Training Handbook for Homelessness and Health Workers

CBD HOMELESSNESS HEALTH ACCESS PROTOCOL
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This training was written by Maureen Dawson-Smith, Live Work Relate and Georgia Savage, INW PCP.
SECTION 1

This section includes the following topics:

- Introduction to the CBD Homelessness Health Access Protocol
- Understanding the Relationship Between Health and Homelessness

This section includes the following activities:

ACTIVITY ONE: Let’s Talk about Health
What is a Protocol?
A protocol is an agreed way of working or an agreed practice which is shared by a number of workers. It usually identifies a number of steps, decisions, and options, but generally the aim of a protocol is to have one standard practice developed because it will get the best result for the client concerned.

Development of the CBD Homelessness Health Access Protocol
In 2009, a number of key homelessness and health services in the CBD acknowledged that there were significant barriers when referring homeless clients into health services. As a response, together they developed the CBD Homelessness Health Access Protocol, which is an agreed set of practices to improve access for homeless people to health services in the CBD of Melbourne. Working as the CBD Health and Homelessness Coordination Network, services signed off and committed to utilising the agreed upon Protocol.

All of these documents are available published on the INW PCP website http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/

SECTION 1: INTRODUCTION TO CBD HOMELESSNESS HEALTH ACCESS PROTOCOL

Training on how to use the Protocol
To better understand and use the Protocol, a training handbook has been developed for frontline workers. It can be completed online at http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/ by those working in homeless and health agencies.

By going through this training handbook and completing the ten activities you will be able to:

- explain what the Protocol is, and understand how to use the tools to improve access to health services for homeless people
- explain the importance of your role in assisting particularly marginalised people to access health services
- provide information on the health services that are available for homeless people that offer health advice and support
- go through a written referral process.
Over the last decade, there has been a growing body of evidence demonstrating that the experience of homelessness causes illness and can exacerbate pre-existing health issues. These issues are then usually only addressed in a partial or fragmented way, especially for those community members who experience frequent and lengthy episodes of homelessness.

People experiencing homelessness, or living in unsuitable and/or insecure housing, often have complex multiple needs which are made worse by their housing circumstances. These include:

- Frailty due to age
- Premature ageing
- Alcohol and substance abuse problems
- Dual disability
- Dual diagnosis
- Chronic health problems
- Mental illness
- Oral disease
- Psychiatric disability

There is an apparent correlation between areas with high levels of homelessness and areas with a high rate of hospital admissions. The lack of appropriate resources to address health needs in terms of basic support, comfort and even privacy to recover from illnesses contributes further to chronically poor health.

People experiencing homelessness are particularly vulnerable to problematic substance abuse and associated health concerns such as poor liver functioning, and respiratory conditions. Poor mental health is also a critical issue facing homeless people, including such conditions as dementia (primarily among older or frail homeless people), depression, anxiety and schizophrenic disorders, alcohol related, drug induced and other psychoses. Other identified health problems (which often occur in combination) amongst homeless people include:

1. Poor dental health
2. Poor nutritional status
3. Eyesight problems
4. Infectious diseases such as tuberculosis, viral hepatitis, STDs
5. Infestation disorders resulting from self neglect and a lack of facilities to maintain personal hygiene
6. Pneumonia
7. Lack of pain management and preventative and routine health care
8. Low compliance with and appropriate use of medication

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**Key Messages for those using the Protocol**

**KEY MESSAGE FOR HOMELESS WORKERS**

The key message for CBD homeless workers is that health agencies which support the Protocol will give your referrals priority and work with you to ensure your clients get the services they need.

**KEY MESSAGE FOR HEALTH WORKERS**

The key message for CBD health services is that you are much more likely to engage and meet the health needs of homeless people by working with homeless workers.

**KEY MESSAGE FOR ALL**

The key message for both sectors is that by addressing health issues earlier, better health and housing outcomes can be achieved for homeless people in the CBD.

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(1) Moreland and Hume’s Health and Homelessness Network, Submission to the Homelessness 2020 Task Force, November 2009
ACTIVITY ONE: Let’s Talk about Health

Imagine each individual in the photo has been living a homeless and transient life. Each individual is different and will require a different conversation about their health. What concerns would you have as a worker regarding the potential health issues for each client?

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What is Health?

Health refers to the physical, mental and spiritual well being of an individual. The World Health Organisation’s Ottawa Charter emphasises certain pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. These are often referred to as the ‘social determinants of health’.

What is homelessness?

Primary Homelessness:
People without conventional accommodation, e.g. living the streets, sleeping in derelict buildings, or using cars for temporary shelter.

Secondary Homelessness:
People who move from one form of temporary shelter to another, including homelessness services, rooming houses, and residing temporarily with friends.

Tertiary Homelessness:
People who live in boarding houses on a medium to long term basis (2).

And/or has complex needs, defined as:
A range of health conditions and behaviours - usually co-existing – that seriously limit the individual’s ability to access services and/or to obtain and retain housing. These conditions include alcohol or drug dependence, mental illness, acquired brain injury, intellectual and other disability, age related frailty, and chronic health problems, with or without challenging behaviours (3).

(3) Howlett, K., 2003, Better Health Care for People with Complex Needs in the CBD, Moonee Valley Melbourne Primary Care Partnership
SECTION 2

This section includes the following topics:
- The Protocol in Action: A Case Study Approach
  - General Practitioner
  - Mental health
  - Women
  - Youth
  - Complex needs

This section includes the following activities:
ACTIVITY TWO: What Works when Making a GP Referral
ACTIVITY THREE: Service Coordination
ACTIVITY FOUR: Good Practice Guidelines
ACTIVITY FIVE: Prevention
ACTIVITY SIX: Getting Health Involved Earlier
SECTION 2: THE PROTOCOL IN ACTION: A CASE STUDY APPROACH

This section utilises case studies to demonstrate how the Protocol works in practice, how it is effective and when you can use it.

There are case studies relating to General Practitioners, mental health, youth, women and complex needs. Each of these case studies has a related activity. You can read either a selection or all of the case studies, and complete the related activities.

SECTION 2: GENERAL PRACTIONER CASE STUDY

**GP Case Study**
Steve is a long term homeless man presently sleeping on couches. He has an extensive history of incarceration, drug and alcohol dependency, history of psychotic episodes and has a likely ABI. Steve had over four presentations at emergency within a three month period for various reasons however due to his complex issues, his sometimes poor communication skills and general fear of hospitals he would prematurely leave or be discharged without proper assessment. Steve was encouraged by his caseworker to visit a GP, however Steve felt uncomfortable and unable to communicate his health concerns. His case worker wrote a letter with Steve’s permission requesting a full medical investigation.

A referral to a GP in a community health service was made, reception staff were told that Steve had not attended the service before and he required a longer appointment – a double appointment was booked. The worker accompanied Steve to the doctors, assisted him in filling out required paper work and then filled in the many gaps with the GP around Steve’s health issues that Steve was not able to communicate. A full medical investigation was launched that included blood tests, scans and x-rays and a follow up appointment, which the worker also accompanied Steve to.

**ACTIVITY TWO: What works when making a GP Referral?**
Read the case study and identify what you believe are the elements of good practice that encourage clients to go to the GP and attend to their health (e.g. reception staff in GP clinic were aware of Steve’s need for a double appointment).

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Mental Health and Disability

Evidence suggests that there is an increased prevalence of people with brain injury, intellectual disability and cognitive impairment in the homeless population (4). Those who suffer these conditions in the homeless population require ongoing support which is almost nonexistent in the current funding arrangements and service models. The literature suggests that people with disabilities require assistance with the tasks of daily living, emotional and wellbeing support, practical assistance and facilitated and supportive referrals to the health and welfare services they require on an 'as needs' basis. This group within the homeless population are often marginalised and require assertive outreach and facilitated connection to community settings and community participation (5).

