Specialist MHS for the Homeless

-evolving issues and forensic interface

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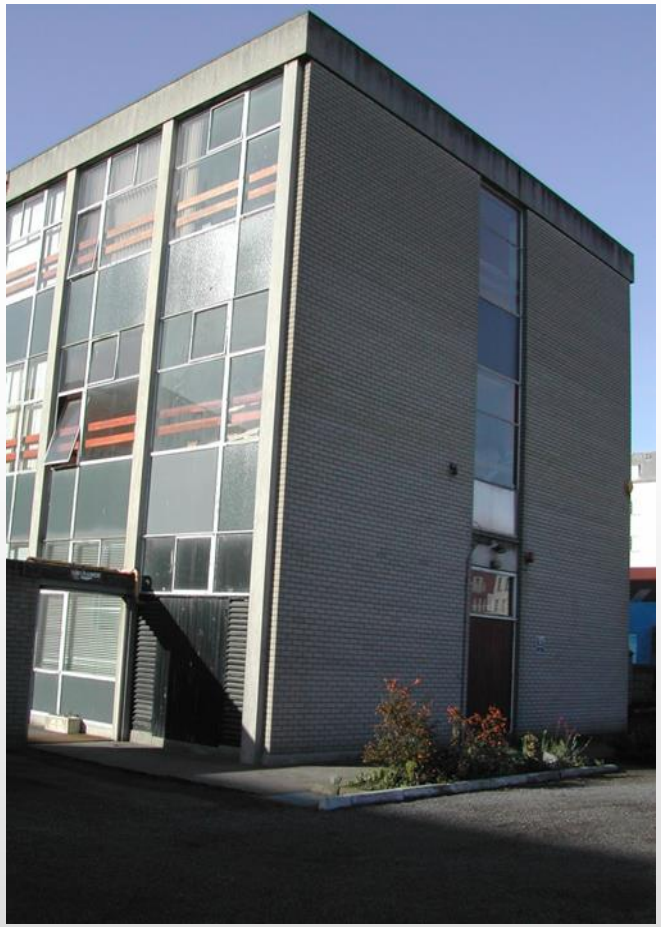
Programme for the Homeless
CPsychI Winter Conference
Killarney

15th November 2018

Usher’s Island Day Hospital



Origins of the programme

- Established at St. Brendan's Hospital 1979
- recognition of unmet need amongst city centre homeless attending AU
- 'an SBH solution for an SBH problem'
- Dr. Joseph Fernandez Cons. Psych. 1979-2004
- Lots of configurational change since 1979
- Closure SBH and opening Phoenix Care Centre 2013
- Two arms now in programme: Assertive Outreach, Day Hospital

Advent of other homeless MHS in Dublin

- ACCES Programme
  - MDT led by Dr Joanne Fenton
  - Est'd April 2004
  - Southside, co-located with DCC
  - Assertive outreach model

- Dr. Siobháin Barry's service thro' Crosscare, Dun Laoghaire
  - Additional to sector responsibility
  - Decommissioned 2008

Stakeholder Aspirations for what spMHSh should provide in Dublin

- Be of Assertive Outreach modality
- Manage all nature & degree of mental disorder
- Manage all broad definition homelessness
- Provide drop-in service to all comers
- Provide inpatient care to all homeless
- Provide 24hr instant access for these
- Provide direct access to primary, homeless and social care providers
- Cover the entire metropolitan area
- Accept people from beyond Dublin
- Accept tourists and asylum seekers
- Retain re-domiciled patients until needs ‘normalise’

the programme must prioritise

- 1st: those needs a spMHSh, such as the programme, alone can meet,
- 2nd: those needs a spMHSh, such as the programme, is best placed to meet and
- 3rd: those needs that could equally be met by other services but which the spMHSh, such as the programme, can also meet and does so in order to reduce the care burden on other services dealing with this population and/or to deliver stakeholder aspiration

