DRUG AND ALCOHOL USE OF THE HOMELESS

Chris Lloyd, Margaret Campbell and Robert King,† QLD

ABSTRACT
Alcohol and drug use is commonly reported in homeless populations. A chart audit was conducted of the clients of the Homeless Health Outreach Team. Fifty four charts were reviewed. It was found that a high percentage of people used alcohol, cannabis, opiates, and amphetamines. The drug and alcohol worker on this team has a pivotal role in the assessment and with providing interventions to this client group. The role of the drug and alcohol worker is described.

† Chris Lloyd, Margaret Campbell Homeless Health Outreach Team, Ashmore City, Queensland
Robert King School of Medicine, The University of Queensland
Contact: Margaretd_Campbell@health.qld.gov.au

20 years strong – and now a renaissance – Proceedings of 20th TheMHS Conference 2010
INTRODUCTION
Deinstitutionalisation, the complexities of health care systems and non-government organisations, social security, and a lack of affordable housing have created circumstances in which people with a serious mental illness are over-represented among those who are chronically homeless (McHugo et al., 2006; Rowe, 2007). People with mental illness are at a greater risk of developing substance use disorders compared to the general population (Greig et al., 2006). More than half of those people who are chronically homeless are both substance abusing and struggling with serious mental illness. People with psychotic disorders experience high rates of functional impairment and disability, decreased quality of life, persistent symptoms, substance use comorbidity and frequent side effects of medication (Jablensky et al., 2000). Homeless people with substance use and mental health problems are at increased risk for chronic homelessness, hospital recidivism, incarceration, and mortality (Bradford et al., 2005). These people tend to use emergency department visits rather than having access to a regular GP or consistent outpatient treatment (Bradford et al., 2005).

The rate of substance use disorders in clients with mental illness within the spectrum of psychotic disorders, such as schizophrenia, schizoaffective disorder and bipolar disorder is higher than the rate observed in the general population and has been associated with increased psychotic symptoms, and increased rate of medication and non-compliance, more frequent and longer hospitalisations, a higher rate of crisis-oriented service utilization, and consequently a higher cost of care (Petrakis, Nich, & Ralevski, 2006). Social problems associated with substance abuse in these clients include legal entanglements, housing instability, lower rates of employment, and poor money management (Petrakis et al., 2006). They also have numerous physical and chronic health conditions, which are often untreated and poorly managed. These clients are unstable, diagnostically complex, difficult to recruit in studies, difficult to engage in treatment, and especially difficult to retain in treatment (McHugo et al., 2006).

Risk factors for this population include poverty, homelessness, lack of adequate housing, incarceration, and unemployment (Fichter & Quadflieg, 2001). It has been found that homeless men and women died three to four times more frequently than the general population. The number of deaths from cardiovascular causes is probably related to the high number of participants who smoked tobacco, although other factors such as a poor diet and excess alcohol may be important (Babidge, Buchrich, & Butler, 2001). Alcohol dependence probably contributed to many of the premature natural deaths from alcoholic liver disease, gastro-intestinal bleeding and seizures. Overdose of prescribed medication was the most common cause of suicide. Accidental deaths resulted from heroin overdosing, heroin being the most commonly used illicit drug.

Homeless substance abusing men have been found to consume twice as much alcohol as women (Lai & Huang, 2007). Research also indicated that men tend to use substances for different reasons compared to women. Men tend to use substances when their first experience of the substance was physically powerful also following a confrontation and anger with a significant other. Kaplan (1996) found that women tended to use more substances following the breakdown of a personal relationship. Homeless individuals pose special challenges for treatment providers because many suffer from a mistrust of services, have multiple problems and tend to be highly mobile (Malcolm, 2004).

METHODS
This research utilized a chart audit to collect the relevant information. The aim of this research was to: Develop a greater understanding of the drug and alcohol use of the homeless people assessed and treated by the Homeless Heath Outreach Team.
RESULTS
There were 54 charts accessed. There were 24 males and 30 females. The most commonly seen diagnoses were schizophrenia, depression, bipolar affective disorder and personality disorder. Of these 7 (13.0%) had experienced primary homelessness; 25 (46.3%) had experienced secondary homelessness; 1 (1.9%) had experienced tertiary homelessness; and 21 (38%) had experienced a combination of the various types of homelessness. Of these 42 (77.8%) had used alcohol; 38 (70.4%) had used cannabis; 24 (44.4%) had used amphetamines; 12 (22.2%) had used opiates; 7 (13.0%) had used benzodiazepines; 15 (27.8%) had used designer drugs; 4 (7.4%) had used inhalants. 95.2% of people had used alcohol within the previous month (daily and weekly). 26.3% had used cannabis within the last month (daily and weekly). 88.2% had used amphetamines within the last month (daily and weekly). 66.7% had used opiates within the last month (daily and weekly). 50% had used benzodiazepines within the last month (daily and weekly). 94.6% had commenced using alcohol in their early teen years.

