Case Scenario for Problematizing Homelessness and Street Outreach

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Summary

This case study highlights core problems challenging the Street Outreach Team in Hamilton, Ontario, Canada. Such issues as homelessness, harm reduction, community capacity building, social determinants of health and collaborative, inner city health care are explored in ways that emphasize the complex nature of poverty and homelessness. It is clear that no one approach can adequately address all the issues that have arisen in this case, and innovative, flexible, collaborative approaches are more effective.

This case study will be used to illuminate some common issues and dilemmas encountered by street outreach workers and their clients.

Lisa is a woman, 44 years old, lives alone, but has a boyfriend who comes to her place frequently. She experiences severe alcohol dependence, cirrhosis of the liver, Hepatitis C, and frequent GI bleeds. For several days at a time, she is able to abstain from drinking alcohol, or employs harm reduction techniques in reducing her intake: switching to beer from mouthwash, etc. Her boyfriend is severely alcohol dependent and drinks mouthwash every day. He is homeless and stays at Lisa's so as not to be out in the weather. He occasionally physically assaults Lisa, who does not press charges, but is assertive – sometimes aggressive – with him to get him to leave her place.

Lisa was homeless for many years before she started receiving service from street outreach. She lived in shelters and drop-ins, and in the summer months slept outside in order to drink. None of the shelters will allow people to stay there who have been drinking and are visibly intoxicated. There is a 24-hour drop-in in Hamilton that allows people who are intoxicated to sleep and eat there, but some individuals feel uncomfortable staying overnight. Its sleeping area comprises bare mats on the floor, a few inches from each other. Frustration and violence are common at the drop-in and many people feel safer out in the community.

Lisa now has an apartment, but it is very small, in the basement of a house. There is not much light and Lisa finds it difficult to keep it clean. Her bed is often covered in blood from her bleeds, there are cigarette butts on the floor, and often there is spilt beer or mouthwash, which is left to dry without being cleaned. The toilet is hard to access and is never cleaned sufficiently.

The difficulty cleaning is largely due to lack of motivation, fatigue, depression and occasional mobility difficulties. Lisa often spends days in bed, often drinking and sleeping, with occasional breaks to go to the toilet. When she is actively drinking, Lisa allows her boyfriend to drink mouthwash in the apartment. Intoxication leads to unhygienic behaviour and the outreach worker has often observed cigarettes, food, blood, spilled alcohol, etc on the floor and on the bed.

Until this month (March 2007), Lisa was receiving Social Assistance of $536/mth. She was recently granted ODSP and has just received her first cheque of approximately $1,000. Upon receipt of these increased funds, Lisa has decided to move into an apartment in a building with an elevator and lots of light.

The street outreach worker sees Lisa generally once a week. She accompanies Lisa to doctors' and specialist appointments, helps out with food vouchers and transportation, assists with landlord issues, and income security. Lisa, until last month did not have a phone, so the street outreach worker often had to go to her apartment the day before appointments to remind Lisa to be ready the next day. If complicated procedure was scheduled (e.g. a colonoscopy), the outreach

worker would ensure that Lisa had all the correct medication and that she would take it as prescribed at the right time. Often Lisa would refuse to attend an appointment when it would arrive, or would refuse to do the necessary preparation. The outreach worker would contact the hospital/doctor and reschedule.

The outreach worker's role is to assist individuals like Lisa to connect with health and social services, mental health and addictions services, income sources and housing. Street Outreach employs a client-centred approach, meeting the individual where they are – be it on the street, in shelters, or drop-ins. We work outside of regular office hours and bring our work outside of traditional office settings. The particular team to which this case study refers is a unique, interdisciplinary team located in a medium-sized Canadian city. The team employs a capacity-building approach to delivering services to people experiencing homelessness, and who are living with mental illness or substance use disorders. Each worker brings his or her own skills-set, which renders the team of twelve extremely effective at addressing the multi-dimensional and complex needs of the people they work with. Workers are employed under a service contract between the City and a grassroots organization in the community using a capacity-building framework. There are Public Health Nurses (PHN), housing specialists, a harm reduction worker, youth workers, and a United Church Minister, to name a few. A Community Advisory Board, composed of consumers and professionals, advises the Program and meets quarterly.

This case study was chosen to explore the elements at work in creating such an interdisciplinary team of practitioners, working in ways that mirror the complex intersections occurring under the social category, 'homeless'. The city has extended its learning to create alliances across sectors, such as: area hospitals and shelters, now working together to address the health needs of people experiencing homelessness; family physicians and shelters in a 'Shelter Health Network' that collaborates to provide proactive primary healthcare to people experiencing homelessness; a management of alcohol program which operates through collaboration among area shelters, addictions agencies and primary healthcare providers to deliver shelter and healthcare to people who are homeless and drinking non-beverage alcohol in the community. While the Mental Health/Outreach Team focuses primarily on its immediate outreach work, our community capacity-building approach to delivery of services has provided the catalyst for many other projects in the community, including those mentioned.