Conceptualisation of Needs

- Severe & Complex MH & SC needs

+/- Substance Misuse

- Severe MH & SC needs

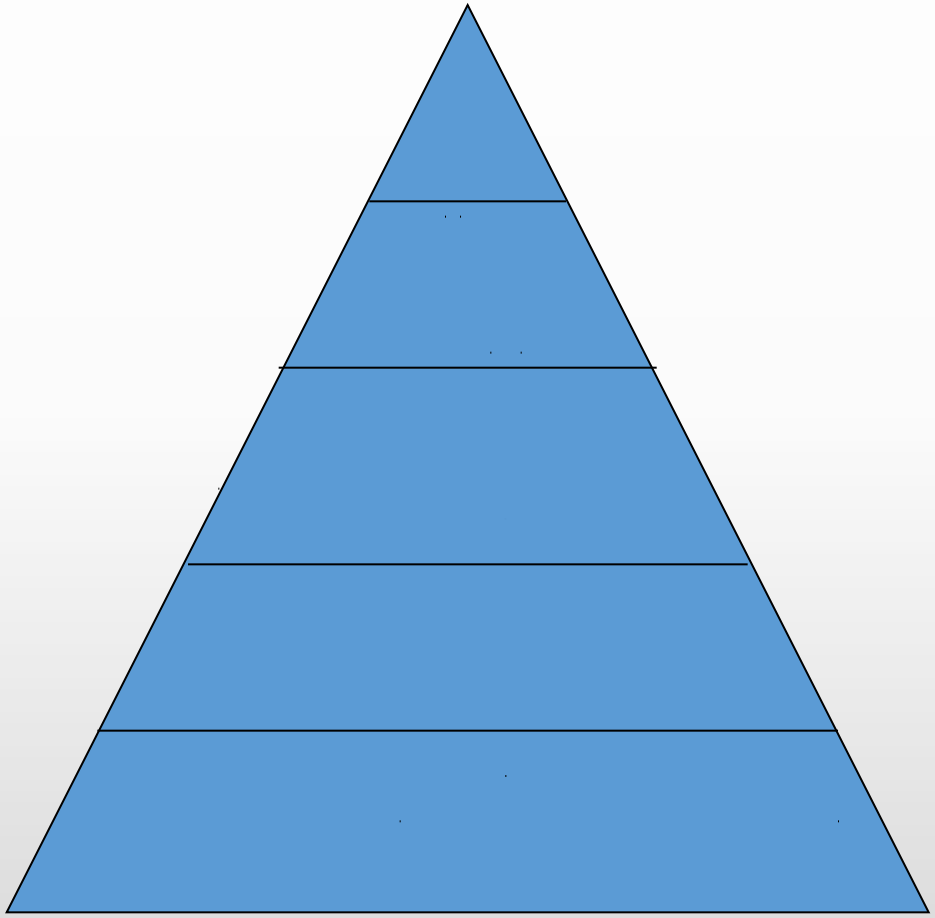
+/- Substance Misuse

- Significant MH & SC needs

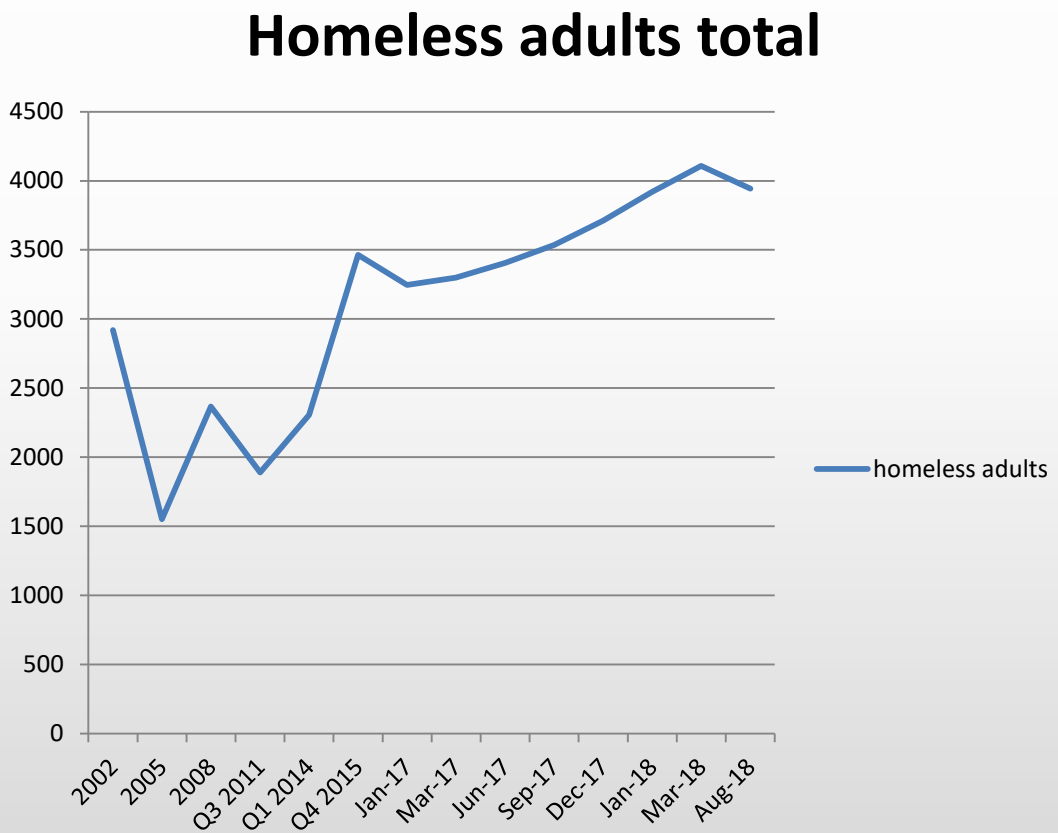
+/- Substance Misuse

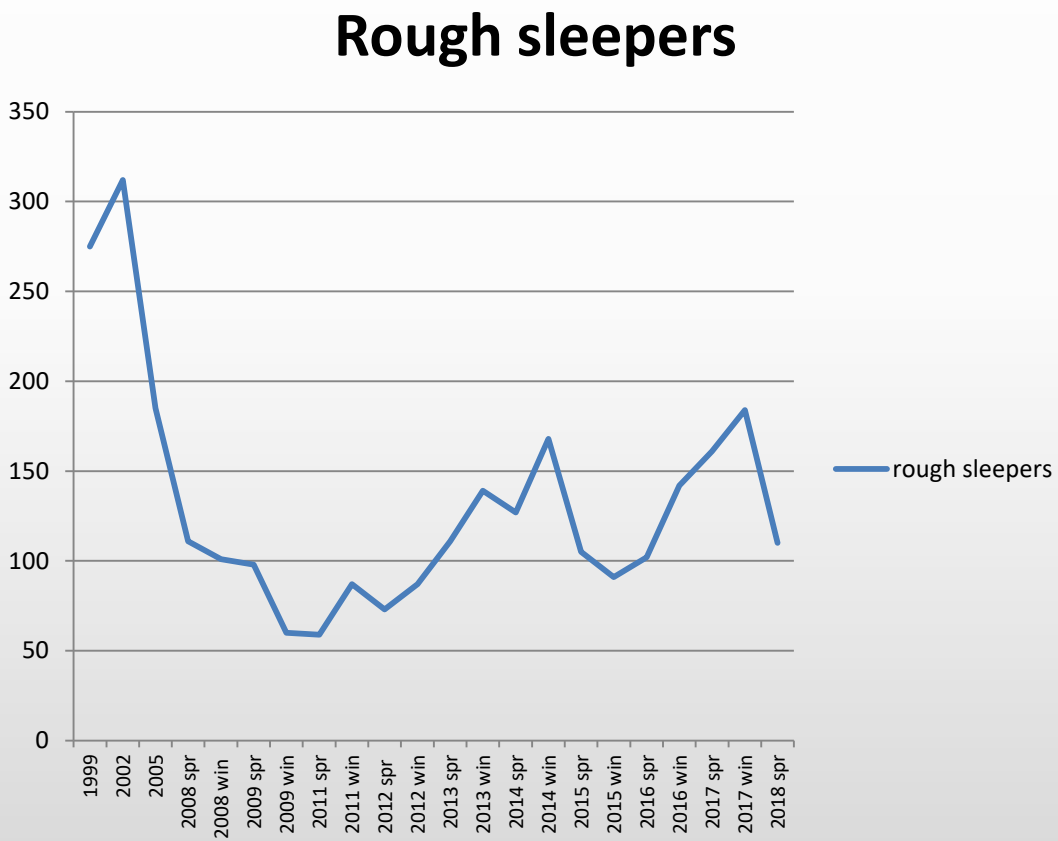
- Minor MH & SC needs

- Social Care (SC) needs



Census trends





AO features

- Higher staff to patient ratio than standard CMHT
- High % of clinical interactions distant from the hospital or clinic
- The ability to maintain higher intensity of patient contact than CMHT
- Explicit acceptance criteria, applied consistently
- Explicit aim of reduction in psychiatric bed usage

- Dartmouth ACT scale
- UK DoH website re AO

Intensity via AO:

- AO services should be 1:8 – 1:15 staff to patient ratio
- ‘The team is the therapy’
- Caseload recommendation 60-100 (Burns & Guest)
- Evidence for max desirable WTE: >16 may undermine team cohesion
- Programme caseload currently 133
- Programme capacity previously: visited pt in nearby hostel thrice daily for 10 days, twice daily for 4 weeks and once daily thereafter
- All MDT staff do AO visits

The need for intensity via AO

- Suicide risk known to be increased in homeless population
- Cork study recently confirmed in an Irish population
- NOSP Director believes risk increased 10 times

- “Splodge”

