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The role of an Australian homeless health outreach team. Part 2: a case study

Laura Murtagh, Chris Lloyd, Hazel Bassett

Background: Throughout the western world, the issue of homelessness has been receiving increasing attention. As a government response to homelessness in Australia, the Queensland State Government developed a strategic plan to address this issue, establishing Homeless Health Outreach Teams.

Contents: This article follows on from the previous issue, where the background to a team's formation is discussed. This article continues this discussion by describing a case study of a homeless service user. The areas that are addressed include the team involvement, recommendations for continuing treatment, and the practical ways in which the service user was assisted.

Conclusions: A key feature of team's work was the close working relationships established with both the non-government and government sectors in order to address the service user's complex needs. The work was challenging, but the potential of working in this way with a population experiencing homelessness is only limited by the creativity of the team.

Key words: ■ Australia ■ collaborative partnerships ■ homelessness ■ mental health issues ■ outreach

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The problem of homelessness has received increasing attention in recent years, and the Queensland Health Homeless Initiative Strategic Plan 2006-2009 targets people who are at risk of homelessness, in addition to those who meet the adopted definition of homelessness (Queensland Health, 2007). It was envisaged that the implementation of this plan would improve the health outcomes for people subject to homelessness by increasing the capacity to respond effectively and consistently to their identified health needs.

There is a close link between health status and the reason a person is homeless or at risk of homelessness (Rota-Bartelink and Lipman, 2007). Health services only provide a small part of the services to homeless people, and cannot alone solve the problems or complex causes. With this being the case, it is necessary to work to improve and maintain health outcomes through collaboration with non-government organizations, the homeless community and other partners. Across the state

of Queensland, Homeless Health Outreach Teams (HHOT) have been established. They are encouraged to actively work in partnership with other agencies including general practitioners (GPs), non-government agencies (NGOs), local councils and other government agencies. It was seen that this approach would assist in the development of a holistic approach to service delivery. Part 1, in the previous issue, provides a literature review which defines homelessness and the extent of the problem. The way in which the HHOT works is also described.

This article describes a case study of a homeless person that the Homeless Health Outreach Team was involved in assessing and treating. She is a fairly typical example of the type of person that is seen by the HHOT. A pseudonym has been used to protect the identity of the service user. Prior to the case study being written up, the service user signed a consent form in line with current Queensland Health policy agreeing that her case could be written up and submitted as a journal article.

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CASE STUDY

Background information

Lee is a 30 year old single female. She was the youngest of four siblings. Lee reported that her parents separated when she was 16. She did well at school and enjoyed school work, sport and dancing. After leaving school, she worked in a coffee shop, real estate, bar work, and as a dancer. Lee gave birth to a child in 2005, which was removed from her care due to Lee's homelessness, chaotic lifestyle, poor social supports, lack of bonding and mental state.

Lee has had many presentations to the emergency department (from 1994–2008) on an approximately monthly basis, in the context of a variety of somatic complaints, for example painful cracked heels, sore arm, soreness between toes, shoulder pain, vaginal bleeding, and menstruation issues.

Lee has experienced long term mental health concerns without appropriate treatment. She was assessed when she gave birth to her child as having a schizoid personality disorder and was commenced on a low dose of oral antipsychotic medication and offered community follow up, although she never engaged. She has a history of itinerancy, unemployment, and limited social supports. Lee describes a history of couch surfing and staying with friends or acquaintances for short periods. Due to this, Lee lost contact with her parents and siblings. Social security records show multiple changes of address (often several times in one month) from 1997–2008. Accommodation appeared to be varied and seems to have been a combination of private residences, hostels, motels, and crisis accommodation facilities.

She is known to have a history of being quite sexually disinhibited. Lee is at risk of being sexually abused in the context of exchanging sex for accommodation, security etc. Lee threatened to kill herself in 2003. This was in the context of intoxication.

Homeless Health Outreach Team Involvement

HHOT were first made aware of Lee by referral from Centrelink, the Government social security agency. At this time, Lee was observed to be quite hostile and guarded, with the person referring her describing her as 'vulnerable and disturbed, with a history of disappearing'. A follow up appointment was arranged, but Lee did not attend and was not sighted at any outreach venues.

Approximately one year later, Lee was sighted at an outreach venue. At this time, she was observed to be guarded, suspicious, thought disordered, neglecting self-care and experiencing incontinence. Members of the public and volunteers at a local soup kitchen were expressing increased concern for her wellbeing. Lee was admitted involuntarily to the hospital following a request and recommendation. On admission to the psychiatric unit, Lee presented with irregular rate and volume of speech, poverty of thought, poor insight and judgement, and anxiety symptoms. She was diagnosed with schizophrenia.

Lee was discharged from hospital into the care of HHOT. Case management was commenced with a focus on rapport building, engagement, psycho-education and relapse prevention. Lee has gradually gained some insight into her illness and has identified that her illness was triggered by homelessness, unemployment, sexual vulnerability, an unwanted pregnancy, and drug use (THC and speed). Lee described her behaviour while unwell as 'erratic', and recognises that she was unable to care for herself during this time. While compliant with medications, Lee continues to lack insight into her need to take medications and the positive impact that medications have had on her mental state. Lee stated that if she was not on an Involuntary Treatment Order (ITO) it would be unlikely that she would continue to accept depot medication or be compliant with oral medication.

A variety of generic and occupational therapy specific assessments were completed, including mental health assessment, functional and financial assessments and cognitive assessments. Assessment findings suggested that with appropriate external support and skills training, Lee may have the capacity to live independently and maintain a tenancy. The following discusses the recommendations for continuing treatment and outlines the practical ways in which Lee was helped.

