



The College of Psychiatry of Ireland
Coláiste Siciatrachta na hÉireann

Specialist Mental Health Services for the Homeless

Position Paper
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The College of Psychiatry of Ireland

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Mental Health Services for the Homeless

Summary Position Paper

The true prevalence of mental health problems in the Homeless is unknown, and estimates vary from 4% to 25%. In 2008, The Homeless Agency Census found there were 2,366 homeless people in Dublin. There are no official national figures available. Simon Community have estimated it is close to 5,000.

Homeless people tend to be high users of GP and Emergency services, but low users of routine outpatient services, including psychiatric services. They find it difficult to access the health and social care they need. Barriers to having needs met include stigma, lack of finances, lack of understanding of state entitlements, negative attitude of healthcare professionals, and the sectorised services in mental health care based on place of residence. Those who are difficult to engage are particularly disadvantaged. There is considerable evidence to show that Specialist Mental Health Services for homeless people are effective.

Specialist Mental Health Services for homeless people in Ireland are located in Dublin and Cork. The service set up by Dr. Joe Fernandez in 1979 in Dublin is one of the oldest specialist services in the world. This service now consists of a multidisciplinary team providing assertive outreach. In 2004, a consultant led team- the ACCES team- was established to provide further outreach to those with severe mental illness in Dublin's homeless population. In 2002 a specialist service was set up in Cork, the Cork Adult Homeless Integrated Service. The team has been incorporated into Cork City Central Primary Care network. This is consistent with the recommendation of 'A Vision for Change' that mental health services for the Homeless outside Dublin be provided from Primary Care networks. This service relies heavily on the services of Social and Rehabilitation Psychiatry from within the mental health services. Limerick, Galway and Waterford have Community Mental Health Nurses working with the Homeless, in two of these cities they are employed by voluntary agencies.

Specialist Mental Health Teams for homeless people accept individuals from standard Mental Health Services when that individual is homeless, is living predominantly in the city centre and the standard mental health service has been unable to engage. Mental Health Services need to identify those at risk of becoming homeless and work closely with existing statutory and non statutory services for the Homeless.

Future developments should be informed by international best practice, emphasising the place of an assertive community outreach approach for this population. 'A Vision for Change' is the guiding document for services in Dublin, and should include two consultant-led teams and a Crisis facility. Around the country the guiding document is the Homeless Strategy, 'The Way Home', which is critical of the development of parallel services for Homeless people, however its success will depend on the development of Primary Care Teams, adequately resourced Mental Health Teams including Rehabilitation Teams, and effective liaison between these along with the non statutory agencies. There is an urgent need to set up an Irish Clinical Network for mental health professionals in Specialist Mental Health Services, offering mutual information, support and education, to underpin best practice in such services throughout the country.

Recommendations

A. We recommend that each area has a timed plan for the development of Mental Health Services for the Homeless in their area and adequate resources are made available. If investment is made in assertive outreach Community Mental Health Teams and Rehabilitation Teams, the likelihood of individuals with severe and enduring mental illness becoming homeless will be reduced.

B. In areas of high prevalence of homelessness, namely inner urban areas, Specialist Mental Health Services for the Homeless make sense and are effective. We recommend that the current services in place in this country should be maintained and are being enhanced as the evidence of need dictates.

C. In Dublin, the two consultant Psychiatrist-led, multi-disciplinary teams must have an appropriate mix and complement of staff, reflective of teams working in the assertive outreach modality and a Crisis Unit be established as recommended in 'A Vision For Change'.

D. Outside Dublin, variable types of Specialist Mental Health Services response will be required, with either individual mental health professionals or multi disciplinary teams necessary, as locally determined appropriate. It is crucial that the existing services in Cork, Waterford, Limerick and Galway, are fully maintained, being enhanced as the evidence of need dictates.

