'If you have mental health, alcohol and drug use issues you often fall through the cracks of the health system': Tackling This Challenge Through a Novel Dual Diagnosis Outreach Service for People Experiencing Homelessness

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Background

The co-existence of mental health, alcohol, and drug issues among people experiencing homelessness is pervasive,[1] often as a result of trauma and adverse childhood experiences, compounded by the experiences of homelessness.[2,3] In a recent Canadian study of people sleeping rough, more than half had co-existing mental health and alcohol and drug (AOD) issues, and often reported difficulties accessing the health services they needed.[4] In Australia, data collected from 8,618 people experiencing homelessness between 2010 and 2017[5]* indicates that 74 per cent reported having a mental health issue, 72.3 per cent an AOD issue, and 57.5 per cent had both.[7]

Clinically, the term dual diagnosis is used to describe people with co-occuring mental health and substance use issues[8] and the two are often entwined (see Box 1). In people with dual diagnoses, support is more effective when mental health and AOD issues are addressed together and in conjunction with underlying determinants of health.[9]

> *'Dual diagnosis in people who are homeless is often rooted in childhood trauma; alcohol and drugs are frequently used to regulate mood and emotions associated with trauma and the severe adversity of homelessness. Practical issues can also perpetuate AOD use – for example women who use meth to keep awake on the streets at night when it is most dangerous'.*
>
> — Entwined mental health and AOD issues, Clinical Lead, RPH Homeless Team

Yet the health system response remains largely 'siloed' — addressing both issues simultaneously are rare, and people with dual diagnoses are commonly 'bounced' back and forth between mental health and AOD services without the coordinated approach needed to improve patient outcomes.

Or, as is the case for many people experiencing homelessness, their mental health and/or AOD issues may not even have been diagnosed. Consequently, mental health and AOD use issues among people experiencing homelessness are big drivers of Emergency Department presentations and unplanned inpatient admissions across Australia.[10,11,12,13,14]

In response to these dual diagnosis challenges and health sector gaps, in February 2019 the Homeless Healthcare General Practitioner (GP) practice (HHC) commenced a pilot outreach service, the Homeless Outreach Dual Diagnosis Service (HODDS) targeting people experiencing homelessness in Perth who have comorbid mental health and AOD issues. The pilot is funded by a WA Department of Health Research Translation Projects Grant, and is being evaluated by the Home2Health Team at UWA.

Given the co-existence of mental health and AOD issues among people experiencing homelessness is widespread across Australia, learnings from the first year of the HODDS pilot in Western Australia (WA) may help to bolster advocacy to close the chasms in healthcare that people can experience when homelessness, mental illness and drug and alcohol use co-occur.

The HODDS Model of Care

HODDS is comprised of a mental health and AOD trained doctor and nurse embedded within the GP practice,[15] seeing most patients in drop-in clinics and outreach settings. In its first year, HODDS has supported 182 patients, and the response from patients themselves, and from homelessness and health services in Perth, testifies to the gap that is being addressed.

The key elements of the outreach service model are:

- addiction and mental health trained doctor and Registered Nurse
- connects patients with GPs for continued mental health and AOD treatment
- integrated within Homeless Healthcare GP clinics
- referals and advocacy to housing and other social services
- connect to other mental health services and treatment.

While dual diagnosis is the primary focus, for people sleeping rough this is invariably accompanied by poor physical health, trauma and a raft of social determinants, including a lack of stable housing, poverty, food insecurity and limited social support. The integration of HODDS within a primary care setting brings enormous benefits in terms of well integrated holistic patient care. Collaboration with the homelessness services in Perth (including clinics conducted at the main homelessness drop-in centres) and with the Royal Perth Hospital Homeless Team is critical,[16] helping to facilitate continuity of care between the hospital,

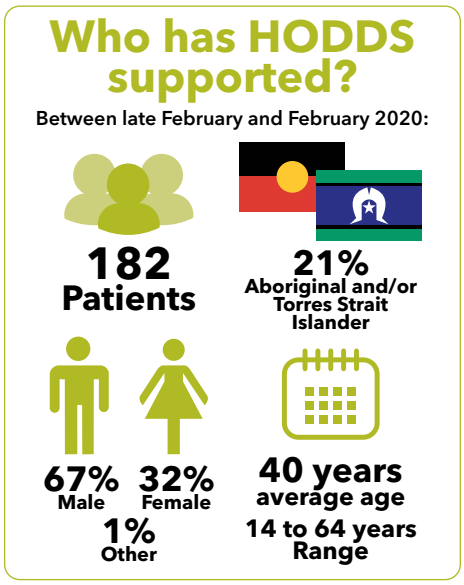

Figure 2 – HODDS Patient Demographics

GP and community settings for patients who present to hospital.