Studies in inner city areas have revealed that up to 75% of people who are homeless (compared with 18% of the general population) have a mental health disorder which both triggers and is a consequence of becoming homeless (6). Of these people, 93% reported at least one experience of extreme trauma, one in two women and one in ten men reported being raped and one in two people have at least one other chronic illness (7). Indeed, layers of disadvantage leads to trauma, isolation and disempowerment. Other studies indicate that 70% of mental health conditions in homeless people have a lifetime diagnosis and male adults who are homeless across every age group usually have at least twice the rate of any psychiatric disorder, mood disorders, substance use disorders and co-morbidity disorders (8).

A consultation held by Urban Seed in 2006 to 2007 (9) identified a number of service gaps and issues in relation to mental health issues and services for people who are homeless in the CBD. In particular they identified that:

• CBD health and welfare workers find that they are rarely able to access a mental health worker for crisis response and secondary consultation
• Homeless people are less likely to access mental health services as their priorities are finding accommodation and support
• A clear gap is providing mental health support to people with personality disorders and those with challenging and/or violent behaviours (such as recurrent suicidal and self harm behaviours associated with borderline personalities)
• Strict intake criteria characterised by a tight mental health definition, severe prioritisation of cases, limited outreach and inflexible clinical approaches are further barriers to service access
• There are very few models of mental health services that provide lifetime support as required with chronic mental health disorders
• Clients with “complex needs” require different service support and access points and a unique service response which is not “mixed in” with other services because homeless people do not, in the main, access mental health services

Communication between the mental health sector and the homelessness and support sector is not optimal. One AHURI study (2003) found that only 50% of people who are homeless leaving an acute mental health service had any discussion about their accommodation arrangements.

SECTION 2: MENTAL HEALTH CASE STUDY

(5) (Dawson-Smith, 2008)
(8) Kamieniecki, G. W. Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: A comparative review (2001)
(9) Hogan S. Consultation on Mental Health Needs of Homeless People in CBD (2006-7)
**Mental Health Case Study**

Adam presented to an emergency relief service responding very loudly to voices in his head. When queried on what he was talking about he became very aggressive and stated that he was not talking to anyone. He was very paranoid and his conversation was very erratic. Lionel, his homelessness worker, contacted the local Area Mental Health Service (AMHS) which covered the geographical area of Adam’s listed home address, and raised concerns about his mental health. Lionel was advised by the AMHS that Adam had not had his medication for considerable number of weeks and he should call police immediately if there was any further aggression or intimidation.

Although Adam left, Lionel continued to follow up with the AMHS. The next day Lionel was advised that Adam’s community treatment order (CTO) had now been revoked and that we should call police when he next appeared. Emergency Services (000) were contacted when he next appeared and within 10mins Adam was safely taken into custody to receive treatment. Without this prompt flag to client’s local community treatment team this client would have become a major threat to himself and others.

**ACTIVITY THREE: Service Coordination**

The text box to the left provides a case study of how a homelessness service and the mental health service worked together to get Adam the support he needed.

- What were the key pieces of information that each agency needed to know from each other in order to deliver the best outcome for Adam?
- In what ways is the mental health service system reliant on agencies to support their clients?
- Think of scenarios when things have not worked in a coordinated way so well and identify some ways to overcome these barriers
SECTION 2: WOMENS CASE STUDY

**Working with Women who are Homeless:**

Evidence suggests that many homeless women are escaping domestic violence or family breakdown, are likely to be at risk of a post-traumatic stress disorder and to have been victims of assault. Evidence also suggests this potential to experience violence continues whilst homeless. This suggests that any women’s homelessness response needs to have active links with a Women’s Health Service, the Centre Against Sexual Assault (CASA) and family violence services. Many women who are homeless report that they prefer to live rough than be placed in unsafe rooming houses or other congregate care living arrangements. Women experiencing primary homelessness are a minority group within the homeless population and often their needs are not meet. The Royal Women’s Hospital indicated that many women who are homeless do not undertake necessary preventive health checks such as breast and cervical tests. They also do not receive the necessary reproductive health service support they require throughout their reproductive years. The Royal Woman’s Hospital identified it wished to form partnerships with community agencies to provide outreach women’s health clinics to meet these needs (10).

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**Women’s Case Study**

Zara arrives at a drop-in program and asks to see a support worker about ‘women’s’ issues. Peta, the female support worker presents and introduces herself and role to the client and moves to a quiet room to discuss her needs. Zara discloses that she is residing at a boarding house and had recently been involved with a male resident, advising that they had unprotected sex on two occasions. She is concerned she may be pregnant, but is unsure how she feels about it. Peta provides information about reproductive health and discusses Zara’s own awareness on sexual health. In response to Zara saying that she feels overwhelmed, Peta provides information about the Women’s Hospital’s programs:

1. **Women’s Health Information Centre (telephone or walk-in);**
2. **The Pregnancy Advisory Service (telephone and face to face service);**
3. **The Well Women’s Clinic (appointment only);** and
4. **The Sexual Health Clinic (appointment only)**

Peta also advises that Zara can make a self-referral by telephoning (or visiting) the Women’s Health Information Centre on (03) 8345 3045 or 1800 442 007, or Peta could assist her in making a referral to link her in. Zara advises she is happy for Peta’s assistance and Peta contacts the Women’s Health Information Centre and asks for referral advice as to the best service for Zara, which in this case is the Sexual Health Clinic. Peta make an appointment with the service, which Zara is happy about as “now they know my problem”. Finally Peta checks that Zara has no difficulty in getting to the hospital but Zara lets her know she is ok as she has a Metcard. They look at the map together and Peta reminds her to tell her how it all went when she comes in next. Zara looks a bit nervous but smiles that she will. Once Zara has left, Peta fills out the necessary referral forms.

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(10) Dawson-Smith, M., 2008, *Homelessness and Primary Health Service Coordination in the Melbourne CBD*, MVM PCP, Victoria
**ACTIVITY FOUR: Good Practice Guidelines**

Read the case study above and list the good practice work undertaken by Peta (e.g. Peta took Sara to a quiet and private room).

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SECTION 2: YOUTH CASE STUDY

Working with Children

Children who are homeless may have experienced trauma or violence in their former home settings and/or were living in often unsafe circumstances. Transience, isolation from family members, lack of consistent access to schools and friends all impact upon the health, wellbeing and development of a child. Children who are members of families with a history of trauma and/or inter-generational social exclusion may require specialist family support services, including parenting support services. Often these children need support to engage with children of their own age, particularly when they have been required to take on greater responsibilities for their siblings and parent’s care.

The 2001, the Census recorded that approximately 56% of homeless people living in Melbourne’s CBD were under the age of 25 years \(^{(1)}\). Youth who are homeless are most vulnerable to exploitation, violence and unsafe lifestyle conditions. Many youth enter homelessness through worn statutory and youth corrective pathways characterised by a history of grief, abandonment and trauma. Other homeless youth may be or are often struggling with issues of identity, including sexual identity, family relationships and troubled adolescence.

There is clear evidence that the experience of a homeless lifestyle can have severe adverse effects on young people. Project I \(^{(12)}\) reported 10% as attempting suicide in the last three months, 30% reporting incidents of self harm, 26% of young homeless people reported a level of psychological distress indicative of a psychiatric disorder, 14% clinical depression, 12% clinical psychosis, 40% high risk alcohol consumption and 49% almost daily use of marijuana. They also concluded that these mental health issues may pre-date homelessness for approximately 50% of participants only. Finally, whilst 40% of those surveyed indicated that they believed they needed help with depression and anxiety, only 55% sought this assistance.

