DIABETES AND THE HOMELESS

Chris Lloyd, Darren Taggart, Rod Nathan\(^1\) and Robert King\(^2\), QLD

**ABSTRACT**

Homeless Health Outreach Teams were established in Queensland to provide services to people who are homeless. The Gold Coast Homeless Health Outreach Team established the Diabetes Awareness Program in an effort to provide screening for diabetes to this vulnerable client group. This presentation talks about the establishment of this program and what the challenges have been.

**INTRODUCTION**

Homelessness is a growing problem. It is estimated that about half of all homeless people suffer from chronic medical conditions. Unfortunately, these people frequently encounter many more barriers to care than the general population thus exacerbating their health problems (Chiu & Hwang, 2006). Diabetes is a common, costly and ever-increasing health problem, with chronic complications that result in a heavy socioeconomic burden for people with the disease, the health care system and society (Ringborg et al., 2009). Chronic complications, the major cause of morbidity, premature mortality and costs of diabetes, can be significantly reduced by control of blood glucose and associated cardiovascular risk factors (Ray et al., 2009). The cost of these treatments is within the range of currently accepted preventative interventions. Despite the available evidence, prevention strategies have not been widely incorporated into clinical practice and the care received by many people with diabetes is less than optimal worldwide (Chan et al., 2009).

The prevalence of diabetes is approximately 10-15% in people who have schizophrenia or bipolar affective disorder. This represents a two to three-fold increased risk compared with the general population (Pendlebury & Holt, 2008). Lifestyle is probably the most important risk of diabetes in severe mental illness. Poverty, urbanisation, poor diet, and physical inactivity are important risk factors for diabetes that occur more frequently in people with severe mental illness. Genetics is also important as demonstrated by the high number of people with severe mental illness who have a first-degree relative with type 2 diabetes (17-50%) (Pendlebury & Holt, 2008). People with schizophrenia who exhibit insulin deficiency at the start of their illness have an increased susceptibility to developing diabetes as a result of the adverse effects of poor diet (Pack, 2009). People with a severe mental illness are more likely to have unhealthy diets, more likely to abuse substances, more likely to smoke, less likely to engage in physical activity, and experience deprivation (Law, 2007). These lifestyle factors are important in considering health-related mortality in people with schizophrenia (Pack, 2009).

The high rates of undiagnosed diabetes and the long duration between diabetes onset and symptom development provide an argument to screen for diabetes in the general population.

\(^1\) Chris Lloyd, Darren Taggart, Rod Nathan - Homeless Health Outreach Team, Ashmore City, Queensland. Contact: Darren.Taggart@health.qld.gov.au

\(^2\) Robert King, School of Medicine, The University of Queensland
This imperative is even stronger when as many as 60-70% of all those diagnosed with severe mental illness and diabetes are undiagnosed (Pendlebury & Holt, 2008). Despite the imperative to screen for diabetes, current evidence suggests that this is not being undertaken (Pendlebury & Holt, 2008). Persons with diabetes can develop many complications as a result of damage to organs, such as the kidneys, eyes, heart, blood vessels, and skin. Treatment of the disease and prevention of these complications require a significant commitment on the part of both the person with diabetes and the care provider. For many people, lifestyle changes may alleviate the need for medications in the early stages of the disease. These changes primarily involve diet and exercise, neither of which is easy to control for persons who sleep on the street and who eat in soup kitchens.

WHAT IS HOMELESSNESS?
Homelessness can affect anybody and people who are homeless come from all age groups, and include women and men and people from all cultural backgrounds. It has been estimated that every night around 105,000 people are homeless. The most widely accepted definition of homelessness in Australia describes three types of homelessness. These include: primary homelessness where people are sleeping rough, in parks or at the beach, squatting in derelict buildings etc.; secondary homelessness includes people who are staying with relatives or friends (couch surfing), people using emergency accommodation, refuges; and tertiary homelessness includes people living in boarding houses or caravans parks with no secure lease and no private facilities (Commonwealth of Australia, 2008). There are many causes of homelessness including lack of affordable housing, domestic violence, long-term unemployment, family breakdown, mental health problems, substance abuse, and people leaving health care services, child protection and correctional facilities.