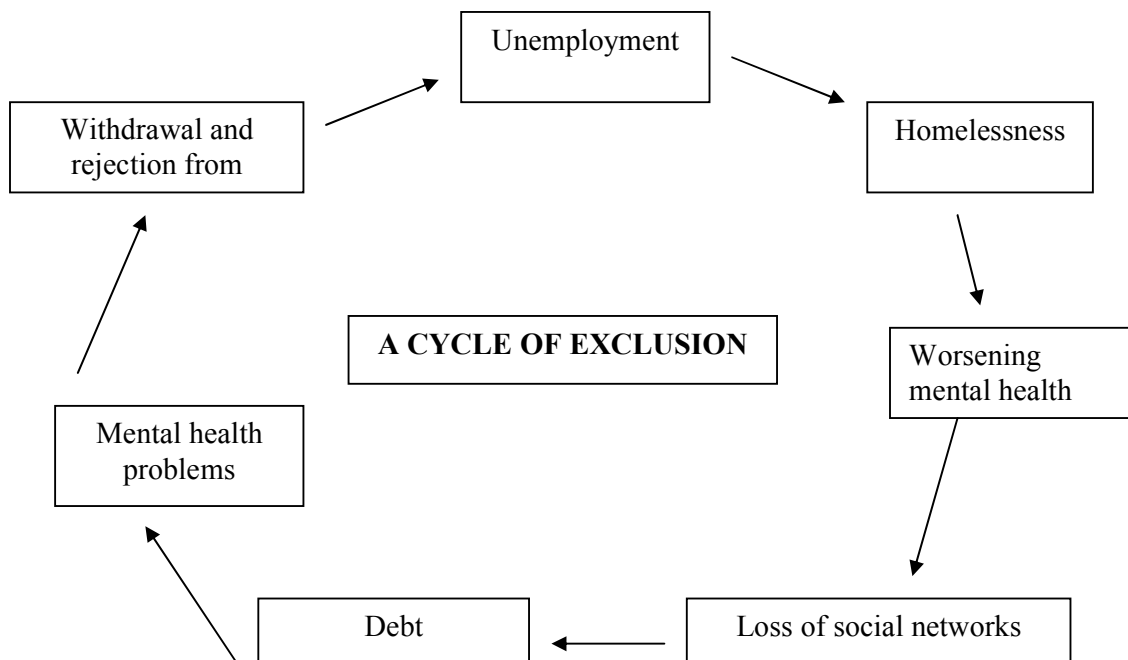
E. We recommend the establishment of an Irish Clinical Network for mental health professionals in Specialist Mental Health Services, offering mutual information, support and education, to underpin best practice in such services throughout the country.

Position Paper of College of Psychiatry of Ireland on the Specialist Mental Health Services for the Homeless

“Few topics are as emotive as the Homeless and mental illness, nor more likely to attract broad statements of simple fixes” - Dr Alex Holmes of WAHOPS, Melbourne’s Specialist Mental Health Service (MHS) for homeless people, in *Australasian Psychiatry*, March 2006.

The true prevalence of mental illness in homeless people is unknown and estimates have varied widely. Variation can be understood if one considers differing definitions of mental illness and homelessness that may be applied, different settings and methodologies. An Irish study conducted in 1997 detected high prevalence of a wide range of chronic mental disorders of varying severity amongst a sample of 502 homeless persons (Holohan 2000). It is well documented that homeless people have higher health needs, including higher prevalence of severe mental illness, than the housed community (Lowry 1990, Timms et al 1997). In London several studies detected a prevalence of severe mental illness in this population at around 25% (Scott 1993, Power & Attenborough 2003). A meta-analysis of studies from several international settings found a prevalence of 11%, with a range from 4% to 16% in 10 ‘methodologically superior studies’ (Folsom D & Jeste DV, 2002).

The reasons for homelessness are complex and incorporate societal and individual factors, among them mental health difficulties. Much has been written about the causes. The diagram below is one attempt to show how mental health and homelessness can relate to each other, pointing to how difficult to break the vicious circle can be. In common with other approaches, it shows how mental health cannot be treated in isolation, with the wider social context needing to be considered.



Source: 2004 Office of the Deputy Prime Minister <Mental Health and Social Inclusion> Social Inclusion Report pg 20

The Homeless Agency conducts a 3 yearly official census of homeless people in Dublin. The most recent detected 2,366 people (counted in 2008). Advocate and voluntary organisations for the Homeless have in general terms accepted this figure, believing it to be more robust methodologically than other measures such as the 3 yearly 'Housing Needs Assessment' by the Department of the Environment, Heritage and the Gaeltacht (Focus Ireland Press Release, 17th August 2009). There are no official national figures available, though Simon Community has estimated there are close to 5,000 homeless people in the Republic of Ireland (www.simon.ie).

