HODDS

Homeless Outreach Dual Diagnosis Service

HOMELESS HEALTHCARE

Evaluation Snapshot
November 2019

WHAT IS HODDS?

In February 2019 Homeless Healthcare (HHC) commenced the pilot of the Homeless Outreach Dual Diagnosis Service (HODDS); an outreach service that works with people experiencing homelessness in Perth who have a dual diagnosis of mental health and alcohol and other drug (AOD) issues. The HODDS team comprises of a Mental Health and AOD trained doctor and nurse. The team works alongside the HHC GP clinic that are in settings familiar to individuals experiencing homelessness. This integrated approach between primary care and specialist mental health/AOD care works effectively to manage all medical , psychological and addiction issues in the community.

HODDS has a flexible and integrated model of care, which is particularly suitable for this complex, multi-morbid patient population. It is centred around providing long-term GP care linked with access to specialist dual diagnosis care. HODDS recognises that tri-morbidity, trauma and a raft of social determinants are common among their patients, and ensure the care they provide extends beyond the medical sphere. The HODDS pilot is funded by a Department of Health Research Translation Projects Grant (Round 12), and is being evaluated by the Home2Health Team at UWA.

AIMS OF HODDS

1. **Reduce** the severity of AOD and MH issues, and work with GPs and primary care to enable more stable and streamlined health care management of these via primary care services.
2. **Reduce** ED presentations and unplanned hospital admissions, and support improved discharge planning and follow up for clients with dual diagnosis.
3. **Advocate** on behalf of clients to housing and other social services to address underlying social determinants of health that impact on mental health, AOD use and homelessness.
4. **Support** clients with severe and persistent mental illness to access appropriate care from public mental health clinics and mainstream services, including hospitalisation when required.
5. **Demonstrate the cost effectiveness** and a positive return on investment, via a net positive reduction in healthcare costs associated with ED presentations and inpatient admissions (after deduction of service operating costs).

MODEL OF CARE

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

Referrals and advocacy to housing and other social services

Connect to other mental health services and treatment

HOW ARE PEOPLE CONNECTED TO HODDS?

- Patients referred to HODDS are first assessed medically by a HHC GP in addition to assessment by HODDS clinicians.
- Following initial assessment patients are provided different levels of support depending on their complexity, including:
  - For higher complexity patients, the Doctor manages their dual diagnosis care with regular appointments until stabilised, whilst the mental health nurse provides ongoing support.
  - For lower complexity patients, HODDS will assist and advise the GPs to support management of patients dual diagnosis issues.
  - For all patients the team liaises with the HHC GP who provide care for their other issues.

WHERE DOES HODDS SEE PATIENTS?

As an outreach service, HODDS sees patients in a wide range of settings that are familiar to people who are experiencing homelessness:

Drop-in Centres

Transitions Clinic

Royal Perth Hospital

Passages Youth Engagement

Other Settings e.g. parks

HODDS team equipped to work in any setting

As HODDS is a pilot project and this is the first service its kind for the people experiencing homelessness in Perth, the locations and ways of engaging with clients continues to evolve over time. We have found that initial engagement and rapport building at the drop-in centres has increased client attendance for appointments at our Transitions clinic – **Melanie Werner, HODDS Registered Nurse**

WHO HAS HODDS SUPPORTED?

Between late February and mid-November 2019:

127 PATIENTS

24% ABORIGINAL AND/OR TORRES STRAIT ISLANDER

70% MALE

30% FEMALE

* Trans people have been allocated to the gender they most identify with

41 YEARS AVERAGE AGE

SERVICES PROVIDED

536

EPISODES OF CARE FROM HODDS TEAM

1,183

EPISODES OF CARE FROM HHC GPS

Patients are receiving the appropriate level of care instead of floundering around unwell on the streets.

- Dr Andrew Davies, Medical Director, Homeless Healthcare

CASE STUDY

Mike is a man in his forties who has a history of rough sleeping, trauma, methamphetamine use and contact with the Justice System. He was recently housed, but has been struggling to connect with new people and started having feelings of isolation and loneliness. His mood began to drop, leading to deterioration in self-care and decreased eating causing dramatic weight loss. He was at risk of drug use relapse and had stopped managing his insulin dependent diabetes.