Youth Case Study

Linda is 17 years old and came to Frontyard Youth Services to get assistance with accommodation. In the process of uncovering her needs to Carolina, the youth worker also identified that Linda had no income stream, was sleeping rough, had recently had unprotected sex and was showing symptoms of anxiety and depression. Linda was subsequently referred to Melbourne Youth Support Services (MYSS), Centrelink and Young People’s Health Service (YPHS). The MYSS engagement led to some crisis accommodation being established.

The engagement with YPHS amongst other things led to a Medicare card being issued which gave her identification that aided the Centrelink processing and an income stream. At the same time the HEADSS assessment tool that the YPHS staff member undertook with Linda lead to some identifiable health outcomes and goals. Mental Health, Drug and Alcohol and Sexual Health are identified as the main issues in the Vulnerable Youth Framework discussion paper and in the course of her engagement with YPHS each of these issues along with some other issues where uncovered. Addressing the physical, mental, social and spiritual wellbeing of the client meant making some suggestions, and the client subsequently underwent a sexual health screen, received a Hep B vaccine and commenced her Gardasil schedule. She was happy in her current usage of alcohol but was made aware of services. Finally she chose to meet the Reconnect program worker at FY to seek to re-engage with her schooling, and some brokerage funding is being sought to allow her to re-engage with her family through a mediator.


\(^{(12)}\) Project I, 2003, 3 year study of 403 young homeless people in Melbourne and Los Angeles between 2001-3, Victoria
**ACTIVITY FIVE: Prevention**

Frontyard has developed a service model which aims to address health, housing and well being outcomes for all clients. Examine this case study and think about how this approach relates to preventing homelessness.
**Health, Homelessness and Complex Needs Case Study**

Gerard is 51 years old has been living a transient and homeless lifestyle in the CBD for the past two years. He sleeps rough, preferring being alone and outdoors than living with others. He says the noise of people talking does his head in. Previous to living rough, Gerard spent many years caught up with drinking every cent he had away. Eventually it was the booze that caused him to lose his job and contact with his children. He separated from his wife over 20 years ago.

He still drinks, but now his stomach reacts badly after a session. He hates feeling crook because it means he finds it difficult to eat, and this in turn makes him feel worse. Gerard’s weight is now dangerously low.

Gerard, is also having troubles with back, leg and foot pain and carrying around his possessions is becoming very difficult for him. He has told the Drop In worker that he is beginning to feel tired all the time and things are now getting him down. The Drop in Worker, gave him a pamphlet to read about a new health service but Gerard’s sight is now so poor he cannot read anything at all.

**Working with People with Complex Needs**

As a community, we would not accept “a system” that ignored those at higher risk of cancer or told someone who had discovered a small lump “wait until it is a large one before you seek medical attention” or “you will be allocated a time limited amount of treatment and or support and then you are on your own with this”, yet we effectively do this in terms of homelessness and are surprised when this response fails (13).

**ACTIVITY SIX: Getting Health Involved Earlier**

Examine the case study and identify what health interventions, treatments or support could be introduced to Gerard to ensure he does not live with such chronic and painful health issues.

(13) K. Jamieson, June 2008, Out of Home Care Manager Wanslea Family Services, Parity, Victoria
SECTION 3

This section includes the following topics:
- Myths about Health Service Referrals
- Barriers for Homeless People when Accessing Health Services
- Key Access Points in Health

This section includes the following activities:
ACTIVITY SEVEN: A Quiz for Busting the Myths about Health Service Referrals
ACTIVITY EIGHT: Reflection on Barriers and Solutions for Homeless People when Accessing Health Services
ACTIVITY NINE: Key Access Points in Health
ACTIVITY SEVEN: A Quiz for Busting the Myths about Health Service Referrals

The Protocol also addresses some myths that exist within the community sector and health sector about making a referral to and receiving a referral in a health service. See how you go with this simple quiz with T (true) or F (false):

1. It is not the job of homelessness workers to be involved in health issues of clients.
   T/F

2. People who are homeless prefer to discuss their health issues with health workers only.
   T/F

3. Homelessness workers can make verbal referrals to health services that support the Protocol for their clients.
   T/F

4. Verbal referrals to health services have the same outcome as written referrals.
   T/F

5. Homelessness workers are not able to make referrals to health services that support the Protocol without written consent from their client.
   T/F

6. A homelessness worker cannot undertake a health initial needs identification (INI). It has to be a qualified health worker.
   T/F

7. Health services that support the Protocol are required to give priority of access to homeless people.
   T/F

8. Homelessness workers are not able to accompany clients to health appointments due to privacy issues.
   T/F

9. Health services are required to communicate with homeless services about the health status of their clients if they have received a written referral.
   T/F

10. The Protocol will stop all problems associated with making a referral and receiving a referral between health and homelessness services.
    T/F
Answers to the Quiz:

1. **It is not the job of homelessness workers to be involved in health issues of clients.**
   
   **FALSE:** It is not true that simply because someone is homeless, they cannot address their own health issues independently, however there is a growing recognition that there are members of the homeless population who through living a homeless lifestyle are marginalised from mainstream services and need assertive support to access them. State and Commonwealth Homelessness Policy calls for a broader focus on health, wellbeing and housing outcomes in support plans to alleviate homelessness. One criterion under the ‘Public Housing segmented priority waiting list’ is the presence of health issues. Therefore, homelessness workers should liaise with health services to identify the health issues of each client and ensure they receive priority for public and community housing.

2. **People who are homeless prefer to discuss their health issues with health workers only.**

   **FALSE:** Some people who are homeless will not want to discuss their health issues with anyone other than a qualified health worker and where this is the case it is appropriate for case workers to respect their privacy and autonomy. However consultations with homeless peer representatives and workers have suggested that some homeless people experience such poor health and pain from untreated health conditions that it impacts upon their capacity to move on from being homeless. In this scenario, homelessness workers have the required engagement skills and empowerment practice to develop the right relationship of trust which can begin the dialogue “How are you feeling?” “I am worried about your arm which you seem to be holding... are you in any pain?” “Have you seen a doctor recently because I can help you to see one that I think is really OK?”

3. **Homelessness workers can make verbal referrals to health services that support the Protocol for their clients.**

   **TRUE:** The Protocol does not require homelessness workers to undertake a written referral. Verbal referrals are acceptable and accepted by health services that support the Protocol. When verbal referrals are made, the homelessness worker should liaise with a health worker who can follow through with ensuring the service is provided and your client’s needs are met.

4. **Verbal referrals to health services have the same outcome as written referrals.**

   **FALSE:** Health services have told us that there is a better outcome for service access, treatment and follow up if they receive a written referral which is consistent with their own referral practice as there is greater monitoring and accountability. If homelessness workers provide a written assessment they will also be provided with information about the services then offered by the health service, thus improving service coordination.

5. **Homelessness workers are not able to make referrals to health services that support the Protocol without written consent from their client.**

   **FALSE:** One of the barriers identified by homelessness workers when making a referral to a health service is the belief that they must have written consent from clients before making that referral. This is not the case. Both health and community service workers share the view that where possible written consent should be obtained but in the case of working with those most marginalised in the...
Undertaking an Initial Needs Identification (INI) for a Health Referral

The Summary and Referral Information Form (appendix 4) can assist workers to identify their client’s:
- initial health needs
- health and wellbeing risks
- network of agencies involved in support

If a homelessness worker uses this form, they will be provided with follow up information from the health service about any health issues that require a coordinated approach.