The forensic need for intensity via AO

HCR-20 study: cross-sectional survey Sept 2008

Caseload number then was 103

H- subscale mean 11.4

Cambridge: For Inpt 12.3; Comm For 12.1; sector team 7.1

England & Wales Community Forensic MHS Cons Psych: avg. 26 pts

Programme Prisoners 2017 & 2018

- Daily average of five patients imprisoned
- 31 separate periods of confinement
- Ranging from few years (rape, firearms) to few days
- 17 different patients
- Dx: SMI and Alco/PSA co-morbid in 14, SMI alone 1 & Alco/PSA in 2
- Most recidivist patient had 7 incarcerations during the period
- 9 new acceptances from Forensic MHS: avg H-score 12.8

Programme acceptance criteria

- Relaxed 4 times in last decade but especially in Jan 2011
- Current version Nov 2014
- Higher threshold of transfer from MHS vs P/H/SC providers
- Currently addresses 3 biggest priorities, unarguably 1st and 2nd ones
- Not immutable: must tighten or relax based on resources vs demands
- Demands have been increasing year on year as will be seen
- Resources increased but not at same rate

Acceptance Criteria

from other MHS

- Adults of 18 years and older, known to have been homeless (sleeping rough or using homeless sector accommodation) for 4 weeks
- Predominantly living in the inner city (‘between the canals’)
- With severe mental illness (SMI) requiring MHS level care, including co-morbid, but not primary, alcohol and substance misuse disorder (but see small print)

from H&SCP

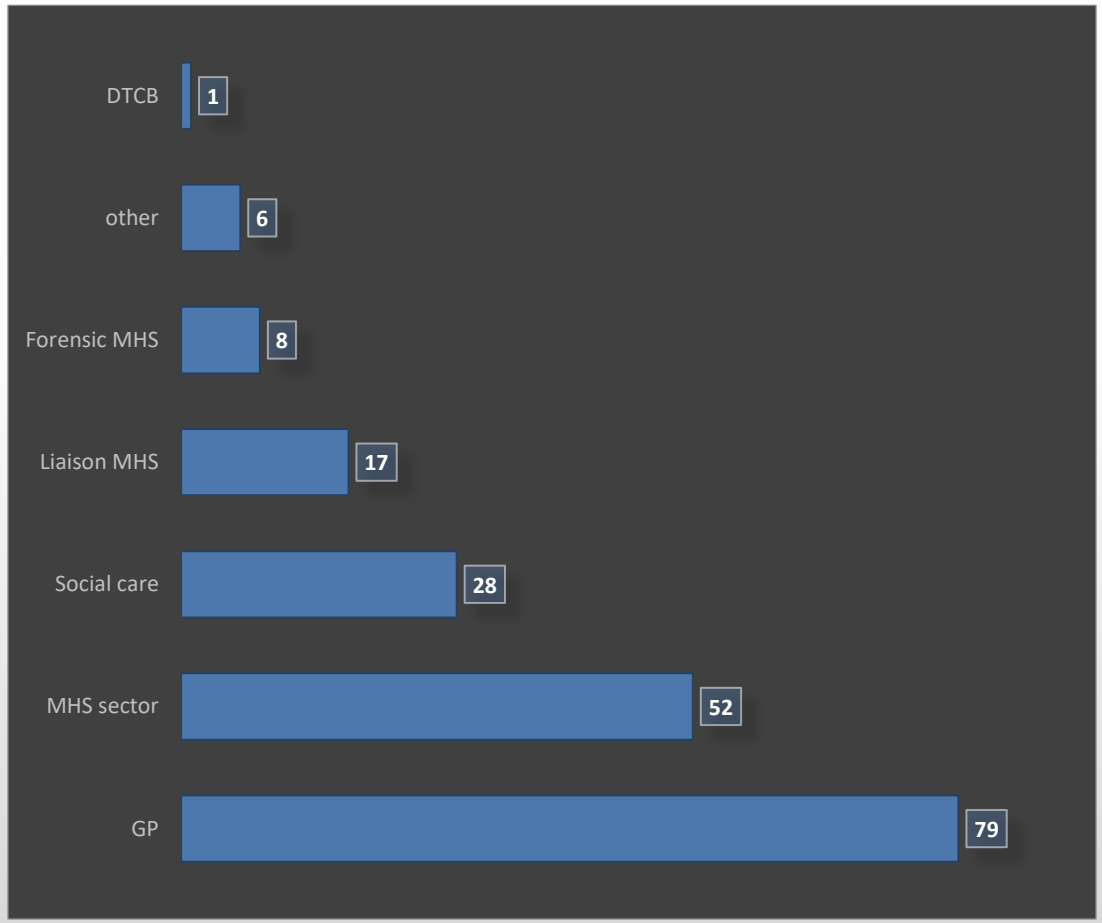
- Referrals from Primary, H&SC Providers have lower threshold:
- Adults of 18 years and older, known to have been homeless for 4 weeks
- Predominantly living in the inner city (‘between the canals’)
- No requirement for SMI
- however, psych sx in the context of primary opiate and alco dep are not accepted

