eventually she was reviewed by a doctor, and following a holistic assessment, was diagnosed with an autoimmune disease and mental health condition and received appropriate care. The results for Bernadette resulted in positive changes to her life and she eventually received accommodation.

Bernadette closed

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

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

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

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

Key messages were:

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

Key summary points:

- Anyone can be homeless.
- We must respect all patients and treat them with dignity and respect.
- Cross jurisdictional/cross sector coordination is required and services must be linked up with healthcare professionals aware of what is available.
- Macro level leadership with cross-sectoral leadership is required. Requires inter government cooperation.
- Health has a culture that has biases towards homeless people and they are not always welcome in the clinical setting.
- There is the opportunity for WA Health to lead.
- WA Health must advocate for programs that work.
- There are many opportunities to utilize existing services and redirect them.
- Need for a comprehensive approach that addresses all the issues, health, social, emotional and physical needs.
- Need for coordination - use resources more wisely, better outcomes for society.
- The solutions don't rest with one organization or sector we need to challenge ourselves to integrate our thinking and share our resources.
- Homeless people tell us that there are significant barriers to accessing GPs unless we are able to go where homeless are and where they feel comfortable, then we cannot provide care.
- Many homeless people have previously been refused service. Our health system is not designed for people to have a relationship. Waiting lists are long- the sooner the appointment the less likely for DNAs.

The afternoon session consisted of two concurrent workshops. Senators developed policy recommendations designed to improve co-ordination of healthcare within WA Health facilities and community health services for people with no fixed address in WA. The recommendations are attached to this report.

In conclusion, it was recognised that WA Health should call on a cross Ministry response to the issue of homelessness. The Clinical Senate recommendations provide the opportunity for the Director General and System Manager to collaborate with Health Service Boards and their cross jurisdictional counterparts to ensure better healthcare for some of our most vulnerable citizens.

A response from the Director General and Health Service Boards to recommendations is requested.

Sincerely



Professor Julie Quinlivan
Chair
Clinical Senate of Western Australia



Professor Gary Geelhoed
Executive Sponsor
Assistant Director General, Clinical Services and
Research, Chief Medical Officer
Department of Health Western Australia

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

Recommendations

Part A: For the attention of the System Manager

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

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

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

Continued on next page

Part B: For the attention of the Health Service Boards

1. The Health Service Boards consider investing in staff education that evaluates the social determinants of health and the linkages to homelessness. The package could address:
 1. The relationship between mental health and homelessness
 2. Personal bias towards homeless people and how attitudes effect care
 3. The knowledge to connect homeless people into community services
 4. Trauma informed care models

2. That Health Service Boards consider how they will manage homeless patients within their catchment area. A Hub and Spoke process is recommended by the Clinical Senate, with a centralised source of expertise that peripheral facilities may access as required.

3. That Health Service Boards should specifically include within their community engagement framework a process that ensures Aboriginal Elders within their catchment have input into service delivery and hospital culture.

Presenters & Expert Witnesses

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

Poster Briefs and Presenters

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

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

Ngatti House

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

YouthLink and YouthReach South provide specialist mental health services

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

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

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

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

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

Audit of homeless people attending Sir Charles Gairdner Emergency department

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

50 Lives 50 Homes

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

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

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

The following additional posters were on display

Street Connect - AnglicareWA

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

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

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

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