The provision of thorough health information assists with determining priority for getting a health service, managing client risks, and the better tailoring of services to individual needs.

If the referring worker does not or cannot complete the INI, they may choose to engage another service or worker better placed to do so. Where this is the case, they are advised to write “not known” in the relevant section of the document rather than leave it blank. This will ensure further follow up of this information by the health service at a later date.

homelessness community this is not always possible. This should not be used as a reason for failing to support individuals to get the health services they need. Therefore the Protocol states verbal consent for referral is adequate and that this verbal consent should be documented by the worker as a way of demonstrating that they have had this discussion with their client.

More detailed information about client consent processes that have been agreed by both homeless and health sector agencies is provided on page 28.

6. **A homelessness worker cannot undertake a health initial needs identification (INI). It has to be a qualified health worker.**

**FALSE:** Health services that support the Protocol encourage homelessness workers to undertake a health INI with their client. They acknowledge that homelessness workers have highly developed “engagement skills” and these skills may enable a more thorough identification of health and general needs. When homelessness workers use the appropriate documentation to make this needs assessment (appendix 4), they will be included in the information loop about further ongoing treatment requirements and health issues to be addressed. This will improve case planning coordination between health and homelessness services and hopefully improve outcomes for clients. This feedback from health services is also useful to assist homeless workers make the appropriate case for community housing.

7. **Health services that support the Protocol are required to give priority of access to homeless people.**

**TRUE:** All health services that support the Protocol are required to review their service access policies to ensure that people who are homeless have priority and urgent access to the health services they need. Many of these services will also ensure that more flexibility is provided to people who are homeless, for example not requiring a fixed appointment or ensuring that arrangements are made to reduce waiting time at the service.
8. **Homelessness workers are not able to accompany clients to health appointments due to privacy issues.**

**FALSE:** Health services that support the Protocol want people who are homeless to access their services. They acknowledge that those who are most vulnerable may need support from their key worker to make and attend these appointments. The health service will respect the wishes of their client in regards to whether they would like a homelessness worker to attend. Homelessness workers will maintain their practice of empowering their clients wherever possible.

9. **Health services are required to communicate with homeless services about the health status of their clients if they have received a written referral.**

**TRUE:** One of the reasons why it is important to make a written referral and undertake an INI, if appropriate, is that the referral forms enable health services to report back to the referring agency about the treatments provided to the client. This dialogue between services will help people who are homeless to get the support they need to complete treatment as health and homelessness services are more coordinated and working together.

10. **The Protocol will stop all problems associated with making a referral and receiving a referral between health and homeless services.**

**FALSE:** The Protocol in itself will not prevent problems occurring when making and receiving referrals, however over time consistent application will assist to change practice over time. Having the Protocol in place will enable agencies to work together to manage particular problems and identify and overcome barriers. One important reason for workers to use the agreed practice outlined in the Protocol is that they will not be alone in identifying service barriers. With the Protocol in place, the INW PCP will be able to monitor and reflect on the relationships and referrals between homelessness and health services. When issues arise when using the Protocol, there will be people in place to take further action on behalf of all services.
SECTION 3: BARRIERS FOR HOMELESS PEOPLE WHEN ACCESSING HEALTH SERVICES

Barriers to Access

The CBD Homelessness Health Access Protocol was developed by both homeless and health sector workers in response to the findings of a consultation process conducted in 2008 (14).

These findings were that community service workers:

• Witness on a daily basis unnecessary suffering related to pain, chronic health conditions, mental health disorders and poor post acute health treatment follow up.
• Struggle to provide a holistic health and well being focus with very limited resources. Time is mostly spent in crisis management.
• As a consequence, find it difficult to gain an appropriate level of understanding of health issues related to homelessness and the health services available for referral.
• Spend considerable time establishing “trust” with their clients and know this trust is a fragile commodity. They are therefore reluctant to risk encouraging their clients to attend a service they do not know. Therefore a key determinate of making a referral was whether workers had an established relationship with the health worker or service.
• Have both good and bad experiences of primary health services, but generally struggle to understand why primary health services do not prioritise their referrals and deliver services in a more flexible and responsive way, sensitive to the lifestyle and personal issues of the person needing the service.
• Tend to make verbal referrals rather than written referrals. Most agencies do not use referral documentation or collect data on health service referrals.
• Value the principal of “client consent” to share information with other agencies but raised concerns that this very principle can be a barrier to making referrals if it is applied rigidly.

The Protocol includes two tools for workers to improve referrals. There is the:
- Guidelines for Making Referrals to Health Services, for homelessness workers, and;
- Guidelines for Receiving Referrals in Health Services, for the health services themselves.

The following activity will provide you with the opportunity to engage with these guidelines.

(14) Dawson-Smith, M., 2008, Homelessness and Primary Health Service Coordination in the Melbourne CBD, MVM PCP, Victoria

ACTIVITY EIGHT: Reflection on the Barriers and Solutions for Homeless People when Accessing Services

Think about the barriers that exist for homeless people in accessing health services. In column one, make a list of these.

Once this is done, read the Guidelines for Making Referrals to Health Services (see page 23) and the Guidelines for Receiving Referrals in Health Services (page 24) and fill in the remaining columns outlining how which of the guidelines supports you to overcome this barrier.
<table>
<thead>
<tr>
<th>Barrier/s</th>
<th>Which of the Guidelines support you to overcome this barrier? (Making/Receiving)</th>
<th>What is the guideline?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult to engage homeless people in their health issues.</td>
<td>Making</td>
<td>1a, 4a, 4b and 4c</td>
</tr>
<tr>
<td></td>
<td>Receiving</td>
<td>5 and 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### CBD Homelessness Health Access Protocol
Guidelines for Making Referrals to Health Services

#### 1. Encourage the person who is experiencing homelessness to attend the health services they need by:

- a. identifying problems relating to attending appointments and working out ways to assist the person to attend;
- b. explain the service and how it works or get someone who can do this for you;
- c. talk through any expectations which may or may not be achieved;
- d. provide material aide to reduce barriers for attendance;
- e. seek consent to make the referral directly if the person cannot do this for themselves. (See section 6 of the Protocol); and
- f. ask how it went and be open to discussing any follow up appointments.

#### 2. In making a referral to an agency:

- a. ask about any protocol for priority of access;
- b. see if it is possible for the person to attend without an appointment;
- c. discuss needs, including longer appointments, gender issues;
- d. seek out a support/contact person within the service to assist;
- e. define your role with the service; and
- f. provide information to reduce duplicated questioning.

#### 3. In supporting someone’s attendance to a health service:

- a. where appropriate, accompany or provide your contact details;
- b. follow up with service and/or person to ensure attendance;
- c. give feedback that will help the service to be more responsive to the needs of people experiencing homelessness; and
- d. attend /offer opportunities for workers to share practice.

#### 4. To ensure that you can support people who experience homelessness to care about their health:

- a. care about everyone’s health and promote good health as a normal part of the work you do;
- b. if some one looks to be in pain or unwell ask the person if you can help them get some assistance;
- c. learn about health issues related to homelessness; and
- d. know the health services that are available to people experiencing homelessness in the CBD of Melbourne and the services that can assist in finding the right service.
# CBD Homelessness Health Access Protocol

Guidelines for Receiving Referrals in Health Services

1. People experiencing homelessness are a priority target group. All staff within the service will have an understanding of appropriate pathway and responses for homeless people requiring services.