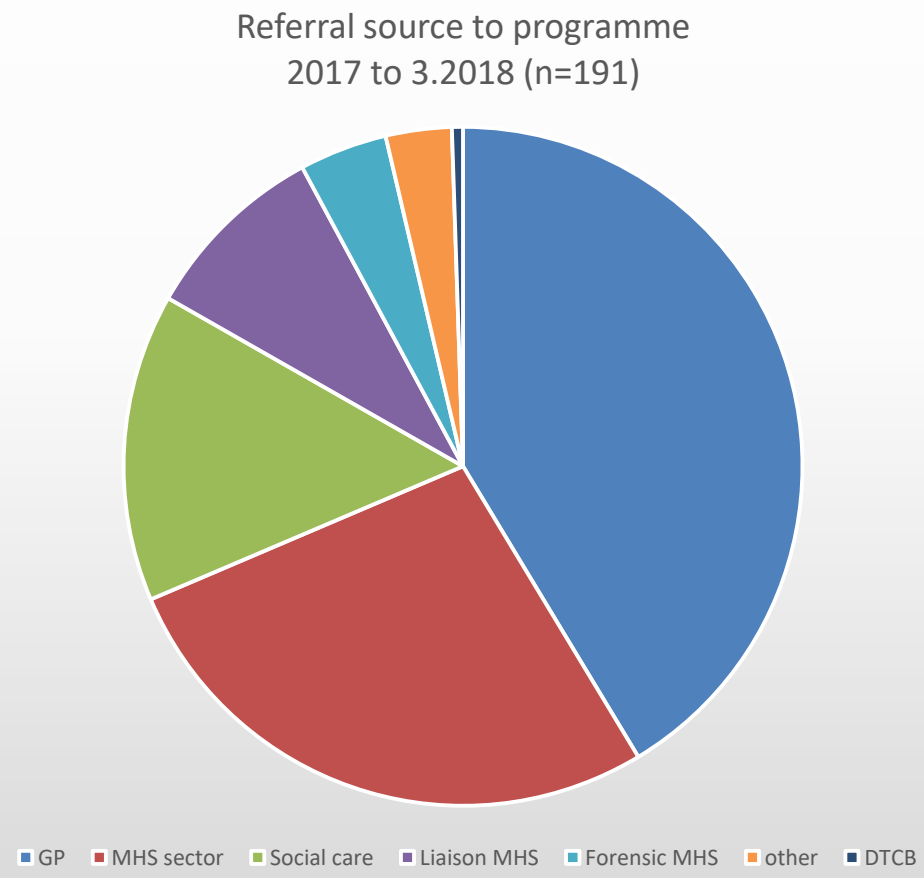
The Acceptance Criteria small print…

- Patients with significant prior association with greater Dublin south of the River Liffey, by residence or health service involvement or, without significant prior association with greater Dublin and homeless in the south inner city when first detected by the referrer, should be referred to this service's counterpart there, ACCES. For the purpose of these criteria, the north inner city is a semi-circular area S. and W. of the Royal Canal, E. of the Phoenix Park, (map available on request). For the purpose of these criteria, the south inner city is a semi-circular area N. of the Grand Canal, between Kilmainham and Grand Canal Dock, (map available on request). Patients who were on a local MHS caseload as of Dec 2010 may be accepted if they meet the 'difficult to engage criterion' that formerly applied to such referrals. Referrals by other MHS of patients with non-SMI mental disorder will be judged on a case-by-case basis. Patients without prior association with greater Dublin may be accepted immediately.

- 'Case by case flexibility' is shown for i) patients referred by other MHS where SMI is not confirmed but patient may be thought of as UHR of development of SMI, ii) patient without SMI is consuming much ED and hospital inpatient resources, iii) Phoenix Park campers and iv) homeless people staying in tourist accommodation

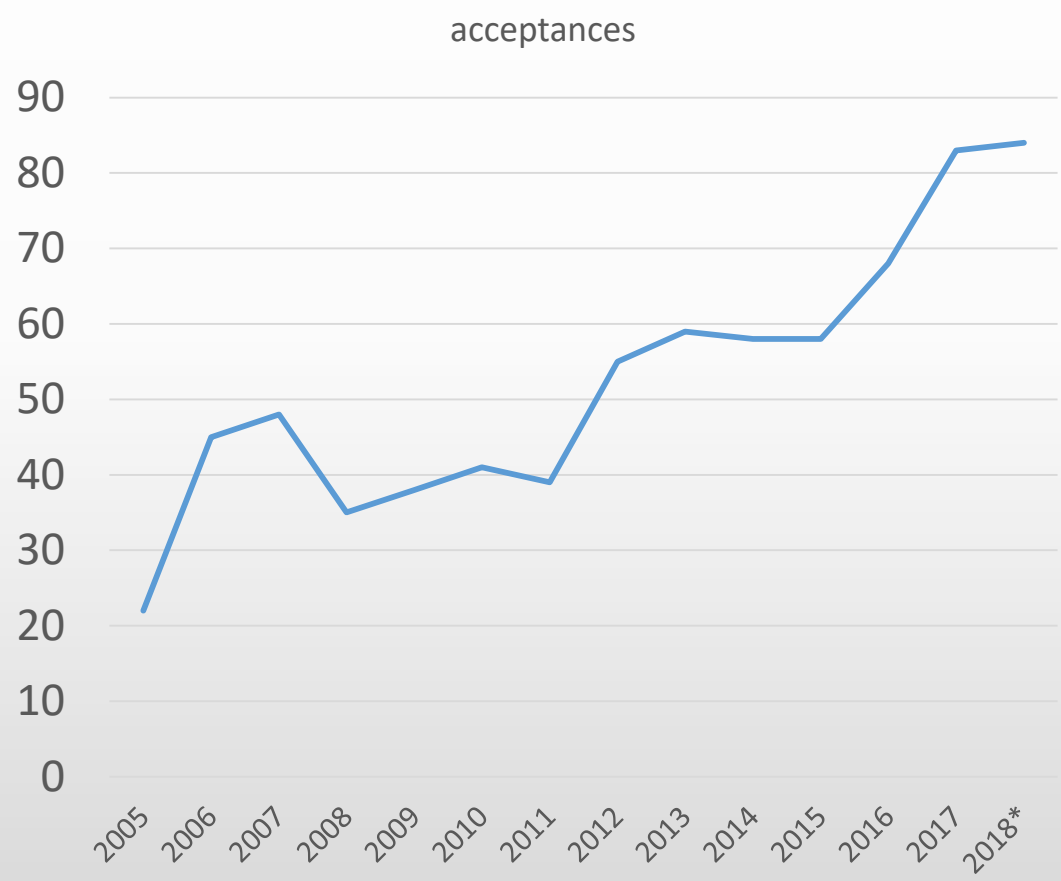
Referrals sources of programme over 15 months from Jan 2017 to March 2018





