Homelessness has recently emerged as a major social issue in most developed countries (Turnbull et al., 2007; Minnery and Greenhalgh, 2008), for example Australia, Canada, the UK and the USA. The profile of people who are homeless has changed over the years, and there are an increasing number of women and young people who are homeless. A significant proportion of people who are homeless have a mental illness and there is a high likelihood that they also have substance use issues (Commonwealth of Australia, 2008).

The work of clinicians who are involved with the homeless is difficult and challenging. It is only in recent times that, in Queensland, Australia, it has been recognized that there has needed to be a government response to working with the homeless. As a result, a number of Homeless Health Outreach Teams have been established in key regions in the state. The aim of these teams is to minimize the health problems of homeless people, and contribute to the prevention and reduction of homelessness within the state through collaboration to facilitate access to appropriate support.

This article describes the role and functions of a Homeless Health Outreach Team (HHOT).

**BACKGROUND**

It has been argued that homelessness is a more complex and multi-dimensional phenomenon than simply the lack of an appropriate dwelling. Posing homelessness only as a housing issue fails to capture the full scale of the problem (Thompson, 2007). Homelessness can be viewed along a continuum, with those living outdoors and in other places not intended for habitation at the extreme (primary homelessness), followed by those living in shelters (secondary homelessness) (Frankish et al., 2005).

Primary homelessness involves people who are living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter. Secondary homelessness involves people who move frequently from one form of temporary shelter to another, e.g. people using emergency accommodation such as hostels for the homeless or night shelters; teenagers staying in youth refuges; women and children escaping domestic violence (staying in women’s refuges); people residing temporarily with other families or those that ‘couch surf’ (because they have no accommodation of their own); and those using boarding houses on an occasional or intermittent basis (Chamberlain and Mackenzie, 1992).

There are many other factors that could be taken into consideration when discussing homelessness, for example, an increasing recognition that domestic violence is intolerable, with more women and children leaving abusive homes; the de-institutionalization of the care of the mentally ill, combined with the policy failure to provide an adequate supply of alternative resources for community living; the decline in unskilled employment accessible to young people leaving home at early ages, together with...
a decrease in the boarding house accommodation they used to be able to live in; and increased levels of drugs and alcohol addictions (Thompson, 2007).

It is now clear that there is a continuum of causes that crosses both structural and individual issues (Minnery and Greenhalgh, 2007). There is no single pathway to homelessness. Individual factors may include physical and/or sexual abuse, childhood trauma, poverty, disability, disease, mental illness, addictive behaviours, comorbidity, male gender, lack of social ties, and childhood poverty. Macro factors may include availability of affordable housing and employment at an acceptable wage. For most individuals homelessness represents a transient one-time crisis or an episodic problem, for a distinctly different subgroup of individuals, homelessness is a chronic problem (Frankish et al, 2005).

Although homelessness is a problem in rural areas, it has become a pressing problem in large urban areas, where availability of affordable housing is limited due to a loss of rental units and a shortage of social housing (Frankish et al, 2005). Waiting lists for public housing in Queensland, Australia are approximately two years (Queensland Health, 2007).

Poor health is a common problem of homeless people. This can include tuberculosis, infestations with scabies and lice, cellulitis venous stasis and fungal infections, and HIV infections. In addition, they suffer from a wide range of chronic medical conditions, including seizures, chronic obstructive pulmonary disease, musculoskeletal disorders, hypertension, and diabetes. Oral and dental health is poor (Frankish et al, 2005; Kim et al, 2008). Psychotic and affective disorders are common, as are alcohol problems (Rota-Bartelink and Lipmann, 2007). Homeless people are at greatly increased risk of death. For example, an Australian study found that homeless people living in inner Sydney have death rates three to four times higher than people in the general population of New South Wales. Excess mortality was greatest for younger age groups (Babidge et al, 2001).

Homeless people are hospitalized up to five times more than the general population, and they are more likely to use emergency departments as their regular source of care (Schanzer et al, 2007). A study conducted by Herrman et al (2004) of homeless people with psychosis found that there were high rates of contact with the community mental health services, primary health care, and hospital emergency services. Beijer and Andreasson (2009) found that the risk of being admitted to hospital care for physical diseases and injuries for homeless women, compared to homeless men, was slightly higher, and double the risk of the women in the control group. It was found that the risk of being admitted to hospital for homeless men was nearly double that of men in the control group. A qualitative study conducted by Martins (2008) of the experiences of homeless people in the health care delivery system found that the main themes that emerged were living without essential resources compromises health; putting off health care until an emergency arises; encountering barriers to receiving health care; and developing underground resourcefulness.