2. Reception/front end staff are welcoming, accepting and understanding of the reality of homelessness for the individual.

3. Respect, acknowledge and where possible, cater for gender and cultural preferences throughout the provision of services by professionals.

4. Ensure tolerance toward any difficult behaviour and be flexible in providing sensitive ways to contain and address difficult behaviour.

5. Engage with the person, not the health issue and where possible designate someone with the service to build this relationship through ongoing support.

6. Provide a service which is of value at the time of first attendance.

7. Gauge whether the person is comfortable answering questions and, where necessary, change or stagger assessment practices to ensure ease of engagement.

8. Having received permission from the client, communicate openly and work collaboratively with the support people that are already available to the person experiencing homelessness.

9. Make sure time is spent with the individual working out the practical details and addressing any barriers to care.

10. Provide medication and treatment materials (where able) and follow-up that they are used appropriately.

11. Provide access to appropriate resources to assist clients in accessing support services.

12. Decide who will be responsible for:
   - Assertive outreach
   - Service follow up
   - Communication with referring agencies.

13. Be welcoming and pleased to see them when they present again.
How to get advice about health and referrals: Key Access Points

A key feature of the CBD Homelessness Health Access Protocol is the role of health service providers who have agreed as part of this Protocol to act as a key across specific areas for opening health service doors to homeless individuals and/or their homelessness workers. In addition to providing their own health services, these agencies will act as a sounding board for homelessness workers to discuss health issues and referral options for their clients. To ensure that health agencies maintain this role and homelessness services know who to contact, we have named a number of agencies as key access points for particular health areas in the Key Access Points in Health: A Quick Reference Guide. There are 8 specific areas, each with 1-2 contact agencies.

Complete the activity below using the Key Access Points in Health on page 26.

**ACTIVITY NINE: Key Access Points in Health**

Using the photos below, look again at the potential health concerns of each individual. Now decide using the Key Access Points in Health on the next page, which agency you would contact to discuss the health concerns of these clients.

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>HEALTH CONCERNS</th>
<th>KEY ACCESS POINT</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Individual 1" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td><img src="image2.png" alt="Individual 2" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td><img src="image3.png" alt="Individual 3" /></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guide to Accessing Services

As well as these Key Access Points in Health, the CBD Homelessness Health Access Protocol includes a Guide to Accessing Services, which lists in full all the support, mental health, dental health, general health, drug and alcohol services and emergency services that operate in the CBD and can assist your homeless clients. It is a small A5 book, and is also available in electronic form at [http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/](http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/)
<table>
<thead>
<tr>
<th>Area</th>
<th>Issues</th>
<th>Advice and Access Point</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL HEALTH CLINICAL</td>
<td>• Crisis/Acute assessment - CAT Access</td>
<td>ROYAL MELBOURNE HOSPITAL North Western Mental Health Centralised Triage – 24 hours</td>
<td>Phone: 1300 874 243</td>
</tr>
<tr>
<td>MENTAL HEALTH NON CLINICAL</td>
<td>• accessing short/long-term case mgmt • advice with referral into residential services • daily living skills</td>
<td>COHEALTH</td>
<td>Referrals via NEAMI central intake Phone: 1300 379 462</td>
</tr>
<tr>
<td>DENTAL General Emergency Dentures Children</td>
<td>• dental services • health and health care service • information • discussing health issues • initial written assessments and referrals</td>
<td>COHEALTH 6 Gower St Kensington</td>
<td>Phone: (03) 8378 1670</td>
</tr>
<tr>
<td>INDEPENDENT LIVING SUPPORT (Aged &amp; Disability)</td>
<td>• aged care packages • meals programs • day programs/social support • allied health • daily living support</td>
<td>CITY OF MELBOURNE (Aged Care Services) Level 3, Council House, 200 Little Collins Street, Melbourne</td>
<td>Phone: (03) 9658 9542 Ask for: Assessment and Intake Worker</td>
</tr>
<tr>
<td>WOMEN’S HEALTH (sexual and reproductive health)</td>
<td>• sexual and reproductive health • cervical screening • antenatal care</td>
<td>THE WOMEN’S HOSPITAL Women’s Health Information Centre, Corner Grattan Street &amp; Flemington Road, Parkville</td>
<td>Phone: (03) 8345 3045 / Email: <a href="mailto:askeanursemidwife@thewomens.org.au">askeanursemidwife@thewomens.org.au</a> Women can drop in - Ask for: Referral options and health information</td>
</tr>
<tr>
<td>EMERGENCY &amp; HOSPITAL CARE</td>
<td>• support in emergency/acute care • post-care follow up • health prevention</td>
<td>ST VINCENT’S HOSPITAL Emergency Department / 24 hours Victoria Parade, Fitzroy</td>
<td>Phone: (03) 9288 2211 Ask for: Triage</td>
</tr>
<tr>
<td>INJECTING DRUG USE AND ALCOHOL TREATMENT</td>
<td>• GP health services • pharmacotherapy prescribing • multidisciplinary team • biopsychosocial support</td>
<td>THE LIVING ROOM 7-9 Hosier Lane, Melbourne</td>
<td>Phone: (03) 9945 2100 Ask for: Team Leader</td>
</tr>
<tr>
<td></td>
<td>• GP specialist support • self-care • treatment programs • prescriptions and dispensing</td>
<td>COHEALTH HEALTH - DRUG SAFETY SERVICES - INNERSPACE 4-6 Johnson Street, Collingwood</td>
<td>Phone: (03) 9417 1299 Ask for: Team Leader – Harm Reduction Services or Team Leader Primary Health</td>
</tr>
<tr>
<td>YOUTH HEALTH</td>
<td>• youth health assessment, treatment and follow up • specialist referrals • health prevention and promotion</td>
<td>FRONT YARD YOUTH SERVICES 19 King Street, Melbourne</td>
<td>Phone: (03) 9611 2411 Ask for: Youth Health Nurse</td>
</tr>
<tr>
<td>HEALTH GENERAL</td>
<td>• general health assessment • assistance with medication • outreach assessments • wound treatment and after care</td>
<td>RDNS HOMELESSNESS OUTREACH HEALTH NURSE located at THE LIVING ROOM 7-9 Hosier Lane, Melbourne</td>
<td>Phone: (03) 9945 2100 ask for: RDNS HPP nurse in CBD</td>
</tr>
<tr>
<td></td>
<td>• general medical &amp; nursing • allied health • social/welfare services • outreach services • Aboriginal health worker</td>
<td>COHEALTH 75 Brunswick Street, Fitzroy</td>
<td>Phone: (03) 9411 3555</td>
</tr>
<tr>
<td></td>
<td>• eye examination • eye health • visual aids • subsidised glasses</td>
<td>OUTREACH SERVICES ABORIGINAL SERVICES AUSTRALIAN COLLEGE OF OPTOMETRY</td>
<td>Phone: (03) 9349 7472 - Ask for: Outreach Services, Aboriginal Services Email: <a href="mailto:outreach@aco.org.au">outreach@aco.org.au</a> Email: <a href="mailto:aboriginalservices@aco.org.au">aboriginalservices@aco.org.au</a></td>
</tr>
<tr>
<td>LEGAL</td>
<td>• Legal advice and casework to people experiencing disadvantage who live, work or study in North Melbourne, West Melbourne, CBD, Docklands, Carlton &amp; Parkville</td>
<td>INNER MELBOURNE COMMUNITY LEGAL 2/508 Queensberry Street, North Melbourne / 9am – 5pm</td>
<td>Phone: (03) 9328 1885</td>
</tr>
</tbody>
</table>
SECTION 4

This section includes the following topics:

• Making a Referral
• Using Forms When Making a Referral
• Receiving Referrals in a Health Service

This section includes the following activities:

ACTIVITY TEN: For Homelessness Workers
ACTIVITY ELEVEN: Receiving Referrals in a Health Service
SECTION 4: MAKING A REFERRAL

The Protocol for Obtaining Client Consent
Both homeless and health providers share the fundamental practice principle that it is important to obtain client consent before making a referral. Paradoxically however, rigid “written consent” policies were identified as being a potential barrier to access for this vulnerable target group.