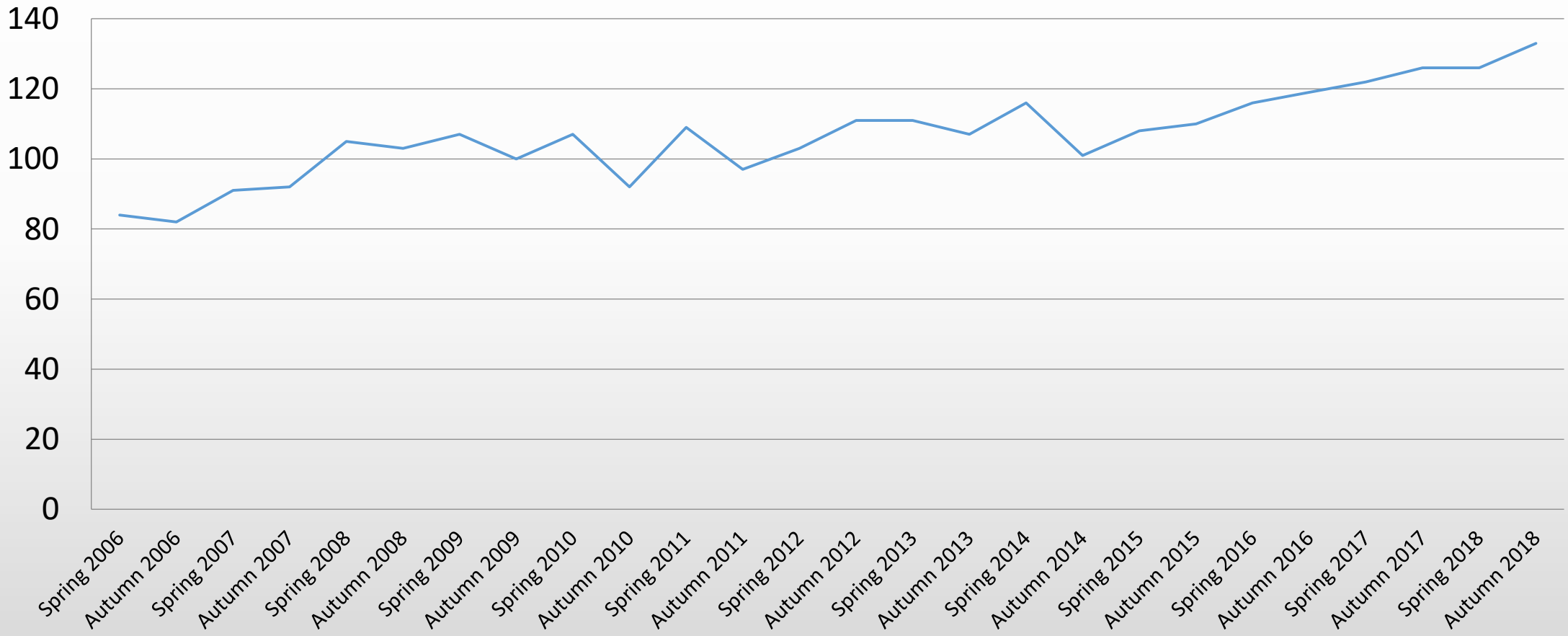
Referrals and acceptances 2005 to 2018*

*projected end October 2018



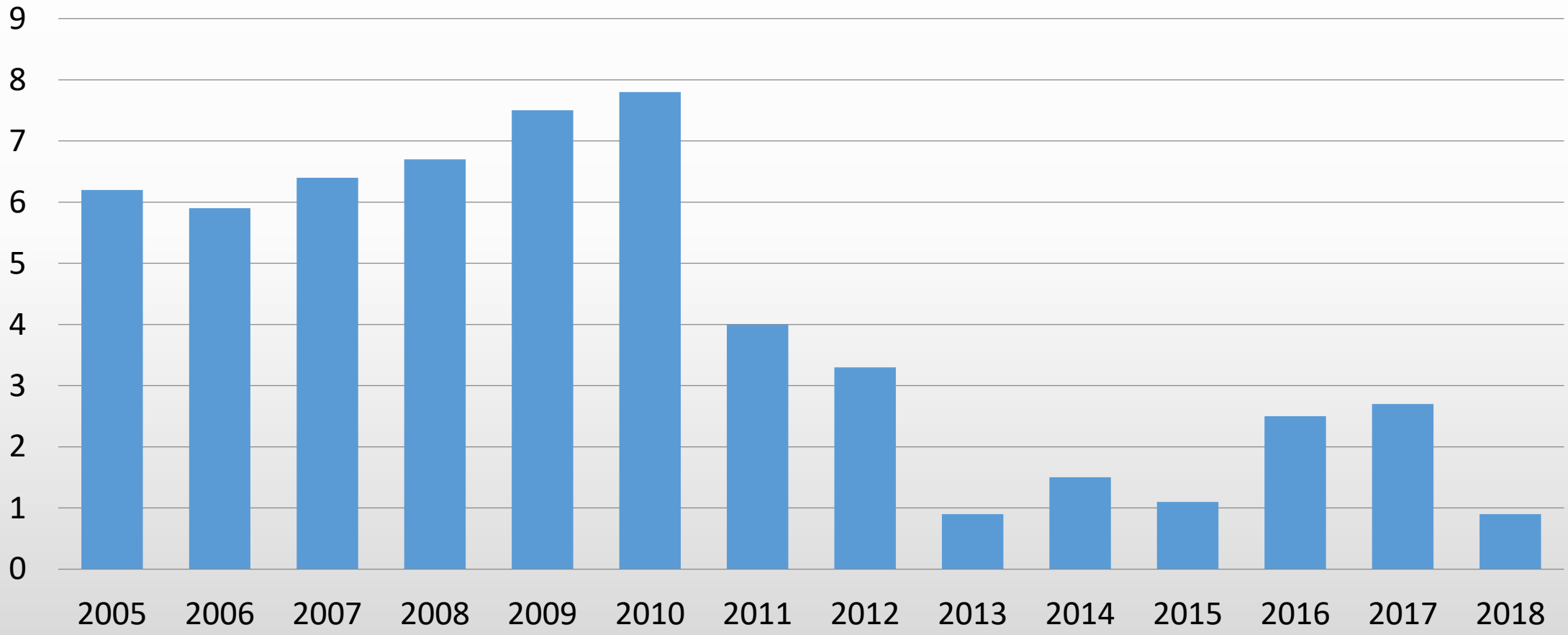
Programme Caseload No.