There is considerable evidence that homeless people have high utilisation of GP, Emergency Department and other hospital (services?), including psychiatric unit services, but low utilisation of planned outpatient services (Redelmeier 1998, Holohan, T. 1998, Martell et al. 1992). They are frequently dissatisfied with these contacts (Ball & Havassy 1984).

Homeless individuals often find it difficult to access the health and social care they need (Usatine RP, Gerlberg L et al 1994). The reasons for this are numerous and include stigma, financial obstacles, lack of knowledge about state entitlements, healthcare system barriers, the competing priorities of homeless persons themselves and lack of community care. There is evidence that healthcare professional attitudes are not always as positive as they could be (Fischer 1993), probably partially explained by the challenges such staff face in dealing with the complexities of need in this population.

In mental health, sectorised services delivered on the basis of domicile can struggle to mount a satisfactory response to the needs of homeless people. Recognised difficulties include discontinuity of care, loss to follow-up and duplication of care (which may be counterproductive or even risky). Homeless people, especially but not only, who are difficult to engage, are clearly disadvantaged in that a basic social substrate, usually taken for granted when health services interact with patients, is often not present (Timms, P. 1996). There is considerable evidence to demonstrate that Specialist Mental Health Services (MHS) for the Homeless can be effective (Power & Attenborough 2003, Holmes 2006).

Specialist Mental Health Services for the Homeless in the Republic of Ireland

The **Programme for the Homeless** at St. Brendan's Hospital is the oldest Specialist MHS for the Homeless in Ireland and the oldest such Mental Health Service in the world. It was set up in 1979, initially under the leadership of Dr J. Fernandez, Consultant Psychiatrist, until his retirement in 2004. The service was set up in recognition of unmet need for the patients of St. Brendan's Hospital, who had a high prevalence of homelessness. At the time of its establishment there were in the region of 1000 hospital beds at St. Brendan's Hospital, less than the roughly 1,600 in the mid-1960s, but more than the current 80.(Year?)

The service from early on in its history had inpatient, on-campus day centre and supported community residence components. A specific continuing care ward within the service was decommissioned around the millennium (The Willows) and the availability of 'lodging' beds in the hospital Assessment Unit ceased. The male day centre moved off-campus in 1997 to Usher's Island, Dublin. Three supported community residences were shed or transferred to other services. The service has gradually increased the assertive outreach component and is more orientated to the community now than it was in 1979 for the reasons just outlined, echoing the changes in MHS in developed countries over the last few

decades. It is staffed by a multi-disciplinary team of psychiatrists, occupational therapists, mental health nurses, a support worker and part time social work.

In 2004, funding was made available for a Consultant Psychiatrist-led team to provide additional service to homeless people with mental illness in Dublin. This **ACCES** team works as an assertive community outreach team. The team consists of a Consultant Psychiatrist 0.7 WTE, 2 Community Mental Health Nurses (CMHN) and a Senior Social Worker. ACCES is an assertive outreach programme and aims to treat homeless adults with severe and enduring mental illness with or without co occurring substance misuse problems. It also provides an educational component on mental health to the voluntary agencies.

The **Ciudad Project** in the **Dun Laoghaire/Rathdown** Council area was also set up in 2004 to provide a Mental Health Service to one shelter, but this has been decommissioned after two years. The volume of people with enduring mental illness did not materialise and many of those with addictions were at the pre contemplation stage of addressing their difficulties.

The population with whom the specialist homeless mental health teams work appears to be changing, as is the context. Recent presentations tend to be younger, with more substance misuse issues and with an increased history of violence, as older hostel residents have been dispersed. For example, in the Programme for the Homeless a history of moderately severe violence, as defined by the HCR-20 risk assessment guidelines, was found in approximately 60% of its caseload. Younger patients tended to have a higher historical (H-) item score.

‘Programme for the Homeless’ was the only Specialist MHS for the Homeless nationally until the advent of the **Cork Adult Homeless Integrated Service** in 2002. This team comprises mental health professionals (CMHN, Psychiatrist and Psychologist) working side by side with a GP and PHN/RGN and an Addiction Counsellor. The mental health element uses an assertive outreach model as advocated in ‘Vision for Change’. The team has been incorporated into Cork City Central Primary Care network. This is consistent with the recommendation of ‘A Vision for Change’ that mental health services outside Dublin are provided from Primary Care networks. The mental health component of the CAHIS has been advised that this will not result in a change of referral pathways, referral criteria, staff supervision or management structures.