Those responsible for the development of the Protocol recommend that providers be encouraged to use the Service Coordination Tool Template: Consent to Share Information (See Appendix 1). This form can be downloaded from www.health.vic.gov.au/pcps/sctt.htm and can be used either electronically via email, using a secure messaging service such as ConnectingCare (www.connectingcare.com).

The following reasons were identified for making this recommendation:
- This Consent to Share Information Form is used by a large number of agencies.
- The procedure for good practice in obtaining “consent” is embedded in the documentation.
- The requirement for “written consent” is not mandatory.
- The form provides the evidence of verbal or written consent
- It may be that agencies have their own “Client Consent” forms and procedures. It is recommended they are reviewed to incorporate the essential elements of this Consumer Consent to Share Information Form so that the practice for ensuring client’s rights to decision making are protected in a way that does not provide a barrier for inter-agency referral.

Referral Forms: The SCTT
The Victorian Government has developed a suite of referral tools called the Service Coordination Tool Templates (SCTT). Using the SCTT can improve communication between health and homelessness service providers, the recording of information generated by screening and assessment processes, information sharing, and the quality of referrals and feedback. This can improve the health outcome for your client.

There are four pages from the SCTT form which are particularly relevant to those working in the homeless sector. These are:

1. Consent to Share Information form
2. Referral Cover Sheet and Acknowledgement form
3. Consumer Information form
4. Summary and Referral Information form

Referral Options

There are three main referrals that can be made:
- a verbal referral
- a written referral to a single service
- a written referral to multiple services and/or for a complex client.

This next section of the training will assist you to understand when and how to make these referrals and use the appropriate forms.
Making a Verbal Referral
You can encourage your client to make a telephone appointment to any health service which has signed up to this Protocol. This is best practice when your client is able, willing and capable of engaging with these services by themselves. However if your client does not have this confidence, you can offer to make the referral on your client’s behalf and this will be accepted by the health service whether by telephone or in person. In this case you should fill out the Consent to Share Information Form and file it as proof that privacy procedures have been followed.

**DOCUMENTS NEEDED:** Consent to Share Information Form (appendix 1) or own agency consent form.

Making a Written Referral to a Single Service
To improve health service referral procedures health services themselves have standardised referral documentation (the SCTT forms) and they have asked homelessness workers to use this documentation when making a written referral to a service. If the referral is just for one service and is not complex it is suggested you fill out the one page Referral Cover Sheet. Make sure that you tick that the appointment is urgent and you make sure you write that this referral is part of the CBD Homelessness Health Access Protocol in the ‘other notes’ section on the Consent to Share Information Form. This will ensure that your client gets the agreed priority access that all health services have agreed to give as part of the Protocol.

**DOCUMENTS NEEDED:** Consent to Share Information Form (appendix 1) and Referral Cover Sheet (appendix 2)

Making a Written Referral to Multiple Services and/or for a Complex Client
Health services have indicated that using the same form for multiple health agencies achieves a better service access outcome for clients and ensures that services are better coordinated from the very beginning of treatment and support. If you are referring your client to multiple agencies you are encouraged to complete an INI using the Summary of Referral and Information Form. The text box on page 19 provides information on why and when it is beneficial for services to undertake an INI of the health needs of clients, and that by making this initial assessment, homelessness workers will be kept in on the information loop about treatment and follow up processes. The Consumer Information Form should also be completed when referring to multiple agencies or working with a complex client, as it allows the collection of further information that may be helpful for your client in obtaining the services they need.

You don’t have to know all the answers to questions, but if you don’t know, please write “not known” rather than leave blank. This will ensure that needs are further explored rather than ignored.

**DOCUMENTS NEEDED:** Consent to Share Information Form (appendix 1) and Referral Cover Sheet & Acknowledgement Form (appendix 2); as well as the Consumer Information Form (appendix 3) and the Summary of Referral and Information Form (appendix 4)
### SECTION 4: USING FORMS WHEN MAKING A REFERRAL

**Summary Forms Used When Making Referrals**

Table 2 summarises what forms to use when making each referral, and why. Copies of the forms are also provided in the back of this training manual in the appendices. They can be printed off and used for each client either sent electronically or via fax. They can also be obtained from the INW PCP website at [http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/](http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/).

**Table 2: Recommended Use of Referral Forms**

<table>
<thead>
<tr>
<th>Method of referral</th>
<th>Consumer Consent to Share Information Form</th>
<th>Confidential Referral Cover Sheet</th>
<th>Consumer Information Form</th>
<th>Summary and Referral Information Form (with INI)</th>
<th>Examples of when to use referral type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal referral</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>Jim, 34, who is known to you and your service and “normally” enjoys good physical health, presents to your service with what appears to be an infected cut on his hand. Jim is not confident when speaking to new people over the phone as he has a stutter. On this instance you encourage Jim to see a GP and offer to call and make an appointment for him. Jim agrees to this action and consents to you calling his GP.</td>
</tr>
<tr>
<td>Written referral to a single service</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>Rachael, 24, presents to your service seeking emergency accommodation as has recently separated from her abusive partner. Throughout this discussion Rachel disclosed that she has had a number of panic attacks and would like to see a counsellor as has found this useful in the past while living interstate. Rachael agrees to referral to see a counsellor. A written referral is made to see a counsellor.</td>
</tr>
<tr>
<td>Written referral to multiple services and/or for a complex client</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Evan, 43, presents to a meal service with no funds to purchase meal. Through having a discussion to arrange a meal “credit”, Evan discloses that he has recently acquired a gambling problem and has a number of fines that require attention. Evan begins getting physically upset and discloses that his wife kicked him out of home 2 months ago and he is clearly distressed and depressed with his situation. To make matters worse, Evan was kicked out without being given his orthotics and is now experiencing significant pain through his right heel and hip. Evan agrees that there are a number of issues that require attention and agrees to work through the referral form.</td>
</tr>
<tr>
<td>Referring agency receiving feedback</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACTIVITY TEN: For Homelessness Workers

Section Two of this manual provides a number of case studies. Chose one of these case studies and imagine you are the worker responsible for filling out the Consent to Share Information Form (appendix 1), the Referral Cover Sheet & Acknowledgement Form (appendix 2) and Summary and Referral Information Form (appendix 4).

Remember that:
- services listed in the Key Access Points in Health: A Quick Reference Guide are available to assist you in filling out these forms.
- written referrals guarantee you will remain in the service loop and this is particularly important in ensuring health issues are identified in public and community housing applications.

In filling in the forms you should:
- identify the referral is urgent and is part of the CBD Homelessness Health Access Protocol for priority access in the ‘other notes’ section of the Consent to Share Form.
- write ‘not known’ for any question on any form rather than leave it blank. This will ensure that these questions will be further followed up by the health service at a later time.
ACTIVITY ELEVEN: Receiving Referrals in a Health Service

Choose one case study in Section 2 of this training manual and imagine or draw on your experience as a worker in a health service in Melbourne’s CBD. You have received referral documentation from a worker in the homelessness sector for a client. Using the Guidelines for Receiving Referrals in Health Services, identify the key steps that you would take to ensure that this person received all the services they needed, in the right order, and with the appropriate follow up?