Spring and Autumn from 2006 to 2018

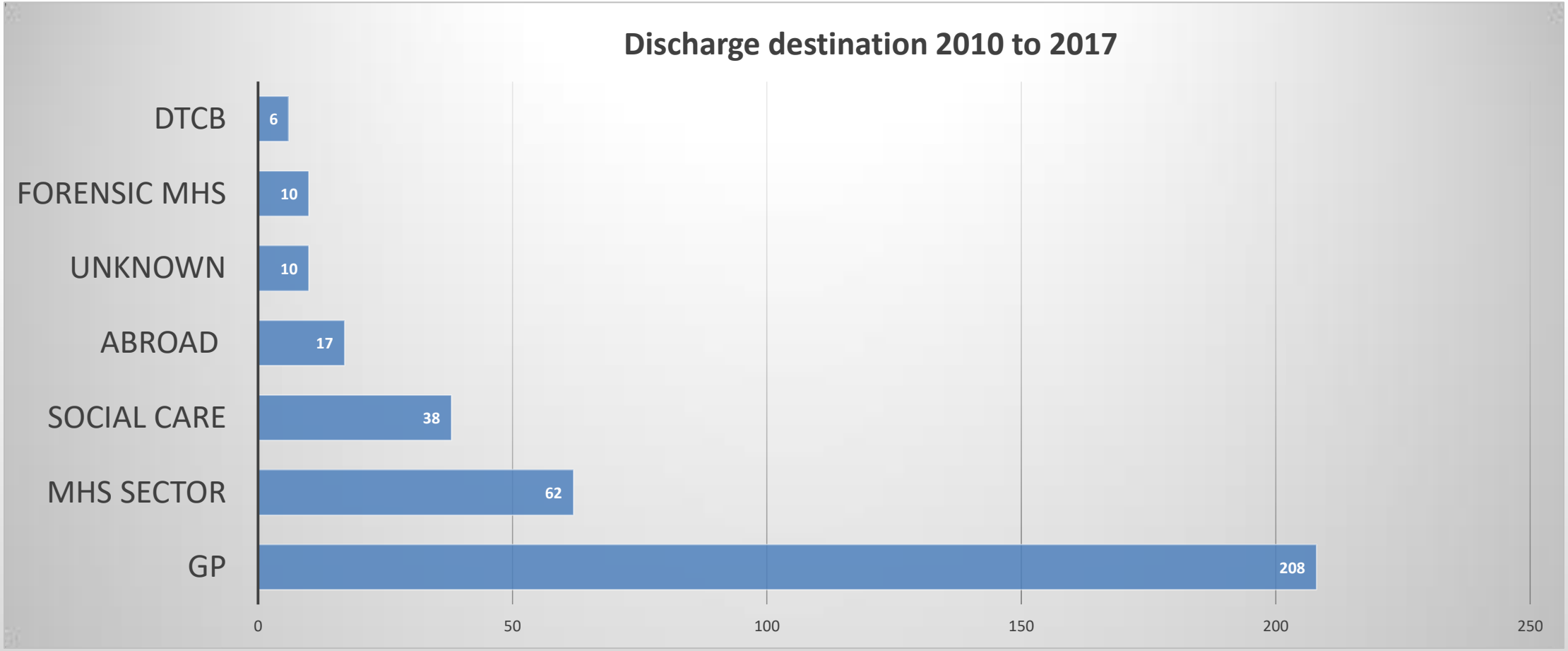


Programme inpatients daily average

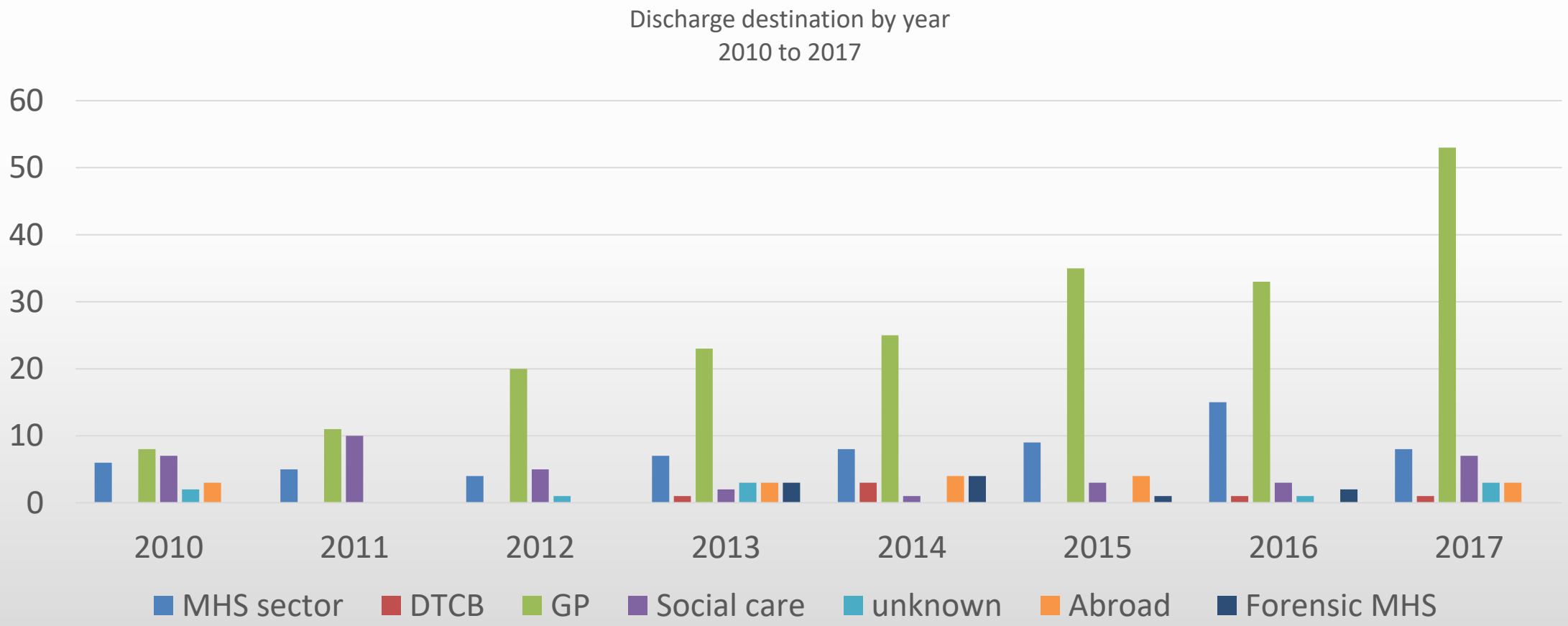
2005 to 2018



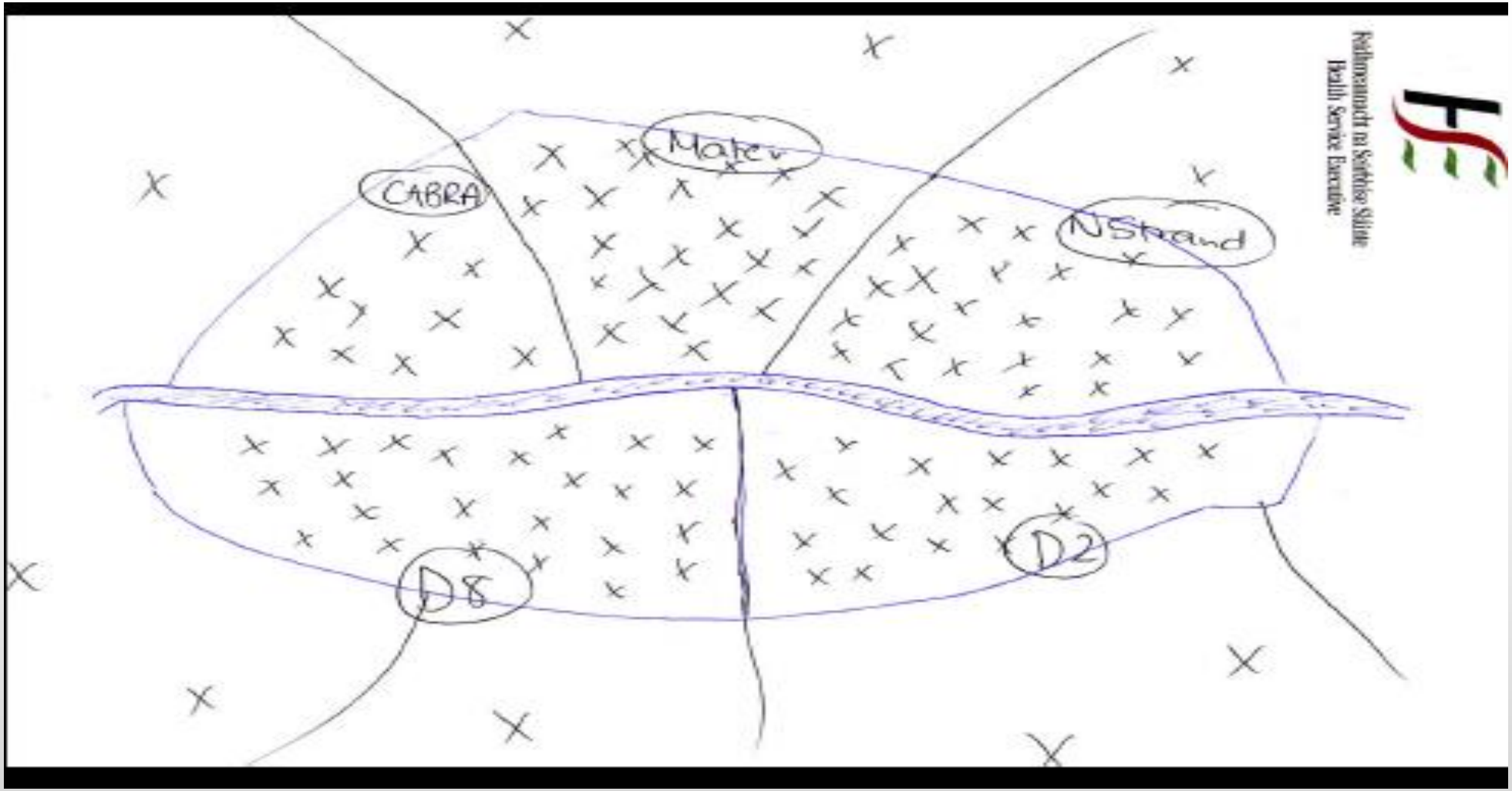
Where discharges went over the last 8 years