In Cork, as elsewhere, those with severe mental illness often remained as long-term residents of emergency hostels for several years. Recent homeless strategies have seen these patients move from emergency shelters to a variety of accommodation options. These have included supported transitional and supported independent accommodation. Those with the most complex difficulties have been placed in long-term residential or high support residential accommodation. These utilise a combination of rehabilitation and recovery models delivered by staff from voluntary agencies in tandem with MHS. It would not be possible to maintain this group of patients, who often have complex and challenging needs, without these support services, which may be under threat. There has been an underestimation of the challenges involved in working with this group. These services should continue to be funded adequately in order to protect this most vulnerable group of individuals.

The cities of **Limerick, Waterford and Galway** all have CMHNs in place, but in 2 cities they are employed by the voluntary organisations in a liaison role linking individuals in with generic services. The assumption by local services of the duty to provide a designated identifiable team with responsibility for the delivery of MHS to homeless people, as outlined in 'Vision for Change', has not happened in any service of which we are aware.

There is a complex range of statutory and non-governmental services offering health and social care to homeless people in the Dublin area. Seventy-one such agencies were detected in 1998 and the Homeless Agency estimates 45 more recently. These provide ongoing support to this vulnerable group.

Current Criteria for acceptance from general MHS to the Specialist MHS for the Homeless in Dublin

The criteria for acceptance of referrals to Dublin Specialist MHS for the Homeless by general MHS have taken into account the pre-existing 'custom and practice' of long-standing, national public health service policy as set out in several documents over the last 2 to 3 decades and Ministerial Memorandum (Mr. M. Martin, T.D., Minister for Health, 2002). These criteria closely parallel those in other Specialist MHS for the Homeless internationally. They can be stated as: homeless adults, predominantly resident in city centre, having a mental disorder necessitating mental health service level care (including co-morbid but not primary substance misuse disorder) and unable to be engaged by the mental health service to which they first present. The latter 'failure to engage' criterion is a common feature of assertive outreach modality teams. It is therefore the case that all general MHS in Dublin manage some homeless people with mental health needs.

Mental Healthcare Services for the Homeless elsewhere

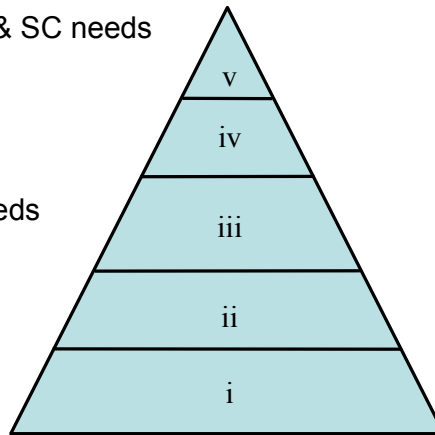
While writing this paper we contacted several colleagues in the field abroad and read some of the international literature in the health and social care areas. It is clear that not all cities have Specialist MHS for homeless, and those that do have different service configurations. There is no international consensus on what constitutes an 'ideal' configuration of such services (Williams & Avebury, 1995). Many different configurations have been described. This is not too surprising if one considers widely recognised difficulties in reaching universal agreement on such concepts as homelessness and mental disorder which resist unambiguous clarification. However, an assertive community outreach approach for this population is widely advocated internationally (Irish Division of the Royal College of Psychiatrists 1998, O'Connell JJ., 2004, A Vision for Change, 2006, Williams & Avebury, 1995).

Mental Health in the WHO European Region

FEANTSA (www.feantsa.org) is the European Federation of National Organisations working with Homeless People. FEANTSA has stated it would warmly welcome an EU strategy on mental health and homelessness.