DISCUSSION
Homeless Health Outreach Teams have been introduced in key regions in Queensland. 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 supports. Services are provided where homeless people gather, for example, community ‘feeds’. Two people on the team are specialist drug and alcohol workers. They are involved in providing drug and alcohol services (counselling, education and advice, and referral) directly to substance abusing individuals that are unwilling or unable to access mainstream services, and harm minimization interventions to homeless consumers and registered clients who continue to substance use.

Drug and alcohol treatment is intended to help individuals manage their compulsive drug and alcohol use better. Treatment can occur in many different ways, for different lengths of time and a variety of different settings. Because drug and alcohol addiction is a chronic disorder that is characterised by occasional relapses, a conventional short-term or one-time treatment is usually not sufficient and in particular when working with consumers with multiple complex problems that include homelessness and mental health problems. For many individuals' drug and alcohol recovery is a long process that includes multiple interventions, strategies and multiple attempts.

The role of the Homeless Health Outreach Team (HHOT) drug and alcohol clinician is to work with people that experience difficulties in their lives due to drug and alcohol use. These difficulties may be caused by substance abuse and or addiction, and can lead to other problems such as financial problems, homelessness, psychological or emotional difficulties, worsening of mental health problems and break down of social and family supports.

The role includes providing drug and alcohol services that include counselling, education, advice, and referral directly to HHOT clients that are unwilling or unable to access mainstream services. The aim is to provide services that suits the consumer's needs, whether it is harm minimisation or complete abstinence. The role also involves providing harm minimisation intervention to homeless consumers and registered clients who continue substance use. HHOT also provides these drug and alcohol services to homeless consumers that are not registered HHOT clients under a “Brief Intervention Model”.

The drug and alcohol clinician within HHOT uses a variety of evidence-based approaches in treating addiction. Drug and alcohol treatment can include behavioural therapy, cognitive behaviour therapy, dialectical behaviour therapy and motivational interviewing. The type of treatment or combination of treatments will be different depending on the individual's needs and on the types of drugs they use. The severity of addiction and previous efforts to stop using drugs can also influence a treatment approach.
Drug and alcohol treatment usually includes screening, assessment and treatment planning, brief interventions, alcohol and drug withdrawal management, psychosocial interventions for substance use disorders, discussions and education around pharmacotherapies for alcohol and drug dependence and providing psychoeducation and counselling on dual diagnosis where relevant.

Behavioural therapy, cognitive behaviour therapy, dialectical behaviour therapy and motivational interviewing is used to help motivate consumers to participate in treatment, offer strategies for reducing harm, offer strategies for coping with drug and alcohol cravings, teach ways to avoid drugs and alcohol and prevent relapse where relevant and help individuals deal with relapse if it occurs.

Another part of the HHOT drug and alcohol clinicians’ role is to provide drug and alcohol consultancy service to other HHOT team members and to work collaboratively in case managing consumers with substance use problems. The role also includes doing training and in-services on a variety of drug and alcohol topics for HHOT staff and staff of non-government organisations and other services involved. These topics include the type of substances abused and their effects, different types of treatment options, identifying withdrawal and harm minimisation to name only a few.

The HHOT drug and alcohol clinician also liaises and networks with Queensland Health Alcohol, Tobacco and Other Drug Services (ATODS) on service delivery matters. The role also includes liaising and networking with other drug and alcohol services provided by non-government organisations to provide the best treatment options to HHOT consumers.

CONCLUSION
Homelessness is a matter of concern. Many of the people seen by the HHOT clinicians not only have mental health issues but have also significant problems with the abuse of substances. The Drug and Alcohol Worker works closely with homeless people who have substance use issues using a variety of treatment interventions. This is a challenging role and is constantly developing in response to the types of people referred to the team.

REFERENCES

