Mental health services for homeless people

Dr Philip Timms
Consultant Psychiatrist
National Psychosis Unit, Bethlem Royal Hospital
Near Charing Cross ..... 1971
Blackfriars Salvation Army Hostel, 1985
What are the difficulties?

Principles of providing a service to homeless people

Some innovative models of service provision for homeless people

What might the psychiatry of homelessness teach the rest of psychiatry?
What are some issues?

- Poor access to GP and specialist services
- Poor fit of services to patient needs
- Lack of recording of housing status
Mental health minimum data set “homeless” codes”

- HM01 Rough sleeper
- HM02 Squatting
- HM03 Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)
- HM04 Sofa surfing (sleeps on different friends floor each night)
- HM05 Placed in temporary accommodation by Local Authority (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation
- HM06 Staying with friends/family as a short term guest
- HM07 Other homeless
Some practical problems .......

Professional attitudes

• Stereotyping - the myth of the tramp / lifestyle choice or, indeed, “NFA”.
• Complexity is the norm – physical, mental, substance abuse, brain injury
• Lack of a “substrate” for health
• Therapeutic nihilism
Some practical problems .......

**Organisation of services**

- Inter-agency working – or lack of same
- IP / community split
- Philosophies of care
- GP model of referral to secondary care services does not work – no outreach component.
- Lack of an outreach ethic in secondary MH services – e.g. closing a case due to erratic engagement.
- The gap between MH services and drug/alcohol services.
The effects of being homeless

• Sleep deprivation
• Hunger
• “Survival” mindset, de-emphasises anything other than short-term gains.
• Limited mobility
• Multiple clashing appointments:
  • Benefits
  • Housing
  • Health care
And the effect on relationships....

**Unrecognised multiple trauma**

- Both in the past and continuing in the present.
- PD Prevalence amongst single homeless people has been estimated at 68% (and 58% using diagnostic measures). Maguire et al 2009
- Links between PD and sustained / repeated traumatic experiences (Keats et al, 2012).
Service principles – Inclusion Health

- Equity
- Competent to deal with multiple morbidity
- Outreach
- Engagement
- Continuous relationship model
- Multi-sector collaboration
- Trauma-informed approach

The principle of equity – all should have equal access to health services.
Addresses the inverse care law - disadvantaged populations have less access to health and social services compared to the more privileged (Tudor Hart 1971).

- Service level agreements (SLAs)
- Annual reviews
- Joint training programme for day centre and hostel workers
- Joint planning
- Joint purchasing

Outreach principles

Psychological expertise within team

Primary, secondary, tertiary

M-D team – see next slide
### Dimensions of Service Provision

<table>
<thead>
<tr>
<th>Site of Service</th>
<th>Type of Service</th>
<th>Temporal Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single / Multiple</td>
<td>Clinical provision (Specialist/GP)</td>
<td>Regular informal visits</td>
</tr>
<tr>
<td>Static / Mobile</td>
<td>Independent/linked</td>
<td>Appointment system</td>
</tr>
<tr>
<td>Health service</td>
<td>Liaison/facilitative</td>
<td>Clinics</td>
</tr>
<tr>
<td>Social service</td>
<td>Educational</td>
<td></td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>Team/single worker</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Outreach Team

• Multi-disciplinary - doctors, nurses and social workers as a minimum, but also-psychologists, housing workers, vocational trainers, peer support workers as necessary.

• Caseload of less than 10 clients per case worker.

• Intensive client contact, up to 4 times per week.

• Emphasis on engagement and creating a therapeutic relationship.

• No time-limit on services.

• Provides or access to evidence-based treatments.

• Working with clients in their own environment and with their social network.

• A supportive team approach.
But, however the service is organised, engagement and managing the helping relationship is the priority
I AM A SOCIAL WORKER AND THESE PEOPLE ARE DOCTORS
Some specific service developments ...

- Critical time intervention
- Housing first
- Training for emergency services
- Enhanced MH assessments using capacity assessment.
- Enhanced access to psychotherapy
- PIEs – psychologically informed environments
Critical Time Intervention

• Many of their homeless clients were dropping out of services when moved from one level of accommodation to a “better” one.

• Solution: to provide extra input to clients during the time of, and after, the move. This lasted 7 – 9 months and involved:
  • Home visits
  • Individual support
  • Support for care givers
  • Negotiation and mediation with care givers when problems arose.
  • Formal handovers to local agencies were negotiated
  • Caseloads were typically held at 15 or less. The meant that the client could establish a new network of dependent relationships so that the withdrawal of the original service provider, with its attendant dependencies and support, would have less impact.

• This reduced the dropout rate from services (and nights spent homeless) by two thirds. Gains over the control group were maintained over the 18 months following the withdrawal of the CTI service.
Housing first

• Not a specifically psychiatric intervention, although it was originated by a Canadian psychologist (Tsemberis 2010).

• Literally, housing is the first issue you address. You find someone permanent housing, then provide the support services they need to survive.

• NO intermediate steps of hostels, shared accommodation etc.

• NO preconditions to entry, such as not drinking, accepting treatment, or otherwise participating in rehabilitation or treatment regimes.

• Treatment goals are developed with the client once they have moved in to their accommodation.

• Supportive services (such as mental health, alcohol and substance abuse services) are offered to the newly-housed client, to address those issues which had initially led to their homelessness.
Enhanced MH assessments + capacity assessment

• Most legislation that regulates mandatory hospital requires that signs and symptoms of mental disorder must be identified to justify such an infringement of ordinary liberties.

• However, outreach teams have noted that such symptoms can be hard to elicit on the street. Consequently, individuals who seem to have an obvious impairment (at least, to those who know them best) do not get the assessment and treatment they need.

• One can change the focus from symptoms, to whether the individual has the capacity (as defined in the Mental Capacity Act 2005) to make an informed choice – such as a decision to refuse services or to stay on the street.

• A capacity assessment can be used to assess if a person is able, or unable, to make such a choice. It does not replace an assessment of symptoms, but complements it. If capacity is compromised regarding a vital decision concerning health and well-being, this should be considered as significant evidence in the assessment for involuntary hospital admission.
“Pre-therapy” relationship-building

• For people still sleeping out, or not engaged with other housing services, and often with a history of poor experiences with services, psychotherapy may seem threatening, unattractive or irrelevant – even if it might be helpful.

• John Connelly, who will speak in a minute, has established a twice-weekly drop-in service at a specialist GP surgery for homeless people in Westminster.

• This provides the basic elements of any sort of therapy – safety, a trusting relationship, speaking the same language and establishing clear boundaries – but without any labels or demands.

• These tentative, “getting to know” each other contacts can then progress to more formal psychotherapy sessions.
Psychologically-informed environments

• Psychological expertise is introduced to “homeless” environments.

• Individual and group therapy are offered to service users.

• Staff are encouraged to practice reflectively, with regular staff meetings with a psychologist or psychotherapist.
10 (Yes, 10) Top Tips for working with a homeless person
• Establish both the recent and the long-term narrative.

• Based on this, establish a narrative formulation and, if necessary, diagnosis

• Try to understand any “difficult” behaviour in terms of multiple trauma and relationship distortions.

• If the mental state is ambiguous, consider psychosis

• “Drug induced psychosis” = Psychosis, until proven otherwise

• “No obvious signs of psychosis” = Schizophrenia, until proven otherwise

• Within every MHA assessment, also do a MCA assessment

• Clarify the patient’s local relationships and support networks, particularly in the voluntary sector.

• Translate “NFA” to “Homeless” ....... and use MHMDS categories

• Take voluntary sector staff ....... very seriously
The End

Main references:
