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Management aspects of care for the homeless mentally ill

P. Timms

People with mental illness have always been marginalised and economically disadvantaged. Warner (1987) has shown that this is particularly true in times of high unemployment. Poor inner-city areas have excessive rates of severe mental illness, usually without the health, housing and social service provisions necessary to deal with them (Faris & Dunham, 1959). The majority of those who suffer major mental illness live in impoverished circumstances somewhere along the continuum of poverty. Homelessness, however defined, is the extreme and most marginalised end of this continuum, and it is here that we find disproportionate numbers of the mentally ill.

Reliable estimates of the numbers of homeless people are difficult to come by, although the last UK census (OPCS, 1992) enumerated around 3000 people sleeping out and 50 000 people living in homelessness hostels of some sort. Although the absolute numbers are small, the homeless suffer high rates of physical and psychiatric morbidity and place disproportionately large demands on service providers. Compared with the general population, at least twice as many homeless people have some kind of significant mental health problem and, in hostel populations, major psychotic illnesses are over-represented by a factor of 20 or 30.

There is no evidence that substantial numbers of the homeless mentally ill have been discharged from long stay beds in mental hospitals. They will however often have had multiple, brief admissions to psychiatric units. Associated drug and alcohol problems are common, as is a reluctance to engage with mainstream psychiatric services.

Although homelessness is often perceived as a London problem, levels of homelessness are significant across other areas of the country (Randall, 1992) and concentrations of homeless people are found in the centres of most other major cities.

Definition of 'homelessness'

The stereotype of the homeless person is the man or woman who sleeps out on the street. However, people who sleep out constitute a small portion of those who are homeless. There is a range of unsatisfactory types of accommodation in which people find themselves (see Box 1).

In these milieux are found such disparate groups as the unemployed, middle-aged drinking men, teenage drug-abusers, individuals with schizophrenia and homeless families with children. Quite clearly these different groups have very different needs. However, the group which has elicited particular concern has been that of people who live in 'traditional' homeless settings. They might be sleeping on the streets, sleeping in night shelters or direct-access hostels, or using other services targeted at homeless people such as day centres or soup runs. It may be asked, if someone is not actually roofless, why should they be considered

Box 1. Accommodation for homeless people

Open-air sleeping ('rough sleepers')
Abandoned buildings ('skippering')
Night shelters
Direct-access hostels
Referral-only hostels
Bed and breakfast hotels
Sleeping on a friend's floor
Prison (if no address prior to release)

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homeless? The main factor to be considered is whether a person's housing status creates problems in access to psychiatric and general health care. This paper will address the needs of this group of people, whatever their particular homeless setting.

Nature of the problem

There are no psychiatric illnesses peculiar to homeless people. However, there are two main differences when compared with a typical inner-city general practice population:

(1) The distribution of psychiatric disorders is completely different, with psychosis predominating.
(2) The social substrate for health, normally assumed by doctors and other helpers, simply does not exist.

The problem to be addressed is not one of unique pathology, but one of a different pattern of pathology existing in the context of extreme deprivation, disability and social marginalisation. Associated with high levels of psychosis is the tendency of those with schizophrenia not to present for treatment (Priest, 1976).

A complicating factor is the high level of chronic chest, skin and dental problems which are commonly untreated.

Box 2. Existing caring agencies

Non-statutory
Salvation/Church Army centres
Soup runs
Street outreach workers
Night shelters
Cold weather shelters
Direct-access hostels
Referral-only hostels
Drug and alcohol agencies
Day-centres
Church, mosque or synagogue
Private bed and breakfast proprietor
Family

Statutory
Local authority
- Social services
- Housing department
- Homeless Persons Unit

Psychiatry
- Hospital services
- Drug and alcohol services
- Forensic services

Other health agencies
- Accident and emergency departments
- General practitioners
- Nurse practitioners

Forensic services
Probation service
Police

Support networks – existing caring agencies

A variety of statutory agencies are involved in providing for the multiple needs of homeless people. However, their involvement with the homeless is often brief and unsatisfactory for both parties, and a plethora of voluntary agencies has sprung up to fill the gaps in provision. The result is a complicated patchwork of services. Although they would best function as a network, they often do not.

The list in Box 2 is not exhaustive and the most relevant agencies will differ between areas. Those providers most consistently and intimately involved with the homeless have been voluntary agencies. Historically, their relationships with the statutory sector have generally been at best distant and, at worst, hostile. This has obscured their role as the primary source of social support and care for homeless mentally ill people.

Barriers to care

Homeless people report that they have been unable to register with general practitioners, have been treated in an offhand manner in hospitals or have been given a hostile reception in accident & emergency departments (Shiner & Leddington, 1991). Agencies advocating on behalf of the homeless urge doctors, nurses and receptionists to behave better. However, little serious thought has been given to the reasons for this apparently unprofessional behaviour on the part of men and women who are usually professional and caring.

Professional attitudes

Stereotyping

Professionals hold many of the same stereotypes about the homeless as do other people. They often perceive the homeless as being alcoholic, personality disordered, feckless, as having chosen to live

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in this way and as not appreciating the help they are given (Jeffery, 1979). This in turn means that they have very low expectations of homeless clients and that they may well not do as much for them as they would if they had an address. However, Morse & Calsyn's (1986) work suggests that, in spite of the fact that they may not be currently receiving them, homeless people are often willing users of psychiatric services.

Multiplicity of needs

Most professionals do not work in a true multi-disciplinary environment. When they are confronted with a client who is both homeless and mentally ill, they are presented with an array of problems, most of which they do not have the skills to deal with. They may therefore experience profound feelings of impotence and feel that they have nothing to offer.

Lack of a 'substrate for health'

Most medical and psychiatric staff are trained to examine fairly circumscribed areas of pathology. Their repertoire of interventions tends to assume the presence of an array of social factors (housing, adequate nutrition and a social network) that make possible health and treatment. In the absence of this substrate for health, purely medical or psychiatric interventions may well be perceived as pointless. Treating a depressive illness may be felt to be futile if a person's situation is so lacking in any of these supportive social factors.

The myth of the tramp

Homeless people are believed, by most service providers, to be highly mobile. This perception breeds a lack of enthusiasm, as there seems little point in providing a committed, sustained intervention if the patient will have moved on in a few days. However, although 'long-distance patients' have been identified in the USA by Chmiel *et al* (1979), most homeless people move infrequently and within a restricted geographical area (Priest, 1970).

Therapeutic nihilism

Taken together, these factors can produce a therapeutic nihilism that may not only prevent professionals from doing what they can, but may even serve as a conscious, or unconscious, justification for neglect. "Staff tend to view these patients as adversaries, thus avoiding the guilt of recognising how little they can in fact offer them" (Breakey, 1987).

Organisation of services

Inter-agency working

The homeless mentally ill have multiple needs requiring the involvement of multiple agencies – health, social and housing, in addition to any specific psychiatric input. In spite of community care legislation, inter-agency working is still limited in many places. Joint funding and hence joint responsibility for projects may better promote joint working where other approaches have failed (Farr, 1985).

No fixed abode (NFA) rotas

Many psychiatric units, especially in large cities, have an NFA rota, allotting to a duty consultant any homeless patients. Unfortunately, allocation in this way may not ensure continuity of care for the patient. If they present on a future occasion, they may be allocated to a different duty consultant and their care unnecessarily fragmented. If a patient is frequently mobile within a relatively small area, allocation of a client via the NFA rota should confer continuing responsibility for them. Very few people labelled as NFA are truly rootless and footloose – ideally they should be taken on by the catchment area team for the geographical area they frequent. This would obviously result in some services being unfairly burdened, but proper recording of such admissions could enable some re-allocation of resources to such services.

Philosophies of care

Different agencies have differing philosophies of care. For instance, most mental health services consider that individuals are unable to make informed choices when in the throes of a severe psychosis. However, many housing organisations take the view that people are always fully responsible for their choices and actions, no matter how thought disordered or deluded they may be. This attitude may precipitate inappropriate evictions, when a disturbed and often distressed client is deemed, by his or her difficult behaviour, to have made a choice. To be fair, the inaccessibility of psychiatric help has often made it difficult for housing agencies to respond in any other way.

Homeless lifestyles

Both physical and psychiatric care rank low in homeless people's hierarchies of needs. The demands of securing immediate survival needs

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Box 3. Priorities for homeless people, in rank order (Ball & Havassy, 1984)

Shelter
Money
Employment
Social activities
Food
Stopping drinking
Counselling
Help with managing money
Other (including health)

(see Box 3) are often more pressing and often more immediately rewarding than appointments with doctors, nurses or social workers.

Poor access to services

Although most surveys have suggested that the majority of homeless people are registered with a general practitioner somewhere, it may not be locally. This may explain why, in spite of the relatively high rate of registration, actual use of primary care is often infrequent. Someone with a home who wishes to make use of psychiatric services will have his or her general practitioner as both a guide to those services and an advocate with them. For the homeless people with no regular general practitioner this is not the case, and they tend to approach services through accident & emergency departments. For obvious reasons, the activities of these departments are orientated towards brief intervention rather than continued involvement and advocacy.

Mobility

Mobility is as often forced upon the homeless as it is chosen. Even so, much of this mobility is relatively local. In spite of this, the consequent crossing of catchment area boundaries may lead to problems with services disclaiming responsibility.

Distrust of officialdom

To official helping agencies, homeless people mean trouble because their predicaments inevitably make demands that cannot be met. Their inadequate response is consequently disappointing for the client. Hospitals and general practitioners are reluctant to take them on. Benefit regulations often seem designed to penalise the homeless. Local authority housing departments are only interested in homeless families and the very vulnerable. The police are often involved in moving them on or arresting them for drunkenness. It is not surprising that homeless people are often suspicious and distrustful of services that regard themselves as caring and helping.

Service provision – strategies

Temporal access

The conventional system of organising access to a psychiatric service by means of general practitioner referral and out-patient attendance does not work well for homeless people. It is often more effective to negotiate times to meet the homeless patient that fit in with their often irregular time-table, which may change from week to week. Even better is a drop-in service, where people can be seen quickly without any need to make an appointment (Segal & Baumohl, 1985).

Geographical access

Providing direct care in hostels has been shown to be more effective in maintaining contact with homeless men than encouraging them to use routine local services (Brent-Smith & Dean, 1990). Ferguson & Dixon (1992) suggested that regular sessions in hostels or day centres may be the best way of providing access to care where such facilities exist. For those with alcohol problems, in-hostel detoxification has been found to offer a relatively rapid response (within 24 hours) and to be preferred by users (Haig & Hibbert, 1990).

Access to community resources

Homeless people have problems in many areas of their lives, most of which are outside the expertise and resources of most doctors. Although in most cities there are extensive networks of voluntary agencies that do have these skills, professionals often find themselves hampered by their lack of knowledge of such agencies. These commonly include hostels, day centres, sources of cheap or free food and clothing, alcohol counselling services and advice centres. Each Health Authority or Trust should obtain or create a directory of these services that is concise enough to be of use in a busy ward, general practice, or accident & emergency department (Editorial, 1986).

Finding a key-worker/advocate

When treatment plans are started with homeless clients, they may fall apart because it is often

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automatically assumed that there is no carer on the outside with whom contact can be maintained. For those with homes it would be a GP or relative, but homeless people often do not have a general practitioner and are usually not in contact with family. However, there is nearly always a person or organisation in some sort of caring role with whom they maintain contact and who should be informed. This might be a hostel or day-centre worker, an alcohol counsellor, a minister of religion, a social worker or a probation officer. Of course, they will usually not be medical personnel and so issues of confidentiality may arise. These can be overcome by obtaining the client's written permission and/or by producing an edited version of documents such as discharge summaries.

Access to housing and benefits

Homeless people are entitled to benefits like anyone else, although they often do not claim consistently or may not be aware of their entitlements, particularly with regard to sickness or invalidity benefit. They are able to claim even when sleeping out, although the benefit will be at a lower level than if they are staying in a hostel. In large cities there may be a specific Benefits Agency office to deal with claims by homeless people.

Applications for housing may be made through the local authority homeless persons unit if the individual is accepted by them as being in priority need under the Housing Act 1985. Policies vary from place to place, but for most local authorities the presence of a significant mental illness is sufficient. Where foreign nationals are concerned, it has recently been established in law that unemployed, vulnerable EU nationals have a right to be housed by a local authority.

For those with more complex needs, a community care act assessment may be the most effective way of unlocking the appropriate resources. These assessments often take time to arrange and so may never occur if a patient moves around. However, hospital admission may offer a window of opportunity. If at all possible, any such assessment should be carried out before discharge.

Enhancing communication and liaison

Increasing use of hostels by the homeless mentally ill of Nottingham prompted the establishment of a support team that encouraged liaison between the different agencies involved in patients' care (Pidgeon, 1991). Although this did not make any new resources available for direct care, it ensured the best use of existing services by making sure that they were properly coordinated.

Prescribing

Craig & Timms (1992) suggested that homeless facilities have been major providers of accommodation and care for the chronically mentally ill. Although hostels have always been meant to provide only temporary accommodation, they have become permanent homes for many people with chronic psychotic illnesses. This is presumably because they are environments where there is usually low expressed emotion. Hostels tend to be tolerant of odd or bizarre behaviour and traditionally have placed very little 'rehabilitation' pressure on residents. These institutional and relatively tolerant milieux may create an opportunity for the introduction or re-introduction of antipsychotic medication.

Supervision and care is basic, but is still more than that received by patients living in independent accommodation. Issues of safety and self-neglect may therefore be less pressing, with less pressure to achieve quick results. In such settings it is often possible to start with low doses of neuroleptics, increasing slowly. This will usually avoid the problems with side-effects and the consequent resistance to treatment that is so common among people who have had to start these drugs in the course of an acute hospital admission. Most people living in hostels hold onto their own medication, although in some circumstances hostel staff may agree to look after it. Even if hostel staff do agree to do this, they should not be seen as dispensing medication, as they do not usually have the training or the procedures in place to do this safely.

It is generally best not to prescribe abusable drugs. Although most homeless patients use their medication responsibly, drugs such as the benzodiazepines, heminevrin and procyclidine have a significant street value. In circumstances where it may be impossible to get hold of money any other way, it can be very tempting to sell a prescription.

Attitude

Various attitudes have been mentioned in the literature as being necessary for successful work with the homeless. Goldfinger & Chafetz (1984) recommended 'therapeutic nihilism', by which they seem to mean hoping for the best but expecting the worst. Breakey (1987) recommends patience, not so much with patients but with the workers in voluntary agencies who have often had bad relationships with psychiatric services in the past. They need to be convinced that the service has staying power and that it is not just a 'project' which is likely to disappear when a key member

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of staff moves on. It is also mutually beneficial for psychiatric workers to value the often extensive knowledge of hostel and day centre staff. Workers need to accommodate to a different set of expectations so that they are not perpetually disappointed and demoralised.

Joint working with the voluntary sector

Voluntary agencies are the front-line providers of care for homeless people, and so it is impossible to provide a good service to the homeless without a close working relationship with such hostels and day-centres. However, this can be a difficult task for both partners, in spite of a mutual commitment to serve the interests of the clients. Their permanent staff, although usually highly experienced, will usually have little or no training in mental health. There is often a residue of resentment built up over years of receiving no acknowledgement or service from local psychiatric providers. A significant proportion of their workers will be volunteers, who will be young, will have had little or no training or experience and who will tend to change frequently. Shift systems may make it difficult to find a patient's keyworker quickly, and staff shortages may make effective keyworking systems impossible. The high levels of stress under which they are working may lead to an impatience with the more measured pace at which psychiatric services tend to work and may generate unrealistic demands. Workers may find it difficult to understand why psychiatrists will detain somebody with schizophrenia in hospital, but not individuals with personality disorders. Anti-psychiatric ideas are still prevalent and, even if not openly expressed, may sometimes sabotage psychiatric involvement. In spite of these problems, joint working can be extremely productive and the voluntary sector should be seen not as a liability, but as a collection of varied, committed resources. It is possible to improve both practice and relationships with such agencies by providing basic training in mental health issues for their staff. A regular psychiatric presence at staff meetings may also be found to be supportive.

Confidentiality

Confidentiality presents particular problems with voluntary agencies as policies regarding confidentiality within the organisations may not exist, or will certainly differ from agency to agency. There may be anxieties about how much information to release to people who are not part of statutory health or social services. It may be helpful to bear in mind that, as mentioned above, workers in voluntary agencies will often be the patient's main carer and may formally be registered as their next of kin. This should inform any decisions about release of information, as such workers may well need to know sensitive information so that they can carry out their work with the patient safely and effectively.

Problems for service providers

Surber *et al* (1987) developed a city-wide service for homeless people in San Francisco. They found that team members tended to have unrealistic expectations of each other and attributed to this their high turnover of staff. They also noted that making appropriate referrals was extremely difficult because the whole system of health and social care was functioning beyond capacity. As a result they shifted their focus from providing a directly clinical service to networking and training other care providers. Experience in services in this country has suggested that homeless agencies often have unrealistic expectations of statutory services and this may cause considerable tension between them.

