

“Accidental” GP helping the homeless

Dr Andrew Davies operates Homeless Healthcare, a specialist GP service for people living on the streets of Perth

DR Andrew Davies describes himself as an “accidental GP” who “fell into” working with homeless people, and now operates Homeless Healthcare in Perth.

In high school he wrote down “medicine” as his first choice of university degree when the person sitting in front of him wrote it down and misspelled it.

“I thought, well, I can at least spell medicine right and put it down as my first choice, and got in,” Dr Davies tells the *MJA* in an exclusive podcast (<https://www.mja.com.au/podcasts>).

Nine years working in the public hospital system left him none the wiser about which specialty he should make his life’s work.

“It really wasn’t until I was just about to enrol for architecture, that I thought I probably should go and give general practice a try.”

Having grown up in the upper middle-class western suburbs of Perth, being sent out to the eastern suburbs was “a real eye-opener in itself”.

“I didn’t realise that life was different from how I’d grown up for some people,” he says.

“One of my first mentors said to me ‘you know what, you like drugs and alcohol and you like mental health, why don’t you go and work on Street Doctor and see what you think’.” Street Doctor was a van that went out in the evenings and tended to homeless people. “I went along and I loved it. So, I completely fell into this job.”

“This job” is the founder and medical director of Homeless Healthcare and it was born of the frustration of treating the daily

wear-and-tear cuts and bruises of homeless people, only to see them again for the same reasons the following week.

“I started to get a bit frustrated,” Dr Davies says. “I was seeing homeless people who were mainly intoxicated, who had lots of chronic diseases, but we were having to stitch up whatever they’d busted because they were fighting with each other. But you tended to do it all again the next week.

“I really felt we weren’t dealing with the underlying problems – which were the chronic diseases and the fact that they were actually homeless.”

In 2007, Dr Davies decided to do something proactive. After researching what was working in other countries, he took \$10 000 and bought enough equipment to stock the back of his car so he could set up clinics in homeless drop-in centres.

“The initial aim was to run two clinics a week – a whole 8 hours,” he says. “By the second week it was double that and within a month it was 40 hours of clinics a week. And in 6 weeks it was 70 hours.

“There’s a huge demand out there.”

Today Homeless Healthcare employs 34, mostly part-time, nurses, GPs, registrars and students. Funding is a moveable feast and comes from many different sources – Medicare bulk-billing for practitioner consultations, a top-up grant from the WA government because of the high ratio of nurses involved, a grant from the East Metro Area Health Service which funds their GP in-reach service at Royal Perth Hospital, and of course, philanthropic donations.

In a narrative review, published by the *MJA* on 3 September (*Med J Aust* 2018; 209: 230-234), Dr Davies and his co-author, Associate Professor Lisa Wood from the University of Western

Australia, identified six core components of a best practice model to improve health outcomes for people experiencing homelessness:

Stable housing

“When you ask someone why they are homeless, they usually give you a financial reason,” Dr Davies tells the *MJA*. “But if you delve into that financial problem you often find that it’s a health problem that caused them to lose their job.

“Once they’ve lost their job, they get bored at home, so they start drinking, their partner kicks them out, and so they then start going through the couch-surfing phase where they stay with different friends until they [wear] all of their friends out, and eventually they’ve got no one socially to turn to and they end up on the street.

“Once they’re on the street it gets much worse – mental health deteriorates, and so does the physical health and to cope people use substances. We call it trimorbidity.”

Continuity of health care

In their narrative review, Davies and Wood write of the need for a “specialist homeless service with trained staff working across as much of the system as possible”.

Specialised homeless general practice

“All GPs who work with us have had trauma-informed care training, and have a good understanding of mental health, drug and alcohol, and complex multimorbidities,” Dr Davies says. “It’s really important that you have people that understand that.

“In the past, to be brutally honest, [GPs weren’t lining up to do this work]. It was seen as scary, I think. But as we’ve built momentum we’re not having as much difficulty finding the right people.”

Hospital inreach

“This needs to be localised,” Dr Davies says. “A nurse and a GP



Dr Andrew Davies

“We weren’t dealing with the underlying problems – which were the chronic diseases and the fact that they were actually homeless”



from our service go to Royal Perth Hospital 5 days a week and team up with a case worker from one of the homelessness organisations.

“We’re given a list of all the people known to be homeless in the hospital. We try to better coordinate their hospital admission, discharge and after-care so they’re not stuck in that cycle of re-presentation all the time.

“One of the things that makes it work well for us is that we have an ED consultant – Amanda Stafford who works alongside us, and helps us deal with the hospital politics which can be quite difficult to get through.”

Outreach

In their narrative review, Davies and Wood wrote that: “flexible service delivery and street outreach allows primary health care services to be delivered in spaces where homeless people feel welcome, resulting in increased engagement and improved outcomes”.

Street Health is part of the Homeless Healthcare organisation.

“One of our nurses teams up with one of the street-to-home workers from

the other services and they go out to the parks to try and engage those really disengaged people who aren’t accessing any services at all,” says Dr Davies.

Medical recovery centres

“If someone is too sick for the streets, but not sick enough to go into hospital, a medical recovery centre is a place they can go to recuperate,” he says.

“But it’s not just medical. There are case workers who work with the client to try and get them rehoused before they’re discharged from the recovery centre.

“It’s really about stabilising the whole person to try and break that cycle of recurrent presentations to hospital.”

There are only two medical recovery centres in Australia at the moment – one in Sydney and one in Melbourne, both run by the respective St Vincent’s Hospitals in those cities. But Dr Davies is hopeful that it’s a model that can be spread further afield.

“People want a model proven before they’ll fund you, and they want it proven locally,” he says.

“What we had to do in the first 2 years was rely solely on Medicare bulk billing. It’s hard enough to make a fixed-site practice operate let alone one that has high ratio of nurses and goes out to drop-in centres to operate.

“It was tough and it really wasn’t until we were getting to the point where we couldn’t do it anymore and we put out a desperate plea to the government for some top-up funding that we got any help.

“I’ve often wondered how do we get what we’re doing here spread to other cities across Australia. One of the things that we’re doing with UWA is getting the data together to show that what we’re doing really does work and saves the system money.

“That’s so that others elsewhere in the country can get the funding up front and not have to face the difficulty that we did.”

Originally published in MJA InSight, reprinted with permission.

Cate Swannell

doi:10.5694/mja18.1709C1