Given the nature of the client group, data on homelessness is difficult to fully ascertain. It has previously been thought that the homeless population is made up of middle-aged to older males with alcohol problems but in recent times there has been a shift towards women and younger people (Minnery and Greenhalgh, 2007). There has also been a shift towards families, youth, the elderly and marginalized ethnic or migrant groups (Minnery and Greenhalgh, 2007). The emergence of this new type of homelessness calls for new responses in the types and levels of service provisions. Queensland’s total homeless population is 24.6% of the Australian homeless population (Queensland Health, 2007). Thirty-five per cent of the homeless in Queensland are between the ages of 12 and 24.

Queensland Health Homeless Initiative

In Australia, the Queensland Health Homeless Initiative is a state-wide response with a primary focus on mental health and alcohol and other drugs. This initiative has funded the development of specialist mental health teams (HHOTs) who provide comprehensive case management, assessment and intervention for homeless people who are experiencing mental illness.

The service also provides general health care and linkage to general health care services. It was seen that the services would respond to the basic needs of the client group and ensure access or assist with access to fundamentals such as food, housing, health care, pension payments and social inclusion. Services are provided where homeless people gather, so mobile clinics were established at shelters, meal centres etc. This service is provided at set times allowing for optimal access (Queensland Health, 2007).

WHAT IS THE ROLE OF THE HOMELESS HEALTH OUTREACH TEAM

HHOT provides health services, including mental health and drug and alcohol services to people within the Gold Coast region who are experiencing either primary or secondary homelessness. HHOT provides assessment and intervention services to people experiencing a diverse range of mental health concerns, including psychosis, mood dis-
orders, anxiety, substance misuse and suicidal thoughts. An extended hours assertive outreach service is provided to people where they reside in the community or where they access food and support, for example, Havafeed, Rosie’s Breakfast, Set Free, St John’s Drop-in Centre.

**The HHOT approach**

The approach adopted by HHOT is to mix in as much as possible by initiating conversations with patrons. If a private conversation is requested, this is usually carried out using nearby seating. At least two clinicians are involved in all outreach occasions. It is preferable that the clinicians are in sight of each other. Support is given through linking people with appropriate community services, for example, the Homelessness Outreach Support Team. Clinics are provided at supported accommodation services, such as Still Waters for single women, and women and children, and Blair Athol which provides support for single adults or families who are homeless or at risk of homelessness. In addition, support and education is given to the non-government agencies with whom HHOT works.

**Demographic breakdown of users**

*Table 1* provides the demographic profile of people who are referred to HHOT over a one-month period.

For 2009, a total of 123 service users were assessed and provided with case management services, 8 service users were lost to follow-up. Diagnoses included depression (28), schizophrenia (26), substance use (13), bipolar affective disorder (10), adjustment disorder (10), anxiety disorder (9), borderline personality disorder (8), personality disorder (6), schizo-affective disorder (5), intellectual disability (3), Alzheimer’s disease (1), psychotic disorder (1), conduct disorder (1), obsessive compulsive disorder (1), and post-traumatic stress disorder (1). It has been interesting to note that for the first three months of 2010, there have been 140 referrals for assessment. The numbers for referral have shown a steady increase since the time the HHOT was established three years ago. This has had an impact upon the workload of the clinicians.

HHOT is a multi-disciplinary team consisting of psychologists, social workers, welfare officers, occupational therapists, mental health nurses, drug and alcohol workers, a psychiatrist, and administrative support. There are currently 20.5 full time equivalent staff on the team. Staff roster times rotate from week to week through the specified shift times. The work of the team occurs seven days per week. Staff members have a combination of generic and discipline specific role and duties within the team. These are briefly described below:

**Psychology**

Psychologists study the way people feel, think, act and interact. Through a range of strategies and therapies they aim to reduce distress and to enhance and promote emotional wellbeing. They are involved in providing interventions for depression/anxiety, emotional regulation, interpersonal relationship issues, trauma/grief and loss, problem solving, and family therapy.

**Social work**

The domain of social work is that of the social context and social consequences of mental illness and the pursuit of social justice. The purpose of practice is to restore and promote individual, family and community wellbeing. They are involved in obtaining resources on mental health and health services and conditions, developing and strengthening social support networks, and developing working partnerships with non-government organizations and government agencies.