Conceptualisation Of Needs

- Severe & Complex MH & SC needs
+/- Substance Misuse
- Severe MH & SC needs
+/- Substance Misuse
- Significant MH & SC needs
+/- Substance Misuse
- Minor MH & SC needs
- Social Care (SC) needs



It is useful to conceptualise the population of homeless people with *ongoing* health and social care needs in the form of a tiered pyramid. Such a conceptualisation is common in healthcare, notably with regard to medical service configuration/stepped care. The bottom tier is the most populous. As one escalates the pyramid through the other tiers, the needs can be viewed as increasing incrementally while the population diminishes in size. In this conceptualisation, five tiers represent homeless people with, from bottom up:

- i) social care needs
- ii) social care needs & minor mental health needs
- iii) social care needs & significant mental health needs including substance misuse issues
- iv) social care needs & severe mental health needs +/- subs. misuse
- v) social care needs & severe and complex mental health needs +/- subs. misuse

As currently configured, the Dublin Specialist MHS for the Homeless deliver services to the top tier, as well as a share of the second from top tier. General MHS provide services to the second from top tier. Substance & alcohol misuse, primary care, homeless and social care providers deliver services to the bottom 3 tiers. Substance & alcohol misuse services often work jointly with general or Specialist homeless MHS in the top 2 tiers. In this conceptualisation, tier (v) incorporates a complex aspect, deriving from the history of difficulties with engagement of the patient. Homeless patients with more common, less severe mental health problems (tiers i, ii & iii) may present to general MHS during the working week, but especially out-of-hours, in crisis, referred by health or social care services or by self.

The definition of homelessness employed by MHS is something which varies widely. It has a significant impact on the structure and function of Specialist MHS for the Homeless. In terms of the conceptualisation above, this will influence the size of the pyramid (the number of people represented by it).

Opinions can differ as to what population (tiers of the pyramid) should be targeted by Specialist MHS for the Homeless. In this paper, the divergence of perspective regarding Specialist MHS for the Homeless' target population in 'Vision for Change' (2006) and the National Homeless Strategy documents is outlined below.

We believe that the need to care for the top tier on an ongoing basis is the paramount priority for Specialist MHS for the Homeless in Dublin. No other service type is better placed to attempt to meet the needs of this group. There are also important secondary priorities to provide a service to the lower tiers. How these different priorities can be reconciled is currently being intensively reviewed. Dublin Specialist MHS for the Homeless intend that the following principles will guide future services:

- Orientated to recovery and social inclusion
- Incorporating a multi-agency approach throughout the inner city, close liaison with primary care, homeless and social care providers and other mental health services.
- As set out in 'A Vision for Change', we will employ an assertive outreach approach and have a clear pathway of care.
- Also, as recommended in Vision for Change, we envisage a Crisis Unit which will be available to homeless mentally ill patients thus reducing their need for inappropriate admissions to psychiatric units.
- This policy document also recommends that community mental health teams should adopt practices to help prevent service users becoming homeless and that interaction and co-ordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged. We would emphasise the importance of that recommendation.

Outside Dublin, 'A Vision for Change' is not the principle document guiding the development of homeless mental health services. The objectives are mainly influenced by the current national homeless strategy document 'The Way Home: A Homeless Strategy to address Adult Homelessness in Ireland 2008-2013'. This report is clear in its support for the HSE Transformation Process. It repeatedly emphasises the need for homeless people to access services from the planned Primary Care Teams and the Primary Care and Social Care networks. The thrust of the report does not support the provision of specialist services for homeless people and is critical of the development of parallel services for homeless people.

The difference in approach between 'A Vision for Change' and 'A Way Home' may reflect the context of the different reports. 'A Vision for Change' is a document written from the Mental Health Services perspective. The Homeless Strategy document is written in collaboration with Dept of Environment (housing) and Dept of Health (from social inclusion budgets) from a social care perspective. The strategy document refers to 'A Vision for Change', quoting some of its recommendations. It does not make any comment as to how it's frequently stated objective of amalgamating existing Specialist MHS into Primary Care Teams dovetails with the view supporting specialist mental health teams in 'A Vision for Change'. Some of the CMHNs involved in homeless services around the country, like the Cork Adult Homeless Integrated Service, are funded by Community Care from its social inclusion budget. The Homeless Strategy is the document whose objectives are seen as paramount, rather than the recommendations of 'Vision for Change', in such services.

Primary Care

In Dublin in recent years, improvements have occurred with the commencement of the SafetyNet Primary Care Initiative and increases in the percentage of homeless people holding Medical Cards. These developments need to be built on. Liaison by specialist MHS for the Homeless with Primary Care is therefore both necessary and valuable, in Dublin and throughout the country.