THE QUEENSLAND HEALTH HOMELESS INITIATIVE
The number of rough sleepers is highest in Queensland. Queensland Health provides a holistic approach to health care for homeless people. They work closely with other departments and non-government organisations to ensure that there is an appropriate response to the health needs of homeless people residing in and around public places. The Queensland Health Homeless Initiative is a state-wide response involving a number of District Health services with a primary focus in mental health and alcohol and other drugs. This initiative has funded the development of specialist mental health teams known as Homeless Health Outreach Teams (HHOT) who provide comprehensive case management, assessment and intervention for homeless persons who are experiencing mental illness (Queensland Health, 2007).

Service delivery is focussed around people and not places which increases the ability of HHOT to successfully engage homeless people and encourage their participation in treatment. The service delivery model has three key components, these being assertive outreach, case management, and collaborative response.

Assertive outreach – is used to help people access and connect with services. It is seen as essential in reaching and engaging people who are homeless as it allows timely, available and responsive access to services to people who do not readily use clinic based services. Assertive outreach may include helping people with medications, housing, finances, and everyday problems in living. It may occur on the streets or it may be provided at places where homeless people are known to gather, for example, shelters, food vans, parks or other homeless agencies (Queensland Health, 2007).

Case management – recognises the importance of other factors that affect one’s health such as social support networks, income, education and training, personal health practices, and coping skills. A primary case manager is provided along with a back-up case manager who with appropriate consents, collaborates with other service providers to ensure continuity in and comprehensive treatment (Queensland Health, 2007).
Collaborative response – co-ordination with other service providers, for example, Housing, Centrelink etc, will ensure that a holistic response is provided. The development of networks and referral pathways between Queensland Health, non-government organisations and other services providers has been encouraged to reduce barriers to service access (Queensland Health, 2007).

THE ROLE OF HOMELESS HEALTH OUTREACH WORKERS
Approximately four years ago HHOT were established in Queensland (Brisbane, Gold Coast, Mt Isa, Townsville, and Cairns and just recently two additional teams have been established (Logan and Sunshine Coast). The Gold Coast HHOT team consists of a team leader and 20 staff who are rostered to work 7 days per week and provide extended hours coverage. The team consists of nursing, social work, welfare officers, occupational therapy, psychology, and dual diagnosis workers. There is a part time psychiatrist on the team and a full time training registrar. The mission of this team is “to minimise the health problems of people experiencing homelessness and contribute to the prevention and reduction of homelessness within Queensland through collaboration to facilitate access to appropriate supports”.

HHOT is not an accommodation service. HHOT provides health services, including drug and alcohol services to people living 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 disorders, 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. Support is provided by linking people with appropriate community services. Support and education is also provided to the non-government agencies that HHOT works with.

Many of the people seen by HHOT have complex needs, which include:
- Poor physical health
- Impaired mental health and drug and alcohol disorder leading to disability;
- Socially excluded – no home, no employment or meaningful activity, no connection to family or community

These individuals are also impacted upon by the triple jeopardy of the links between poor housing and social care, poor health and justice issues. They have often been excluded or bounced from accommodation to accommodation and there is a noted deterioration in their circumstances. These people require collaborative case management and planning to respond to their needs.

It was this awareness of the complex health needs that led the HHOT to develop a program (Diabetes Awareness Program) to assess the health risks experienced by homeless people. This program focuses on the physical health of people in addition to their mental health. When on outreach staff approach rough sleepers and offer to do a physical health check which includes taking a person’s blood pressure, blood sugar levels and weight. In addition, a physical check (particularly the person’s feet) is conducted to see if the person has any wounds or ulcers. If they have dressings are applied. The clinician asks questions related to diet, alcohol intake, their activity levels, finances, and whether or not they have any chronic illnesses. If it appears that the person has untreated diabetes he/she is taken to a GP for diabetes advice and management. Any follow up that is required is managed by the HHOT. For further diabetes education and management the person is taken to the Diabetes Resource Centre (the CNC at the Diabetes Resource Centre provides supervision to the nurse who runs the Diabetes Awareness Program).
CASE STUDY
The involvement of HHOT clinicians is described below.