Recommendations for continuing treatment

It was recommended that HHOT case management be continued with a focus on:

- Maintaining engagement
- Ensuring compliance with Involuntary Treatment Order (ITO)
- Psychoeducation
- Facilitating goal setting
- Practical assistance
- Advocacy and support.

Practical measures

Some of the practical ways in which Lee was helped are listed below.

Meaningful activities and groups.

Lee was referred to the mental health rehabilitation programme and completed the 'Mind, Body, Life' programme which focuses on healthy lifestyles, and has now engaged in a cooking group and a leisure/fitness group.

Regaining her drivers licence.

Lee had to go to court in relation to current charges related to driving and to pay the fines owing for driving infringements. The case manager assisted with transport to the court and offered support while the case was being heard. Her support workers assisted her in revising for and attending her written test.

Employment or relevant education/training

The case manager attended the initial appointment with Job Futures, a supported employment service, as a support/advocate. The case manager assisted Lee to investigate options for short courses at the local college. She was interested in learning computer and administrative skills. This has been handed over to Lee's support workers, who are assisting her to explore her options further.

Gaining some contact with her daughter

The case manager attended the initial appointment with the Department of Child Safety to provide support and provided the Department with any information as relevant. Lee has met with the foster carer and has written letters and sent photos. She has also had contact with her daughter which the case manager attended. There are plans for further contact due to the positive nature of the first meeting.

Permanent stable housing

The case manager provided support to maintain tenancy with the Mosaic programme, a supported accommodation service through regular appointments, monitoring mental state and regular communication, support and education with Mosaic support staff. The case manager provided the Department of Housing with information when requested. The case manager also provided support with budgeting, to assist Lee to save money for the purchase of household items. Lee will remain with the Mosaic programme for 12 months before moving into permanent, stable and appropriate accommodation, provided by the Department of Housing.

Contact with her family

After gaining permission from Lee, the case manager contacted Lee's parents to gain more information about her personal history to build a more complete picture of Lee's background. Lee has had regular phone contact with her parents and has received letters and photos from her brothers and sisters. Lee has been saving money as she intends to go to New Zealand next year to visit her family.

Independent living skills

Lee was referred to a rehabilitation group which focuses on meal planning, shopping and cooking. The case manager drew up a plan to give to the Mosaic support workers so that they could assist Lee with these skills in her supervised housing.

Gaining knowledge about her mental illness.

The case manager provided psycho-education about mental illness and medication, and helped Lee to develop a relapse prevention plan, focusing on her early warning signs. Lee has been managing her illness well and has not had an admission to hospital for over a year.

DISCUSSION

Previously many of the homeless population in Australia were middle-aged and older males, but recent data has shown that there has been a marked shift towards this population having a great number of women and younger people. Thirty-nine percent of the homeless population in Queensland are women between the ages of 25–34 (Queensland Health, 2007). It appears that the causes of homelessness of Lee relate mostly to individual factors, including poverty, unemployment, and poor mental and physical health, with structural factors such as adverse housing and labour markets and rising levels of poverty playing a part.

There are a range of health issues which affect many homeless people. While mental health is one of the most pressing health issues facing people who are homeless, there are other health issues which have an impact. It is estimated that 75% of the homeless population have some form of, in most cases untreated, mental illness. It can be seen that Lee had a diagnosis of schizophrenia and at times had been troubled by physical health concerns.

It can be seen that in the work with Lee, there was an active partnership formed with both non-government and government agencies.

This approach assists in the development of a holistic approach to service delivery. It is evident that homelessness occurs irrespective of the boundaries of government agencies, organizations or services, so therefore it is important that the model for service provision such as the one employed by the Homeless Health Outreach Team reflects this.

Assertive outreach is used to help people to access and connect with services (Queensland Health, 2008). It is essential to reaching and engaging people who are homeless. The key point of assertive outreach is that it brings the service to the people in their community setting. The approach is holistic, as can be seen from the case of Lee who was assisted with medications, housing, finances, the legal system, and the problems of everyday living.

Case management recognises the other factors which can affect one's health, such as social support networks, income, education and training, personal health practices and coping skills (Queensland Health, 2008). In this instance, Lee was provided with a primary case manager, an occupational therapist, who collaborated with other service providers to ensure continuity and comprehensive treatment.

Much of the available literature on the role of occupational therapy in working with the homeless population focuses on work within homeless shelters (e.g. Herzberg and Finlayson, 2001; Schultz-Krohn, 2004; Griner, 2006; Munoz et al, 2006). Griner (2006) stated that the profession of occupational therapy exists to help people with physical and mental health needs. People who are homeless have many needs, for example, employment, affordable housing, managing money, getting along with others, managing legal issues, and using resources. This has been illustrated by the case study presented here.

CONCLUSION

Homelessness is an issue that has gained increasing attention over the last few years. As a response, Homeless Health Outreach Teams have been established to help deal with this issue. This article describes the work of one such team in working with a homeless service user. The work is challenging and the work practices move 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 service users. The potential of working in this

way with a population experiencing homelessness is only limited by the creativity of the team. The team is still developing and part of the challenge of the team is to maintain flexibility of service delivery. In light of the need for evidence-based practice, the team is engaging in research activities and evaluating outcomes of services. **IJTR**

Conflict of interest: none

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KEY POINTS

- The service user was discharged from hospital into the care of the Homeless Health Outreach Team, which was appropriate in light of her chronic homelessness and disconnection to society.
- A comprehensive assessment was conducted.
- The service user was assisted through case management to achieve a number of self-defined goals.
- It was found that with appropriate support and skill training the service user had the capacity to live independently and to maintain tenancy.
- An active partnership was formed with both non-government and government agencies when working with the service user.