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**Table 1. Database demographics**

<table>
<thead>
<tr>
<th>Number of active/open service users</th>
<th>Total</th>
<th>Comments (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of active/open service users</td>
<td>64</td>
<td>Provision of case management e.g. recovery plans, goal setting, mental state monitoring, risk management, psycho-education, distress tolerance strategies, service co-ordination</td>
</tr>
</tbody>
</table>

| Gender breakdown | Male: 28 | Female: 36 | The connection to the domestic violence services appear to have led to an increase in female participants |

<table>
<thead>
<tr>
<th>Indigenous</th>
<th>4</th>
<th>The indigenous population on the Gold Coast is only 4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culturally and linguistically diverse (CALD)</td>
<td>12</td>
<td>Picked up through domestic violence services</td>
</tr>
<tr>
<td>Under 18</td>
<td>0</td>
<td>Not a targeted group of service users</td>
</tr>
<tr>
<td>Over 65</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>New service users referred</td>
<td>48</td>
<td>4 – opened 21 – no further action 23 – awaiting assessment</td>
</tr>
<tr>
<td>Involuntary treatment order</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Service users discharged</td>
<td>6</td>
<td>5 – referred to GP 1 – not referred on</td>
</tr>
<tr>
<td>Service users assisted to access housing</td>
<td>2</td>
<td>1 into affordable housing 1 into permanent housing</td>
</tr>
<tr>
<td>Service users returning to education/employment</td>
<td>1</td>
<td>0 returning to employment 1 to continue university studies</td>
</tr>
<tr>
<td>Unregistered service users</td>
<td>200</td>
<td>Being monitored through outreach activities</td>
</tr>
</tbody>
</table>
Welfare
Welfare work within community mental health is a generic role that supports many disciplines. This entails variable skills that include abilities to be adaptive and flexible to all situations, to consult and deliver appropriate and consistent care for the service user. The role includes engagement, linking, building partnerships with non-government organizations, navigating and collecting resources that may support the multidisciplinary team.

Occupational therapy
Occupational therapists aim to assist individuals, groups or communities to maximize strengths and build skills to participate effectively in everyday activities. Occupations are seen as the things and activities that occupy time and energy and give meaning to people’s lives. The role may consist of occupational therapy functional assessments, financial assessments, and cognitive assessments.

Mental health nursing
Nurses are interested in engagement with lived experience and the personal journey, rather than only diagnosis and treatment. The role of the nurses involves providing outreach, assessments, health promotion, and supporting consumers with their medications, for example, administering depots.

Drug and alcohol
The people in these positions come from a psychology and occupational therapy background. They are involved in providing drug and alcohol services (counselling, education and advice, referrals) directly to HHOT service users that are unwilling or unable to access mainstream services, and harm minimization intervention to homeless consumers and registered service users who continue substance use.

Psychiatry
There is one part time psychiatrist on the team plus a full-time training registrar. The medical staff are involved in providing assessment and prescription of medication.

THE PROCESS OF REFERRAL

The process of referral is illustrated in Figure 1. It first involves checking whether the person referred is homeless. They may be residing in unconventional accommodation, e.g. sleeping on the street, sleeping in a park, staying in caravan parks, squatting in derelict buildings, or using cars for shelter. It is then necessary to check whether this person has concerns regarding mental health. This might include suicidal thoughts and plans, risk of hurting self or others, low mood, delusions, hallucinations, panic attacks, very high levels of stress, substance misuse, disorganized thoughts, or symptoms of physical illness or injury. If risk of harm to self or others exists it is necessary to call the ambulance.

Finally it is necessary to check whether the person is a current service user, or has been discharged in the past three months by the community mental health services. If yes, advice is provided on how to find accommodation and the person is encouraged to re-engage with the existing service provider for health needs. HHOT has one exclusion criteria: being already case managed by a community mental health team.

The initial management plan is devised in collaboration with the HHOT and the service user. This usually involves facilitating access to accommodation options, for example, referral to the Homeless Outreach Support Team (HOST) or the Department of Housing, clarifying social security status, and addressing acute physical health needs.

If psychotropic medication is indicated, a plan is developed that will provide the greatest chance of this occurring with the service user’s cooperation. Once engaged with the team, service users may continue under care management for a number of months. Only when significant accommodation stability and adequate cooperation with psychiatric services have been achieved is the service user’s care transferred, either to a continuing care mental health services team or to primary care. Service users who tend to be highly mobile may remain engaged with the team for only a few weeks before moving away. They then may reappear some time later when previously established goals may be revisited.
DISCUSSION

Homelessness is an emotive topic with people often making broad statements about how the situation can be changed. In practice, the homeless situation is complex and dynamic, and are the solutions. A recent development has been the introduction of specialized homeless health outreach teams in mental health services, such as described in this article.

The basic principles of practice in the HHOT are consistent with services in other countries. These principles aim to engage the most socially excluded, using approaches that are often difficult to conduct with a busy continuing care community mental health team. The homeless service aims to support the pathway out of homelessness, maintaining continuity for as long as is required.

KEY ELEMENTS OF HHOT

The key elements of the HHOT involve the following components:

Engagement

Service users have a variety of ways of engaging in services. They may make direct contact, or other service providers may make referrals. An important part of the role is to be available at the various ‘feeds’ to provide support to the agencies who provide this service, to assess people who appear to be in need, and to provide follow-up services. A ‘feed’ is free food provided by non-government organizations at various community locations specifically for homeless and disadvantaged people. Also, for some people it may be necessary to give them their depot medications or to provide a medical consultation.