In focusing on Lisa's case, I am attempting to elucidate the complex nature of homelessness and to understand it in terms of the social determinants of health. Lisa lived a different life before she was homeless. She was married, has a son, and had a few different jobs. She is high school educated and is very bright. Her home life growing up was not good and she endured physical and sexual abuse. She is Métis and is not in touch with her aboriginal heritage in any concrete way. Life took a downturn sometime in Lisa's late twenties. Her marriage ended, she

lost her son and she started drinking heavily. She got involved in various relationships with men, many of them violent. She drifted, finally ending up on the street and living in a local drop-in. The drop-in is used by people like Lisa, who want to continue drinking after dark, but still need a place to sleep. The drop-in's policy of harm reduction and tolerance prevents people from choosing to stay outside during extreme weather in order to continue drinking. There is now a managed alcohol program in Hamilton to further and more comprehensively address this issue, but for many years the drop-in was it. Lisa is not interested in living in the managed alcohol program at this time, as she wishes to maintain her independence.

Of course, many concomitant problems are created by policies such as those employed at the drop-in. Violence, fights, and health problems associated with intoxication and poverty are regular occurrences. It does a fine job to trying to ensure everyone's safety, but it is not easy to live harmoniously in a drop-in where space is limited.

Poverty and homelessness, and life in shelters and drop-ins or on the street are major determinants of poor health. Various responses to this reality have been created n the past year. The Shelter Health Network has put primary care physicians and nurses into shelters; the managed alcohol program operates as a complex continuing care unit; a local men's hostel now has twenty-one medical beds right in the shelter, which are used by clients just discharged from hospital but who are also homeless; the Hospitals-Shelters Working Group is focusing on education of healthcare practitioners in the city, as well as on communication and collaboration between systems; crisis beds have recently opened up in the city to help divert individuals experiencing a mental health crisis from the emergency department; and a new housing initiative targets individuals who have been in the shelter system for more than a year, offering supported, independent housing in the community.

All the initiatives cited above have come about as a result of cognizance in the community that issues of poverty, homelessness, family breakdown, etc are related in intimate ways to health and healthcare utilization. Government is recognizing and responding to the fiscal challenges presented by a system that might have in the past cut off its nose to spite its face. There is recognition that shelter beds and emergency room visits cost far more than an apartment with supports, or even a step-down unit in the community that will prevent that person from reentering the hospital. Having physicians and nurses in the shelters has drastically cut non-emergent visits to ER, and the managed alcohol program has reduced interactions with paramedics by 70% and with police and jail by 100%. Emergency room visits have been cut by 50%, and days spent in hospital have reduced by 60%[1]. Communication and collaboration have greatly enhanced the hospital visits of our clients and complex discharges are now executed smoothly

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[1]Semogas, D., Sanford, S., Evans, J.E., Muckle, W. (2007). Homeless and Living with Alcoholism: Measuring the Impact on Health and Social Services (in progress).

and appropriately. It is predicated that the crisis beds will dramatically reduce the number of individuals presenting at the local Emergency Psychiatric Treatment (EPT) department.

Lisa is utilizing street outreach in ways that provides her access to the kinds of services that she has decided she wants. Client-centred care often means that the program the outreach worker deems most appropriate is not taken up. The outreach worker would like Lisa to be safe in the managed alcohol program. Her bleeds are occurring more frequently (approximately 4 in the last three months), and she won't go to the step-down unit because it's too much like a shelter. She has been recently diagnosed with diabetes and receives a minimal amount extra on her disability cheque for a special diet. The outreach worker often gives her food vouchers and bus tickets so she can get around and eat properly. She has been housed for two years now, but the landlord has been looking for reasons to evict her since she moved in. Only because the outreach worker has been reminding him of his responsibilities as a landlord, and of her rights as a tenant, has he not attempted to evict her. At one time it may have seemed that Lisa would never stay housed – but she has, and perhaps that same hope can be extended to her someday abstaining from alcohol; in her own time, in her own way.

Addressing homelessness is as much about prevention as it is about moving people out of shelters into housing. It is concerned in complex ways with physical and mental health, requires non-judgmental analyses of poverty and homelessness, and invites creative problem-solving – finding solutions to problems that often don't immediately seem connected to the role of street outreach.