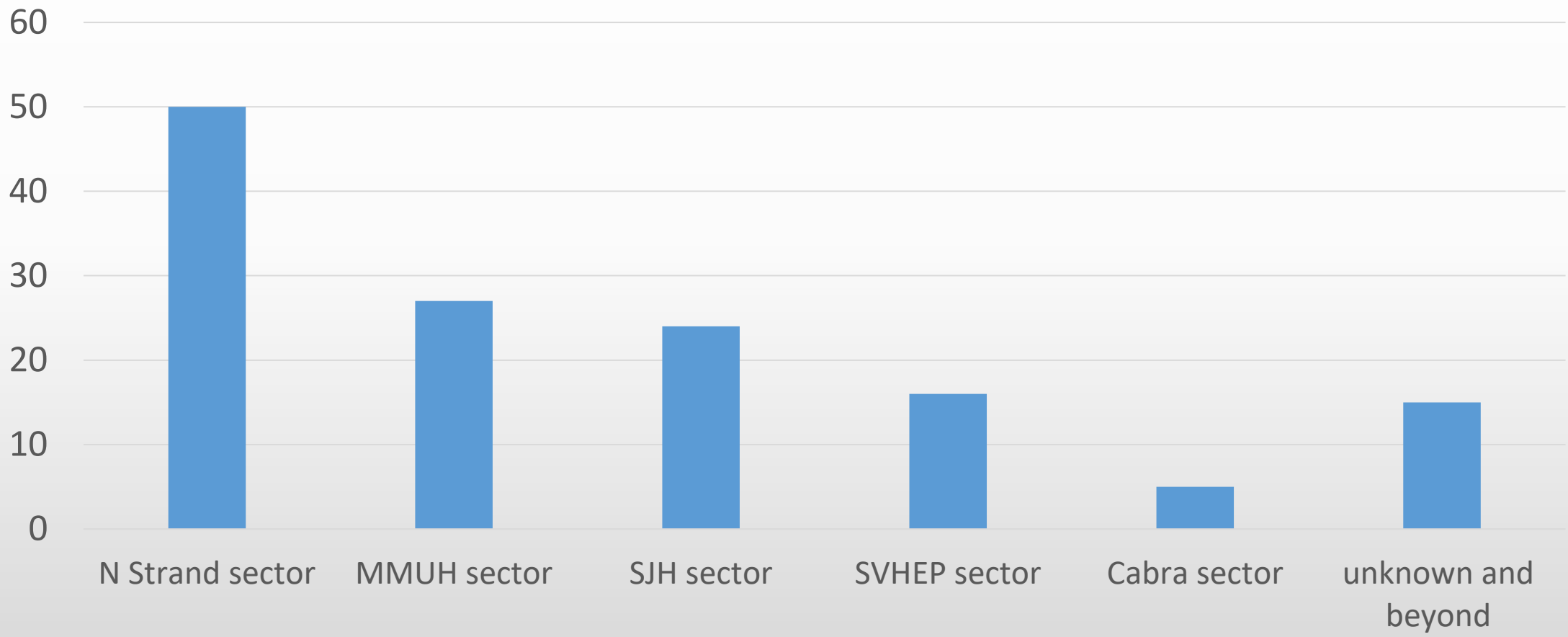
Discharge destination over 8 years, by year (indirect evidence of large increase Tier 3 pts)



Mental Map of homeless SMI



Location of acceptances at referral Jan 2017 to Aug 2018 inclusive n=137



Comparison of Dublin spMHSh

Programme

- circa 16 WTEs
- Over a 7 day service
- Day Hospital
- 0.9 Cons Psych
- Inner city: ‘between the canals’
- Full NCHD recruitment

- Accept referrals from top 3 tiers from Primary Care plus from Homeless and Social Care Providers
- Accept all top 2 tiers from other MHS
- Accept some tier 3 from other MHS: most challenging cases

ACCES

- circa 8 WTEs
- Over a 5 day service
- No Day Hospital
- 0.6 Cons Psych
- South Dublin and beyond
- Frequent NCHD & other vacancies

- Does not accept referrals from Homeless and Social Care Providers
- Accept top 2 tiers from Primary Care only
- Accept tier 1 from other MHS

The wider perspective of State spending

- Tusla 4,000 employees throughout state
- Circa 2,000 H&SC Providers in wider Dublin
- Over 70 homeless non-statutory agencies in Dublin receive €160m
- Four biggest NGOs have over 900 employees wages over €80m
- They employ public relations professionals
- NGO and state reports' constant refrain: more MH support needed

The wider perspective, cont'd

- Programme estimated costs €1.2m
- My wild guess for ACCES: €0.35m
- Total spMHSh in Dublin circa 24 MHP WTEs