Outreach

The HHOT operates under an assertive outreach treatment model (Queensland Health, 2007). This is essential when working with people who do not readily use clinic-based services. Assertive outreach brings the service to the people in their community setting. This may include shelters, food vans, parks or other homeless agencies. Assertive outreach also includes general health services. Staff may be called upon to assist people to access emergency departments, general practitioner (GP) or specialist outpatient services, e.g. the diabetes clinic.

Assessment

With people referred to HHOT, a full bio-psychosocial assessment is conducted. This may comprise psychological screening, functional, occupational, family and social assessments and a comprehensive psychiatric review. Risk assessments are undertaken with all service users. This may include environmental assessment of the location where the service user is located. Physical health checks are considered on all assessments, as is the assessment of alcohol and drug use.

Recovery plan

Queensland Health is strongly committed to recovery principles and the development of a comprehensive community-based service system that works in a positive manner to address the full impact of mental illness (Queensland Health, 2005). A mandatory requirement is ensuring that each service user has a recovery plan. An essential part of this process is to develop a relapse prevention plan where the early warning signs are identified and strategies to avert a relapse are listed.

Individual interventions

Individual interventions include both psychological treatment plus medication management. Psychological interventions may include motivational interviewing, cognitive behaviour therapy, dialectic behaviour therapy or cognitive remediation therapy. There is a focus on using interventions to increase the service user’s resilience during and following crisis. Techniques used may include problem solving skill development, stress management, and supportive counselling. Services are also provided to assist with budgeting, shopping or other psychosocial skill development. Medication management includes prescribing medication, monitoring of medication, education of the service user and carers and medication review.

Group work

Group work is conducted both in accommodation support facilities plus in the local community. For example, groups are provided to a domestic violence refuge and an accommodation support service. Groups that are run include stress management, relaxation, and drug and alcohol. Groups in the community include a fishing group for case managed service users, and a cricket group for people attending one of the ‘feeds’.

Case management

Each service user referred to HHOT is allocated a case manager with another member of the multidisciplinary team as a second. Each case manager is allocated up to 10 service users. The minimum time a service user may be followed up once securely housed is six months, to allow for appropriate transition to mainstream services. Case managers are involved in secondary consultation, provision of education and training and linkage with primary care providers.
Linkage with other agencies

Strong partnerships have been developed and maintained with other local health and mental health providers. This has included linking service users to available services including disability support services. An essential part of this has been the development of service agreements and memorandums of understanding with a range of community based services. It has been necessary to develop networks and referral pathways between HHOT and non-government organizations to reduce barriers to service access. Additionally, HHOT provides secondary consultation/ liaison and assistance with homeless service users who are currently managed by other teams. HHOT also provide education and training to all partner organizations covering topics risk assessment, borderline personality disorder, substance misuse, self-care for workers, and counselling. The partner organizations direct the education and training provided.

Research

The HHOT currently has a number of research projects which are designed to evaluate various aspects of service delivery with the overall aim to provide information that could be used to improve services for the homeless. See Table 2.

CONCLUSION

Homelessness is an issue that has gained increasing attention over the last few years. HHOT is one example of the development of specialized homeless mental health services that has occurred in Australia. The target population are those individuals or families who are homeless or at risk of homelessness. The majority of service users experience moderate to severe impairment in functioning due to their mental illness, and have difficulty accessing and maintaining accommodation and psychosocial supports. The HHOT team is engaged in assertive outreach and case management and is heavily involved in facilitating networks and linkages with a range of government and non-government services in order to reduce barriers to access. The following article, in the next issue, provides an illustrative case study of the way the team works, and providing an indication of its usefulness in assisting with the problems of homelessness. UTR

TABLE 2. Current research projects

<table>
<thead>
<tr>
<th>Project Description</th>
<th>References</th>
</tr>
</thead>
</table>

CONFLICT OF INTEREST: none

ACKNOWLEDGEMENTS: We thank Merran Fiqia for her assistance in the revisions of this article.


KEY POINTS

- Homelessness is a major social issue in most developed countries.
- The Queensland Health Homeless initiative is a state-wide response which has funded the development of specialist mental health teams.
- The Homeless Health Outreach Team provides health services to people experiencing either primary or secondary homelessness on the Gold Coast.
- The Homeless Health Outreach Team is a multidisciplinary team that has a combination of generic and discipline-specific roles/duties within the team.
- Duties of the staff within the Homeless Health Outreach Team include engagement, outreach, assessment, developing a management/recovery plan, individual interventions, group work, case management, and linkage with other agencies.