Practice in ensuring access to services

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Practice working with the client

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Practice to develop a treatment plan

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Practice working with homelessness sector to coordinate services

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

SECTION 4: RECEIVING REFERRALS IN A HEALTH SERVICE

Receiving a Referral
As part of the Protocol, there are Guidelines for Receiving Referrals in Health Services (see page 24). Health services in this Protocol are required to ensure priority access for people who are homeless and improved communication with referral workers and agencies so that follow up treatment and be supported and completed. All health service workers, from reception to specialist workers are required to have an understanding of homelessness and its impact and be prepared to provide services in a more flexible way. This may include ensuring people do not need to wait inside the service or have a quiet area alone if they must wait at all. It may mean spending more time explaining health issues and treatment, or ensuring that follow up treatment can be provided by other health workers. The following exercise is designed to give you more time to familiarise yourself with the Protocol for receiving referrals and what this means for your role in practice.
SECTION 5

This section includes the following topics:

- What to do if you’re having trouble using the **CBD Homelessness Health Access Protocol**: feedback and comments
- Evaluation
- Appendices
  1. Consent to Share Information Form
  2. Referral Cover Sheet and Acknowledgement Form
  3. Consumer Information Form
  4. Summary and Referral Information Form
  5. List of Homelessness and Health Agencies
SECTION 5: WHAT TO DO IF YOU’RE HAVING TROUBLE USING THE CBD HOMELESSNESS HEALTH ACCESS PROTOCOL: FEEDBACK AND COMMENTS

Having Trouble Using the **CBD Homelessness Health Access Protocol**?

When you try to use the **CBD Homelessness Health Access Protocol**, it may not always work in agencies and across the health and welfare sectors during the first stage of implementation. This Protocol relies on you to help with this implementation. It will take time for agencies to ensure the guidelines and practices set out in the Protocol are in place for all staff as well as new staff coming on board. If you are having problems, here are some points that you can use to introduce them to the Protocol:

1. Identify that you work for an organisation that is using the **CBD Homelessness Health Access Protocol**, and ask a worker if they are aware of the Protocol.
2. If they are not aware of the Protocol, outline some of the major points of the Protocol:
   - The Protocol aims to improve access for homelessness people in CBD to health services
   - It does this by setting out the agreed good practice for encouraging and supporting homeless people to use primary health services
   - It provides guidelines for making referrals and information on consent from your client
   - A number of services in the CBD have agreed to implement the Protocol, and all services should ensure they prioritise access for this vulnerable population.
3. Request that the service, especially if they are listed in the Access Guide and/or Key Access Points, accept the referral and give it priority of access.

If you are still having difficulty, you can contact the services listed under the ‘Key Access Points in Health’, as they may be able to offer some practical advice or assistance in getting your referral accepted.

In general, when discussing the referral, ask workers from other organisations to engage with you about your client’s problems and seek their support in coming up with solutions that work. Your approach to engaging with other services and workers will impact on how well you achieve the goal you want for your client.

**Feedback and Comments**

Feedback on your experience using the **CBD Homelessness Health Access Protocol** can also be provided via a comments section on the INW PCP website at [http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/](http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/). These comments will be used to further develop and improve the Protocol so it is more usable for you, the worker, and achieves better outcomes for your homeless clients. If you come across an incorrect phone number in the Protocol, please let us know via the comments section, so that we can update the Protocol and keep it current.

SECTION 5: EVALUATION

**Evaluation**

As well as using the feedback as an evaluation tool, INW PCP will be conducting a survey of workers and agencies that provide services for homeless people in Melbourne’s CBD to assess if and how the Protocol is being used. We would appreciate if you could take the time to complete this survey if it appears in your inbox, as it will help us improve the Protocol.

Findings from the survey and the comments will be provided to workers and agencies via the INW PCP website and networks, so make sure you keep a look out!
Appendices

1. Consent to Share Information Form
2. Referral Cover Sheet and Acknowledgement Form
3. Consumer Information Form
4. Summary and Referral Information Form
5. List of Homelessness and Health Agencies
1. Consent to Share Information Form

### Consent to share information

**Purpose:** to record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.

#### Section 1: Personal/health information to be shared

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Name of Agency</th>
<th>Type of Information</th>
<th>Purpose/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>- physiotherapy</td>
<td>- Strawberry Community Health centre</td>
<td>- all relevant information</td>
<td>- referral</td>
</tr>
<tr>
<td>- counseling</td>
<td>- Blueberry City Council</td>
<td>- exceptions as stated by consumer</td>
<td>- shared care/case planning</td>
</tr>
</tbody>
</table>

#### Section 2: Record of consent

- **Written consumer consent**
  The worker/practitioner has discussed with me how and why certain information about me may be shared with other service providers, as above. I understand this and I give my consent for the information to be shared.

  Signed: ____________________________
  Dated (dd/mm/yyyy): __/____
  or

- **Verbal consumer consent**
  I have discussed with the consumer how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.

  or

- **Consumer does not have the capacity to provide consent**
  (that is, they do not understand the nature of what they are consenting to, or the consequences)

  - Consent given by authorised representative: ____________________________
  - There is no Authorising representative or they were uncontactable; therefore, the information will be shared as set out in the Health Records Act 2001*

*If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out in the Health Records Act 2001. This includes where the sharing of information is done by a health service provider and is reasonably necessary for the provision of a health service or where there is a statutory requirement.

To ensure that the consumer’s authorised representative can make an informed decision about consenting to the sharing of information as detailed above, the worker/practitioner should (tick when completed):

1. Discuss with the consumer the proposed sharing of information with other services/agency
2. Explain that the consumer’s information will only be shared with these services/agency if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed
3. Provide the consumer with information about privacy, such as the brochure Your Information – It’s Private
4. Provide the consumer with a copy of this form once completed.

---

**Consent obtained/witnessed by:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position/Agency:</th>
<th>Sign:</th>
<th>Date: dd/mm/yyyy</th>
<th>Contact number:</th>
</tr>
</thead>
</table>

---

*Produced by the Victorian Department of Health, 2012*
2. Referral Cover Sheet and Acknowledgement Form

### Referral cover sheet and acknowledgement

**Purpose:** To send with a referral or to acknowledge receipt of a referral.

<table>
<thead>
<tr>
<th>Consumer</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth: dd/mm/yyyy</td>
<td>/</td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
</tr>
<tr>
<td>UR Number:</td>
<td>or affix label here</td>
</tr>
</tbody>
</table>

**Date:** dd/mm/yyyy   /   /

#### Referral

<table>
<thead>
<tr>
<th>From</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Position:</td>
<td></td>
</tr>
<tr>
<td>Organisation:</td>
<td></td>
</tr>
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<td>Phone:</td>
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<tr>
<td>Email:</td>
<td>Fax:</td>
</tr>
<tr>
<td>Role with consumer:</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>To</th>
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<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Position:</td>
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<td>Organisation:</td>
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<td>Phone:</td>
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<td>Email:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

**Referral for type of service/service requested:**

- [ ] urgent (list reason in notes)
- [ ] non-urgent

**SCTT attached:**

- [ ] consumer information
- [ ] summary and referral information
- [ ] other (list)

**Other documents attached:**

- [ ] assessment information/report
- [ ] care plan
- [ ] other (list)