As a pilot, the referral process to HODDS has evolved over time. Patients referred to HODDS are first assessed medically by a HHC GP prior to assessment by HODDS clinicians. Following initial assessment patients are provided different levels of support depending on their complexity. For example:

- *higher complexity patients:* GP manages their dual diagnosis care with regular appointments, while the mental health nurse provides ongoing support.
- *lower complexity patients:* HODDS provides advice to support GP management.
- Ongoing collaboration between HODDS and the HHC GP ensures holistic care.

Where are People Seen?

Overcoming barriers to healthcare access[17] by taking services to where people are is a core ethos of the HHC General Practice and the HODDS team sees people in a range of settings:

- weekly clinics at drop-in centres for people who are sleeping rough
- 'home' visits to clients living in transitional accommodation or housed through 50 Lives
- Royal Perth Hospital inreach to establish rapport before discharge
- within mental health inpatient or drug and alcohol units
- outreach contact with people sleeping rough in a range of places, including shopping malls, parks, inner-city streets or caves at local beaches where people often sleep.

People Supported by HODDS in its First Year

In its first 12 months, the team has supported 182 people, the demographic profile of whom seen is shown in Figure 2. Many have a complex history of mental health and AOD conditions, most of the people seen have multiple mental health diagnoses, and two-three AOD co-existing issues is not uncommon.

The most common diagnosed conditions for this cohort of 182 patients are shown in Figure 3. The prevalence of these various mental health and AOD conditions are not surprisingly, substantially higher than the general population. Nearly one in five (18 per cent) for example have a diagnosis of PTSD, three times higher than the prevalence of PTSD in the Australian population.[18] Further, in the clinical view of the HODDS team, PTSD tends to be under-recognised in the homeless population in Australia, and in the mainstream mental health system, is at times misdiagnosed as an underlying personality disorders or described as 'anti-social behaviour'.

Outcomes to Date

In the 12-month period the HODDS team provided 791 episodes of care, complemented by more than 1300 episodes of care from GPs within the HHC practice. By having HODDS mental health practitioners working in close collaboration with the GPs, they can more effectively deal with the comorbidities that so many people experiencing homelessness face.

One aim of HODDS is also to reduce ED presentations and unplanned hospital inpatient admissions, and in the coming year the UWA evaluation will be looking at patterns of hospital use pre and post intervention for patients seen by HODDS. The case study below is one example where significant changes in hospital use have already been observed.

Conclusion

With nearly 60 per cent of people homeless in Australia having co-occuring mental health, alcohol and/or drug issues, and underlying trauma pervasive, there is an enormous unmet need for targeted

