WORKING WITH THE HOMELESS: THE CHALLENGES FACED BY THE HOMELESS HEALTH OUTREACH TEAM

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ABSTRACT
It has been estimated that every night around 105,000 people are homeless. There are many causes of homelessness. The Queensland Health Homeless Initiative has funded the development of specialist mental health teams known as Homeless Health Outreach Teams (HHOT) who provide comprehensive care management, assessment and intervention for homeless people who are experiencing mental illness or drug and alcohol issues. A multidisciplinary team works in the Gold Coast HHOT. The primary aim is to assist individuals to maximize strengths and to build skills to participate effectively in everyday activities. The role of staff involves conducting assessments (MSE and risk), goal setting, and formulating a relapse prevention plan, and focussed interventions. People who are homeless have many needs, for example employment, affordable housing, managing money, getting along with others and with using resources. Developing the role of the team has been challenging as the work practices have moved outside traditional case management with more of a focus on assertive outreach and active collaboration with both non-government and government agencies in an attempt to address the multiple and complex needs of the homeless.

INTRODUCTION
Every night around 105,000 people are homeless. The rates of rough sleepers are highest in the Northern Territory, Queensland and Western Australia. On census night there were 56% men and 44% women who were homeless (Queensland Health, 2007). There are many causes of homelessness and people who are at risk of homelessness tend to face many difficulties, for example, domestic and family violence, mental health problems, drug and alcohol addiction, and poverty (Commonwealth of Australia, 2006). Homelessness has a direct impact on health. Homeless people, particularly rough sleepers, have a higher rate of serious morbidity compared to the general population. They are responsible for a disproportionate use of judicial, social and health care resources. This paper describes the work of the HHOT.

The Homeless Health Outreach Team
Across the state of Queensland, Homeless Health Outreach Teams have been established. They are multidisciplinary teams consisting of medical, nursing, occupational therapy, social work, and psychology staff. Their focus is on mental health and alcohol and drug issues. They are encouraged to actively work in partnership with other agencies including general practitioners, non-government organisations, local councils and other government agencies, for example, housing and Centrelink. This approach is designed to develop a holistic approach to service delivery. A recovery approach is followed recognising that clients have the greatest knowledge and expertise regarding their needs and service requirements. With people who are referred, a comprehensive assessment is conducted and staff work collaboratively with clients to develop an agreed individual treatment plan.

The service delivery model has three key components: assertive outreach, case management, and collaborative response.

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Assertive outreach: This is essential in reaching out and engaging with people who are homeless. Most importantly it brings the service to people in their own community setting. This may include parks, shelters and food vans.

Types of outreach include: general outreach which involves walking the streets; planned outreach which involves attending places where another services provides services for people who are homeless such as food, welfare etc.; outreach clinics which can be provided in planned outreach settings or emergency accommodation venues such as the Salvation Army and domestic violence refuges.

Case management: A primary case manager is allocated to each referred person with a second staff member acting as the back up.

Collaborative response: Co-ordination with other service providers is essential. This has seen the development of networks and referral pathways between Queensland Health, other government and non-government agencies to reduce barriers to service access.

Staff in the HHOT work extended hours across seven days per week, 365 days of the year. They have a combination of generic and discipline specific role and duties within the team. To meet criteria for the Gold Coast Team, the person referred must meet criteria for primary (without conventional accommodation) or secondary (shelters, refuges, boarding houses) homelessness (Chamberlain & McKenzie, 1992) and have either a mental health problem or a substance use issue. Diagnoses commonly seen by the HHOT team include depression, schizophrenia, substance use, bipolar affective disorder or personality disorder. On average, the team has approximately 46 referrals to the team per month (Lloyd & Bassett, 2010). It is recommended that service support should be provided as long as it is required.

Benefits for the clients: Provision of regular service in the client’s own environment, assistance with practical issues, consistency of services, advocacy, and a point of connection with the wider community.

Working in the HHOT involves the following:

Engagement: People may make direct contact or other service providers may make referrals. An important aspect of HHOT is being available at the various feeds for example to provide support to the agencies who provide this service.

Outreach: Staff may be called upon to assist people to access emergency departments, GPs, or specialist outpatient services.