Models of service provision

Over the last 15 years and particularly in the USA, a considerable stock of expertise has developed in providing psychiatric services directly to disadvantaged and marginalised populations, including the homeless. A huge range of specialist psychiatric services has been developed in response to the large numbers of homeless mentally ill people. These may broadly be classified as:

(1) Primary outreach: where psychiatric staff make the first initial approach to potential patients.
(2) Secondary outreach: where the initial contact is made by a voluntary agency which initiates or provides the venue for subsequent contact with a psychiatric team.
(3) Residential stabilisation: special housing and support arrangements are made for homeless patients following episodes of hospital care.

Case management is the most common approach to individual casework, in the sense of having a particular worker taking responsibility for the coordination and delivery of care from several systems. Although commonly used with the severely and chronically mentally ill in the general

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Box 4. Desirable service characteristics (Breakey, 1987)

Rapid response
Willing and tolerant – informal and non-stigmatising
Capable – of linking mental health services and accommodation
Flexible – in terms of sites of work, use of facilities etc
Comprehensive – dealing with a range of social needs
Continuous – good flow of information within and between services
Individualised – care planning and intervention
Collaborative – part of a wider service network
Meaningful – consonant with users' hierarchy of needs
Responsive to changing circumstances

population, this approach makes particular sense for homeless people as their multiple needs will rarely if ever be met by one profession or worker.

Care Programme Approach and Supervision Registers

The Care Programme Approach (CPA) has two main arms:

Allocation of a named keyworker. This should facilitate the development of effective case management, and will be particularly valuable for homeless people whose tendency to be involved with multiple agencies may result in responsibility being taken by none.

Ensuring that comprehensive assessments, care plans and regular review meetings are carried out. The essential activity generated is communication between complex networks of caring agencies and consequent coordination of their activities. Homeless people do tend to be more mobile, so their networks are often more complex and change more frequently than those for domiciled patients. They are consequently very difficult to maintain, particularly in terms of arranging regular review meetings. Voluntary agencies tend to be short-staffed and so may find it difficult to attend CPA meetings. Even so, it is essential to try to involve voluntary sector workers in any CPA planning meetings before discharge from hospital.

Although these new arrangements offer considerable scope for ensuring that vulnerable individuals receive the coordinated care they require, a considerable investment in time and resources will be necessary in practice.

Supervision Registers. All the above principles and problems apply to Supervision Registers, which can at their best ensure focused, multi-agency, consistent work with difficult or potentially dangerous individuals. An unforseen problem that has been encountered recently is that some hostels are now reluctant to accept or retain residents who have been placed on a Supervision Register.

Conclusion

In spite of the long association of homelessness with mental illness, the active provision of psychiatric services to homeless people is a relatively recent development. All effective treatment programmes have involved psychiatric provision as a coordinated part of more general provision of housing and social services. In many ways, they have anticipated the needs-led assessment, case management and coordination that have been specified as part of the CPA. Most of the characteristics of these services are really nothing more than the requirements for an effective, non-institutional community psychiatry, whether its recipients are domiciled or not.

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Multiple choice questions

1. If a homeless in-patient:
   a Discharges himself from hospital there is usually no family member or carer to contact
   b Is subject to the CPA, hostel or day-centre staff should be invited to attend a care planning meeting prior to discharge
   c Needs a community care act assessment, it is good practice for this to be done after discharge to temporary accommodation
   d Wishes to name as next of kin a hostel or day centre worker, he or she may do so.

2. Housing and benefits:
   a Unemployed vulnerable homeless EU nationals have a right to be re-housed by the relevant local authority
   b Homeless single people with mental illness have no rights to re-housing under current housing legislation
   c Homeless mentally ill people have a right to a community care act assessment
   d Sickness benefit is not payable to homeless people.

3. Homeless mentally ill people:
   a Have commonly been discharged from long-stay beds in mental hospitals
   b Have usually had no prior contact with psychiatric services
   c Will commonly have associated problems of drug or alcohol use
   d Are often willing to have contact with psychiatric services.

4. Prescribing for homeless people:
   a Hostel-dwellers are not usually allowed to hold their own medication
   b Hostel staff are required to regularly dispense medication
   c High-doses of neuroleptics are often required
   d Benzodiazepines are contraindicated.

MCQ answers

1	2	3	4
a F	a T	a F	a F
b T	b F	b F	b F
c F	c T	c T	c F
d T	d F	d T	d T

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