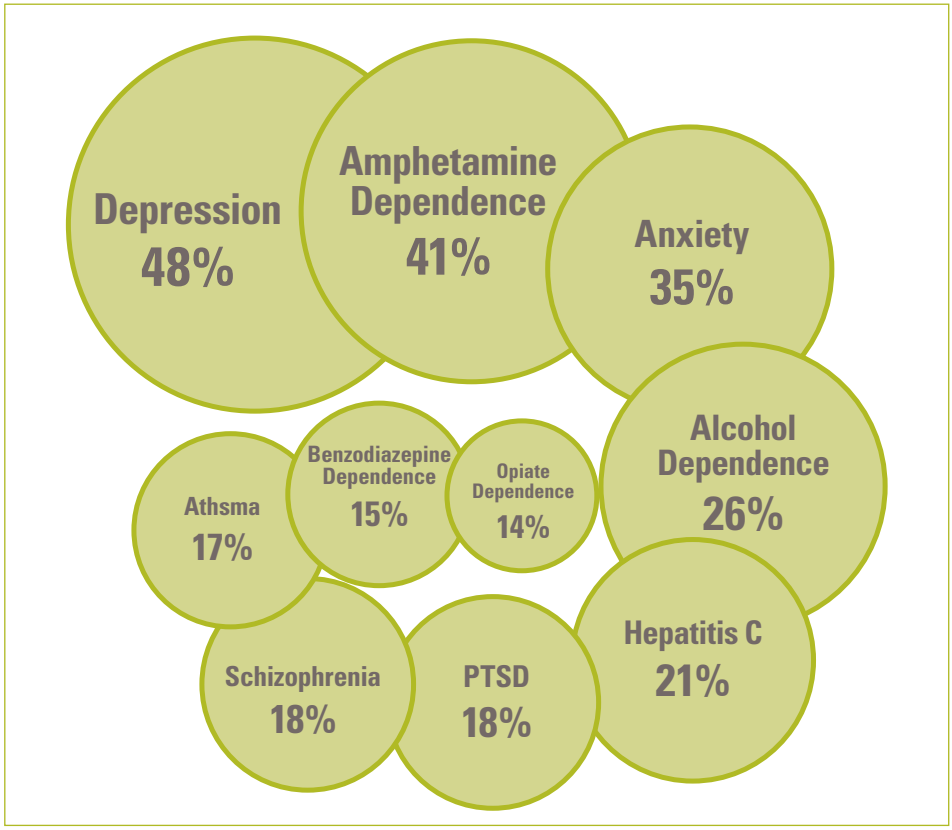

Figure 3: Most common mental health and AOD diagnoses

Background

Ben is a man in his thirties who sustained severe brain damage after being hit by a motorbike as a pedestrian 15 years ago. He spent an extended period in hospital rehabilitation, and as a result of his injuries, lost his job, and his long-term relationship ended. Since the accident, he has struggled with emotional regulation, executive function and impulsivity, consistent with personality changes observable in people with frontal lobe damage. This has led to difficulties in maintaining stable accommodation, resulting in long-term homelessness. Ben has multiple medical problems, including insulin dependent diabetes, suicidal ideation and occasional drug use. Between May 2018 and September 2019, Ben had 42 ED presentations and 12 days of inpatient admission resulting in a cost of $70,104 to the health system.[19]

HODDS Support

Ben was first seen by HODDS at a drop in centre in mid-2019. He was agitated and HODDS has spent a lot of time building trust and rapport. In addition to psychotherapeutic support, HODDS has advocated to the Public Trustee on his behalf, facilitated an application for a Healthcare Card, and supported him to procure stable long term accommodation. Ben was connected to 50 Lives (the WA Housing First program) in August 2019, and received public housing in October.

Current Situation

Now that he is housed, HODDS has been visiting him in his home and supporting him to build a social support structure, and find meaningful activity, while also working within an acceptance and commitment approach to managing his emotions and understanding his reactions. Since being housed and with continuing HODDS support, he has had no further presentations or admissions to hospitals in WA. He is keen to look for employment, is managing his bills, and growing vegetables in his courtyard, all things that would have seemed inconceivable six months ago. The combination of attending to his mental health and housing crises concurrently has been instrumental in stabilising his wellbeing. In the past, the lack of attention to one element has undermined actions to help the other.

dual diagnosis care. There is also a dearth of mobile psychiatry and addiction services in Australia and the HODDS pilot is demonstrating the enormous benefit of combining these in an outreach model that can work across community, primary care and the hospital setting. HODDS is filling a vital gap in services for homeless patients whose combined mental health and substance use problems see them rejected by mainstream specialist services as too complex or not within their narrow scope. For some patients, it is the first time they have received regular, dependable mental health care that is responsive to the complexity of dual diagnosis and the tangled web of social determinants of health that accompany homelessness.

** Registry week data is collected by homelessness services in a growing number of locations across Australia[5] using the VI-SPDAT internationally developed survey[6] that is done with individuals and families experiencing homelessness to determine a level of risk and vulnerability that can be then used to prioritise assistance. The VI-SPDAT includes questions about health conditions.*

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