Prevention of homelessness in people with mental illness

Prevention of homelessness in people with mental disorder is a key function of health, homeless and social care providers. As expressed in a variety of health and social policy documents, there must be an integrated and focussed response by local health, social and housing agencies to prevent homelessness. This includes:

- A robust response by local MHS to meet the needs of mentally disordered people in unstable accommodation, persisting even after the patient has become homeless, if that applies.
- Vulnerable housed individuals should be identified early and specialised supports put in place to prevent an individual becoming homeless.
- A long-term enhanced commitment by local MHS to robustly and rapidly respond to the needs of formerly homeless patients who have become re-domiciled, given that they are self-evidently 'vulnerable to homelessness'. This may necessitate joint working with a Specialist MHS for the Homeless for a period, as the patient is re-establishing a domicile, to ensure a secure transition. In many locations, there has been a shift in policy terms away from provision of homeless sector accommodation, to a focus on rapid transfer to independent accommodation. This is generally to be welcomed.

Non-statutory homeless care providers

These agencies often play a vital role in supporting homeless people and are not always fully acknowledged by statutory services. Enhanced liaison and co-operation with these services is very important, both for general MHS and Specialist MHS for the Homeless. This is emphasised in 'A Vision for Change'. Service Level Agreements between the HSE and Voluntary Agencies are an essential requirement in improving care for the Homeless Mentally Disordered.

Summary

Homeless people experience a similar range of mental disorder to their domiciled counterparts, but on average they have a greater health and social care need. There is clear evidence internationally that the extent and complexity of their need results in a diminished access to the services, including MHS.

This paper, like many other health and social policy documents in Ireland over several decades, restates the right of mentally disordered homeless people to have their needs robustly addressed by mainstream health and social care services. Given that mainstream MHS are configured on the basis of domicile, such services must often make a greater

effort to address the needs of such patients. Such MHS must take the lead role in the prevention of homelessness. In this regard, 'A Vision for Change', recommending a local team designated in all areas to address this issue, should be followed.

In addition to the right to mainstream services, homeless mentally disordered people have a need for Specialist MHS for the Homeless in urban areas with a higher prevalence of homelessness. In these areas of high prevalence, Specialist MHS for the Homeless make sense and are effective.

Within Dublin, the Specialist MHS for the Homeless should be aligned more closely with what is envisaged in 'A Vision for Change', This incorporates 2 collaborative, Consultant Psychiatrist-led multi-disciplinary teams, with an assertive outreach and inter-agency approach, inpatient care provision from the "bed complement of the city" and a Crisis House. These multi-disciplinary teams must have an appropriate mix and complement of staff, reflective of teams working in the assertive outreach modality.

Outside Dublin, a variable Specialist MHS for the Homeless response will be required, with either individual mental health professionals or MDTs necessary, as locally determined appropriate, often drawing on a social care perspective.

We recommend the establishment of an Irish Clinical Network for mental health professionals in Specialist MHS, offering mutual information, support and education, to underpin best practice in such services throughout the country.

Recommendations

A. We recommend that each area has a timed plan for the development of mental health services for the Homeless in their area and adequate resources are made available. If investment is made in assertive outreach Community Mental Health Teams and Rehabilitation Teams, the likelihood of individuals with severe and enduring mental illness becoming homeless will be reduced.

B. In areas of high prevalence of homelessness, namely inner urban areas, Specialist Mental Health Services for the Homeless make sense and are effective. We recommend that the current services in place in this country should be maintained and are enhanced as the evidence of need dictates.

C. In Dublin, the two consultant Psychiatrist-led, multi-disciplinary teams must have an appropriate mix and complement of staff, reflective of teams working in the assertive outreach modality and a Crisis Unit be established as recommended in 'A Vision For Change'.

D. Outside Dublin, variable types of Specialist Mental Health Service response will be required, with either individual mental health professionals or multi disciplinary teams necessary, as locally determined appropriate. It is crucial that the existing services in Cork, Waterford, Limerick and Galway, are fully maintained, being enhanced as the evidence of need dictates.

E. We recommend the establishment of an Irish Clinical Network for mental health professionals in Specialist Mental Health Service, offering mutual information, support and education, to underpin best practice in such services throughout the country.

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