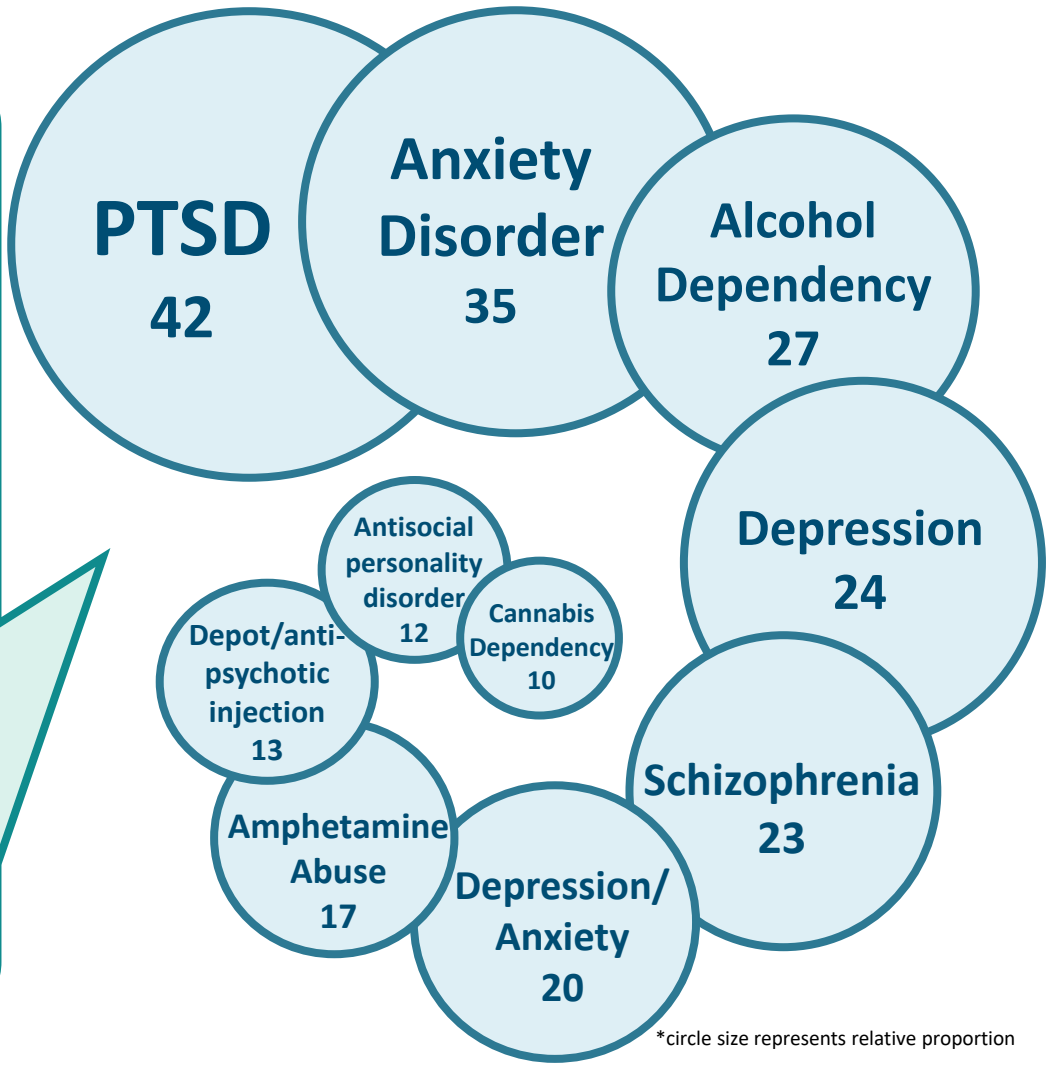
After being referred by his HHC GP in July 2019, HODDS spent time building rapport and trust. After completing the initial risk and mental health assessment Mike was referred for an inpatient admission to stabilise his diabetes and restart antidepressant therapy. Without the support from HODDS it is likely that Mike's mood disorder would have worsened and his diabetes would have progressed with further organ damage or he may have relapsed into substance abuse.

MOST COMMON PRESENTING DIAGNOSIS

Number of episodes of care where the following are the primary presenting diagnosis*:

Trauma can be both a cause and consequence of homelessness, as evident in the lives of many patients seen by HODDS to date. PTSD is common, but often has not been formally diagnosed, and it can be sometimes misconstrued as anti-social behaviour or as a component of an underlying personality disorder. We need to routinely screen for, and actively consider PTSD as a potential contributor to the often agitated crisis presentations of people who are experiencing homelessness.

– Dr James Hickey, HODDS Clinician



*circle size represents relative proportion

HOSPITAL USE BY HODDS PATIENTS

One of the aims of HODDS is to reduce ED presentations and unplanned hospital inpatient admissions. However, it is recognised that often patients have undiagnosed or untreated mental health or AOD issues that require planned hospital admissions.

CASE STUDY

Background

Ben is a man in his forties who sustained severe brain damage after being hit by a motorbike as a pedestrian in 2005. 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, which are 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. Ben received a sizeable payout following the accident making him ineligible to access supported accommodation or a disability pension. However, he has restricted access to these funds as his finances are under the control of the Public Trust, and was struggling to meet the cost of his medications.

HODDS Support

Ben was first seen by HODDS at a drop in centre in mid 2019. He was agitated and HODDS spent a lot of time building trust and rapport. In addition to psychotherapeutic support, HODDS has advocated to the Public Trust on his behalf, facilitated his application for a healthcare card, and supported him to procure stable long term accommodation.

Hospital Utilisation and Cost*

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. Since September, he has had no further presentations or admissions to hospitals in WA.

Current Situation

Ben was offered public housing in October. Since contact with HODDS, his community workers report that he has become easier to interact with. His Public Trust manager has changes his fund disbursement from daily to weekly, an indication that his ability to manage his funds has improved, and a stepping stone to potentially being released from his Administration Order. Now that Ben is housed, HODDS work will move from advocacy to community engagement and therapy; slowly building a social support structure, and meaningful activity, whilst also working within an acceptance and commitment approach to managing his emotions and understanding his reactions.

*Independent Hospital Pricing Authority. National Hospital Cost Data Collection, Public Hospitals Cost Report, Round 21. 2019. WA hospital average ED presentation $838 and inpatient stay $2,909.

The HODDS Team

The RPH Homeless Team has engaged HODDS in the care of some very complex patients and their damaged and chaotic lives have been transformed. Due to the care they receive, they generally simply disappear from the hospital system, back into a more normal life with the supports they need. For many patients, it will be the first time they have received regular, dependable mental health care. For some, the journey towards recovery will start with a mental health admission before community based care can succeed. – **Dr Amanda Stafford, RPH Homeless Team Clinical Lead**

This snapshot has been prepared as part of the independent UWA evaluation of HODDS
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THE UNIVERSITY OF WESTERN AUSTRALIA