- Now a high risk HSE may spend money with large opportunity cost

Conceptualisation of Needs: Tier 3 reminder

- Severe & Complex MH & SC needs

+/- Substance Misuse

- Severe MH & SC needs

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- Significant MH & SC needs

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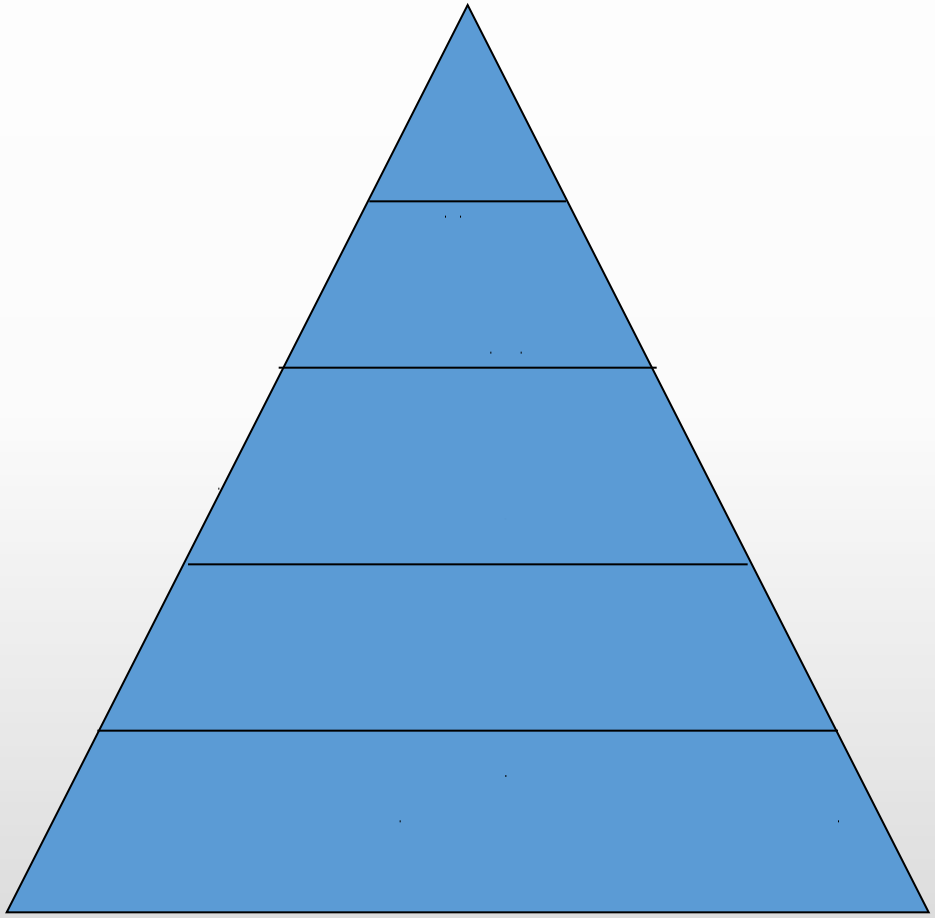
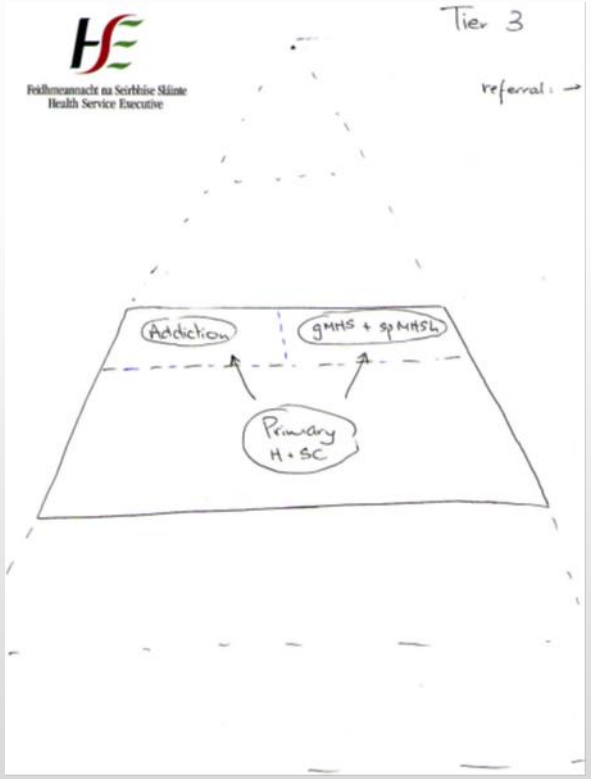
- Minor MH & SC needs

- Social Care (SC) needs

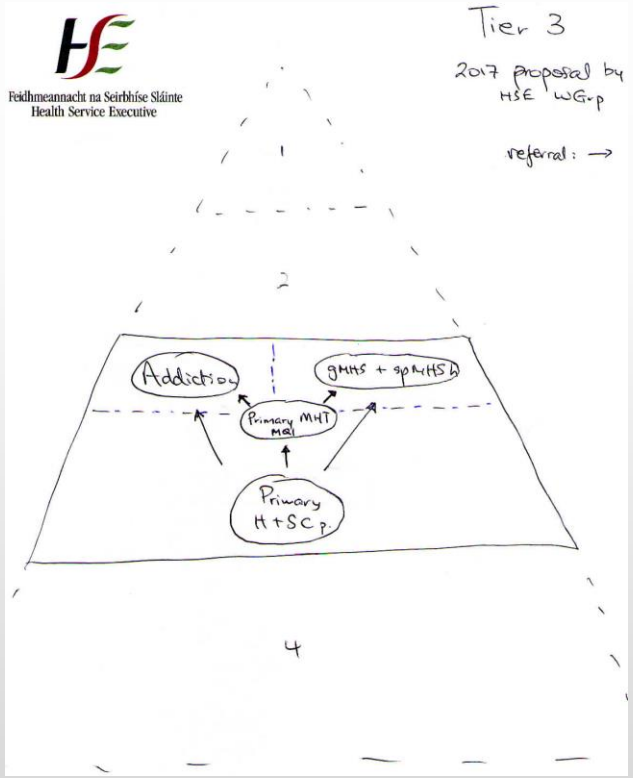


Services for Tier 3 patients

as it should remain



proposed Primary MH Team model



Inner Urban MHS in Dublin

Require sensible investment without opportunity cost

- spMHSh
- The inner city sector MHS
- Opiate dependence SM MHS
- Alcohol dependence MHS

- Priority investing significantly in ACCES service necessary for cross River Liffey spMHSh symmetrical provision by
- Next Addiction Services (resources and governance), in my opinion
- Then Inner City Sector MHS and Programme, in my opinion
- Equitable approach South of River Liffey to spMHSh (CHO 6&7) is needed: no resource fault line between these inner city CHOs

We need a coalition of Cons Psychs seeking:

- Strengthening of existing inner city MHS
- Funnelling resources to statutory MHS under HSE governance
- Pursuit of national MH policy: Vision for Change (2006)
- ‘Significant’ increase in state expenditure to existing MHS
- Will still be ‘paltry sums’ compared to that other services receive
- Attention to the governance of state funded Addiction Services
- No untried novel models of care to be commissioned prior to above
- Suburban MHS to assess needs and make a case as required
- If 2 spMHS proves insufficient over time: reassess resource allocation

Thank You

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