Assessment: A full biopsychosocial assessment is conducted (including a risk assessment, drug and alcohol use, physical health checks).

Recovery plan: Every client has a recovery plan and a relapse prevention plan where early warning signs are identified and strategies to avert a relapse are listed.

Individual interventions: This includes both psychological treatment in addition to medication management. There is a focus on using interventions to increase the service user’s resilience during and following crisis.

Group work: Groups are run in the crisis accommodation services such as relaxation, communication and in the community, for example fishing.

Case management: Each team member has up to 10 service users. All home visits or visits to the consumer are done in pairs. Case management may involve secondary consultations, provision of education and training, medication management, and linkage with primary care providers.

Linkage with other agencies: It is important that strong ties have been developed and maintained with other local health and mental health providers, other government agencies e.g. Centrelink, and crisis accommodation services and domestic violence shelters. HHOT provides education and training to all partner organisations covering such topics as risk assessments, substance misuse.

Research: A number of the team are actively involved in conducting research projects, for example the family connections of homeless people, an investigation of the drug and alcohol use of homeless people seen by the Homeless Health Outreach team.

Challenges

There have been a number of challenges in establishing the HHOT team. Initially the team began with 4 members and today it consists of 20.5 staff. In the initial days, it was considered very important to get to know the other services who were involved with the homeless. This involved many meetings with a focus on learning about the services they provided and the types of services that the HHOT could offer.

The staff initially did not work extended hours but as staffing levels increased this was addressed with the staff working two shifts per day and on the weekends as well. Working in the evenings has its own challenges. In the evenings two staff attend various feeds on the Gold Coast. Not all feeds are run well and sometimes there is drunkenness and violence. It is important that staff are able to conduct a though risk assessment of the environment before deciding to attend the feed or not. This may well be sitting in the car and observing what is going on before making a decision to go to the feed.

Some clients are difficult to follow up. Not all people have mobile phones or accept going into emergency shelters. This may well necessitate seeing the person and making the arrangement to meet the person again at a specified time in a public location e.g. in a park or down by the beach. Other clients may be on involuntary treatment orders which means that they have to be followed up. If they do not keep appointments or stop taking medication steps are taken e.g. getting in contact with the police to bring them in for an assessment/interview. Some clients have a history of violence which means that it is not safe to see them in their own environment, and so arrangements are made to see them in the emergency department or at the clinic when a security guard is present.

A team such as the HHOT requires staff to have very good clinical skills. As many of the clients come from disadvantaged backgrounds, they have many issues to deal with. Staff need to have a broad range of skills to be able to offer appropriate treatment. For some staff this can be an issue when they are required to conduct a greater proportion of their time on generic work (mental state examinations, risk assessments, monitoring mental state) which leaves them little time to do discipline specific work.

A key aspect of working in HHOT is that of staff attitudes. People are required to think outside the traditional mental health roles and to be flexible in service delivery. It is important that the client is placed in the centre. This means that staff may well have to negotiate various times and places to see the person. It is not an office based position that works regular hours.

A high percentage of people seen by HHOT have drug and alcohol issues. There are two drug and alcohol workers on the team but at times, it is problematic as to whether adequate drug and alcohol assessments are made and whether people are referred on to the drug and alcohol workers for specific drug and alcohol related counselling and referral to appropriate agencies.

Working with the homeless requires individual clinicians to have excellent links with other agencies and services. Staff need to be able to advocate for their clients and ensure that they are referred to the appropriate services. For example, many homeless people don’t have a GP or they are not on the housing list.
Then there are administrative tasks which can be a challenge. Staff are required to enter all their notes on the electronic database. This should be a simple task but the number of computers that are available makes it quite difficult. There are only a set number of cars that are available for use and given that this is a very mobile team with an outreach focus, it can be difficult at times to obtain a car to do the required duties of the day. The actual headquarters of the team is also an issue as it is far too small to comfortably accommodate such a large team.

CONCLUSION
In establishing the HHOT team there have been opportunities to develop a role in a relatively new area of practice. There are many ongoing challenges. But the team has shown strength by being able to address many of these challenges.

REFERENCES