Mike Gun was found in a local park on the Gold Coast. It was not hard to spot Mike as he
was lying in the open, on the ground, in a pair of shorts and a t-shirt, on a chilly winter
morning at around 7.30am. Mike was approached by two HHOT clinicians and asked very
casually "how’s things?" Mike presented as: slim, untidy, unshaven, grey haired gentlemen
who looked physically older than his age of 41, by a good 10 to 15 years. Mike’s initial
problems were not evident as after a small introduction he reported "I’m fine and I don’t
require any assistance". The HHOT team provided Mike with a 'survival pack' which is a
backpack with roughly 5 days worth of food in it, a space blanket, a torch etc. Mike was left
with his backpack and observed from a distance. It was strange how Mike walked away from
his recently provided supplies and laid once again on the ground and began to sleep. Mike
was again approached by the HHOT team and asked “are things OK?” Mike reported with
difficulty due to him stuttering that he is “having difficulty finding clean food to eat”. After
careful, thoughtful psychiatric assessment it became evident that Mike had delusions
involving him believing that most food was poisoned by the Government, in an attempt to
take away his thoughts. Many things needed to be considered in addition to Mike’s mental
health as his physical health was severely compromised and he was not agreeing to any
help. The HHOT team realized that further planning was required to improve Mike’s health
status.

The planning process involved the HHOT clinicians returning to the car and discussing
options. However, these appeared to be limited. In the space of about ten minutes Mike’s
fate was decided. He would be put under the Mental Health Act and transported to Gold
Coast Hospital Emergency Department for a long overdue Medical and Psychiatric
assessment. After more discussions with Mike he agreed to enter the car and attend the
hospital with the HHOT clinicians. Although further down the road the situation changed as
Mike’s delusional beliefs and his internal voices were not going to let him go to hospital. Mike
came agitated and angry and refused to go any further in the car. The HHOT team pulled
the car over and Mike got out and walked towards a bus shelter where he sat. There was
nothing the clinicians could currently do as Mike jumped on a bus and was off. The HHOT
team spent the remainder of the afternoon faxing, communicating to the police and relevant
non government organizations to ensure that Mike could be located tomorrow. The next
Morning the HHOT team headed at 6.30am to the park where Mike had previously been
located. A quick phone call to the local Police ensured that they would meet the clinicians
there. It was a long shot that Mike would be there but sometimes, long shots are all you
have. Arriving at the park with the police proved successful as Mike was located in the same
location. This time Mike agreed to get in the police vehicle and be taken to Gold Coast
Hospital

After arriving at the hospital Mike was given a full physical and mental health assessment,
provided with food, drink, shelter and dignity. Mike spent two weeks in hospital. Mike further
received treatment for diabetes type 2 which involved medication, and some relevant
education on diet and general health.