**Notes:**

#### Acknowledgment

- [ ] To acknowledge a referral you have received, complete this section

<table>
<thead>
<tr>
<th>From</th>
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<tbody>
<tr>
<td>Name:</td>
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<td>Position:</td>
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<td>Organisation:</td>
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<td>Fax:</td>
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<tr>
<th>To</th>
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<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Position:</td>
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<td>Organisation:</td>
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<td>Phone:</td>
<td></td>
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<tr>
<td>Email:</td>
<td>Fax:</td>
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</tbody>
</table>

**Date referral received:** dd/mm/yyyy   /   /

**Status of referral:**

- [ ] accepted
- [ ] wait listed
- [ ] rejected (note reason and suggest alternatives)

**Estimated date of assessment:** dd/mm/yyyy   /   /

**Contact person for further information:**

- [ ] as above (from details)
- [ ] new contact (provide in notes)

**Notes:**

---

**Practitioner signature:** __________________________

**Position:** __________________________

**Contact (phone/email):** __________________________

**Total number of pages sent:** _____
3. Consumer Information Form

<table>
<thead>
<tr>
<th>Consumer Information Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consumer</strong></td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Date of Birth: dd/mm/yyyy</td>
</tr>
<tr>
<td>Sex:</td>
</tr>
<tr>
<td>UR Number:</td>
</tr>
<tr>
<td>or affix label here</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Consumer Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family name:</strong></td>
</tr>
<tr>
<td><strong>Given names:</strong></td>
</tr>
<tr>
<td><strong>Preferred name/s:</strong></td>
</tr>
<tr>
<td><strong>Date of birth:</strong> dd/mm/yyyy</td>
</tr>
<tr>
<td><strong>Is the date of birth estimated?</strong> Code:</td>
</tr>
<tr>
<td><strong>Gender:</strong> Code:</td>
</tr>
<tr>
<td><strong>Title:</strong></td>
</tr>
<tr>
<td><strong>Home address:</strong></td>
</tr>
<tr>
<td><strong>Postal address:</strong> (if different from above):</td>
</tr>
<tr>
<td><strong>Post code:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Contact phone numbers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post code:</strong> Can leave message?</td>
</tr>
<tr>
<td><strong>Home:</strong> ( )</td>
</tr>
<tr>
<td><strong>Work:</strong> ( )</td>
</tr>
<tr>
<td><strong>Mobile:</strong> ( )</td>
</tr>
<tr>
<td><strong>Email:</strong> ( )</td>
</tr>
<tr>
<td><strong>Are you a care or care recipient?</strong> Code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Employment/student status</strong> Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comments:</strong></td>
</tr>
<tr>
<td><strong>Country of birth:</strong></td>
</tr>
<tr>
<td><strong>Indigenous status:</strong></td>
</tr>
<tr>
<td><strong>Are you of Aboriginal and/or a Torres Strait Islander origin?</strong> Code:</td>
</tr>
<tr>
<td><strong>Refugee status:</strong> Yes No Not stated/unknown</td>
</tr>
<tr>
<td><strong>If yes, year of arrival:</strong></td>
</tr>
<tr>
<td><strong>Need for interpreter services:</strong></td>
</tr>
<tr>
<td><strong>Preferred language:</strong> Code:</td>
</tr>
<tr>
<td><strong>Communication method:</strong> Code:</td>
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<table>
<thead>
<tr>
<th><strong>General Practitioner (GP)</strong></th>
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<tbody>
<tr>
<td><strong>GP name:</strong></td>
</tr>
<tr>
<td><strong>Practice name:</strong></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
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<tr>
<td><strong>Phone:</strong></td>
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<tr>
<td><strong>Fax:</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Who the agency can contact if necessary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact 1 Name:</strong> Address</td>
</tr>
<tr>
<td><strong>Post code:</strong></td>
</tr>
<tr>
<td><strong>Phone numbers</strong></td>
</tr>
<tr>
<td><strong>Home:</strong></td>
</tr>
<tr>
<td><strong>Work:</strong></td>
</tr>
<tr>
<td><strong>Mobile:</strong></td>
</tr>
<tr>
<td><strong>Relationship to consumer:</strong> Code:</td>
</tr>
</tbody>
</table>

| **Contact 2 Name:** Address                |
| **Post code:**                             |
| **Phone numbers**                          |
| **Home:**                                  |
| **Work:**                                  |
| **Mobile:**                                |
| **Relationship to Consumer:** Code:        |

<table>
<thead>
<tr>
<th><strong>Government pension/benefit status:</strong> Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If on a disability support pension nature of disability:</td>
</tr>
<tr>
<td><strong>Health care card holder status:</strong> Card number: Code:</td>
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<tr>
<td><strong>Medicare card &amp; status:</strong> Card number: Code:</td>
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<tr>
<td><strong>Health insurance status:</strong> Card number: Code:</td>
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<tr>
<td><strong>DVA card entitlement:</strong> Card number: Code:</td>
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<tr>
<td><strong>Compensable funding source:</strong> Code:</td>
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<tr>
<td><strong>Comments</strong></td>
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</tbody>
</table>

Produced by the Victorian Department of Health, 2012
4. Summary and Referral Information Form

Summary and referral information
Purpose: to record and share a summary of the consumer’s presenting and identified issues and other information to assist in a referral.

<table>
<thead>
<tr>
<th>Consumer</th>
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<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Date of Birth: dd/mm/yyyy / /</td>
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<tr>
<td>Sex:</td>
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<tr>
<td>UR Number:</td>
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Alerts

| Allergies: |
| Code: |

| Risks: (attach any available risk assessments) |
| Code: |

| Risk management strategies: |
| Code: |

| There are concerns that the consumer is not capable of making their own decisions |
| Code: |

| Enduring powers of attorney are in place |
| Code: |

Access to the referred service has been discussed with the consumer? Yes No

Barriers to Service:

Support required to address barrier to service:

Current services
Services used in the last twelve months. Consider all health and community services.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Service type Code:</th>
<th>Record contact details or other information as appropriate (eg key contact)</th>
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<tbody>
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Referrals sent

<table>
<thead>
<tr>
<th>Agency</th>
<th>Service type Code:</th>
<th>Contact details</th>
<th>Purpose of referral</th>
<th>Feedback required</th>
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<tbody>
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**Produced by the Victorian Department of Health, 2013**
5. List of Homelessness and Health Agencies

The homelessness and health agencies listed below have all agreed to adopt and enact the CBD Homelessness Health Access Protocol and the various Guidelines which sit underneath it (current in September 2011).

These are:

Alfred Homeless Outreach Psychiatry Service (HOPS) / Inner South East Mental Health Service
Australian College of Optometry
Centre Against Sexual Assault (CASA House)
City of Melbourne
Clarendon HOPS/ Inner Urban East Mental Health Service
cohealth
Council to Homeless Persons
Department of Health
Department of Human Services
Frontyard Youth Services, Melbourne City Mission
Homeground
Inner North West Melbourne Medicare Local
Inner North West Primary Care Partnership
InnerSpace, cohealth
Inner West Area Mental Health Service
Living Room Primary Health Service, Youth Projects Inc.
North Richmond Community Health Centre
North West Housing Network
Macedon Ranges and North Western Melbourne Medicare Local StreetHealth
Ozanam Community Centre, VincentCare
Royal District Nursing Service Homeless Persons Program
St Vincent’s Hospital ALERT program
The Lazarus Centre, Anglicare
The Royal Dental Hospital of Melbourne, Dental Health Services Victoria
The Royal Melbourne Hospital (Emergency Department)
The Salvation Army, Project 614
The Women’s
Travellers Aid
Urban Seed
Women’s Domestic Violence Crisis Centre
Young People’s Health Service, Centre for Adolescent Health, Royal Children’s Hospital
Youth Support and Advocacy Service