Mike’s journey began after discharge from hospital. Mike’s internal voices and delusions had
settled enough for him to eat and drink regularly. But changing his homeless lifestyle and his
poor commitment to his health would take a long assertive commitment by HHOT and other
services. Mike currently still lives in various parks around the coast and is generally
untouchable. When Mike is found his BSL’s are checked and he is provided with education
in regards to diet, and reducing alcohol consumption. Mike is agreeable to follow-up
although he does not make it easy. Mike was initially housed in a hostel when he left hospital
but Mike reported that he felt to restricted there. So once a week the HHOT team attempt
and generally succeed in making contact with Mike and supplying him with medication.
DISCUSSION
People with chronic diseases such as schizophrenia can expect to live 9-12 years fewer, on average, than those in the general population (Lambert, Velakoulis & Pantelis, 2003). People with mental illness also have high rates of physical comorbidity. Unfortunately, it has been found that the detection rate of physical illness among people with mental illness is very poor. High mortality and morbidity in schizophrenia many be attributed to an environment in which unhealthy and high risk behaviours such as smoking, substance abuse, lack of exercise and poor diet are prevalent (Lambert et al., 2003). Despite the high comorbidity and mortality rates in people with serious mental illness, there are significant barriers to the early detection and treatment of physical comorbidity. Barriers to effective physical healthcare for mentally ill people include patient-related elements, the nature of the illness, the medical system and available resources, and the attitudes of medical practitioners themselves. It is well recognised that there is an increased incidence of type 2 diabetes in people with a diagnosis of schizophrenia. It has been suggested that the prevalence of diabetes among people with schizophrenia may to two to four times higher than in the general population (Gough & Peveler, 2004). It has been suggested that type 2 diabetes may begin, on average, 9-12 years before the condition is diagnosed. Type 2 diabetes has an insidious onset and is associated with non-specific symptoms (polyuria, polydipsia, nocturia, unexplained weight loss, loss of energy, recurrent infections such as candidiasis, and blurred vision) that could be easily attributed to other causes (Gough & Peveler, 2004). Identifying patients as early as possible in the course of their condition, ideally at the pre-diabetic stage, would allow for early intervention, a slowing of disease progression, and possibly even a reversal of some of the underlying pathological changes.

Peet (2004) suggests that in order to reduce the risk of obesity, diabetes and coronary heart disease in people with schizophrenia, it is important to focus on developing a healthy lifestyle, including good dietary practice and sufficient exercise. Lifestyle advice should be provided to all patients with a diagnosis of schizophrenia. Physical activity is now known as one of the most protective factors against diabetes and cardiovascular disease, and even reduces morbidity and mortality in people who are obese (Smith et al., 2007). All people with type 2 diabetes need specific lifestyle advice including: decrease the energy and fat content in their diet and increase fibre intake; increase their intake of fruit and vegetables; eat complex rather than simple carbohydrates e.g. whole wheat bread rather than refined white bread; avoid sugary drinks; and exercise for at least 10-15 minutes per day (Gough & Peveler, 2004). Staff in the Diabetes Awareness Program have taken increased responsibility for managing the health issues of the homeless people that they see. This has included screening for diabetes, providing education about healthy living, and involving other specialists (e.g. Diabetes Resource Centre) or primary care (e.g. GPs) where necessary.

CONCLUSION
The Diabetes Awareness Program is one of the programs run by the Homeless Health Outreach Team. This presentation has talked about the establishment of this program, the types of clients, how the staff screen for diabetes, the healthy lifestyle approach taken by the staff, and the various locations where people are seen. This has been a big challenge but the team believes that they are providing a valuable service to a most disadvantage group of clients.

REFERENCES
REFUGEE RESETTLEMENT AND PARTICIPATING AS A PEER IN AUSTRALIAN SOCIETY

Jay Marlowe,¹ Auckland, NZ

ABSTRACT:
Numerous studies acknowledge the increased mental health concerns of refugees who have experienced trauma from forced migration. Whilst past traumatic experiences may place people at risk, it is recognised that resettlement is an equally salient concern. Australia’s most recent National Mental Health Policy has several overarching aims which endeavour to promote well being, prevent mental illness and help facilitate recovery for individuals, families and the community. To accomplish such goals with resettling refugee populations, it is important to create spaces that provide people the opportunity to voice their story and perspective – recognising they are often marginalised by a number of factors that may include past traumatic experiences and difficulties adapting to a new life in Australia. This paper relates to Sudanese men’s narratives about resettlement and their perspectives of participating in Australian society as key considerations towards the promotion of health and well-being.

¹ Address Correspondence to: Jay M. Marlowe, School of Counselling, Human Services and Social Work, Faculty of Education, The University of Auckland, Private Bag 92601, Auckland 1150, NEW ZEALAND. Phone number: (64 9) 623 8899 (ext 48248) fax number: (64 9) 623 8898; e-mail: jmarlowe@aubdcl.ac.nz