



The College of Psychiatry of Ireland  
*Coláiste Síciatrachta na hÉireann*

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# Specialist Mental Health Services for Homeless People

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Position Paper  
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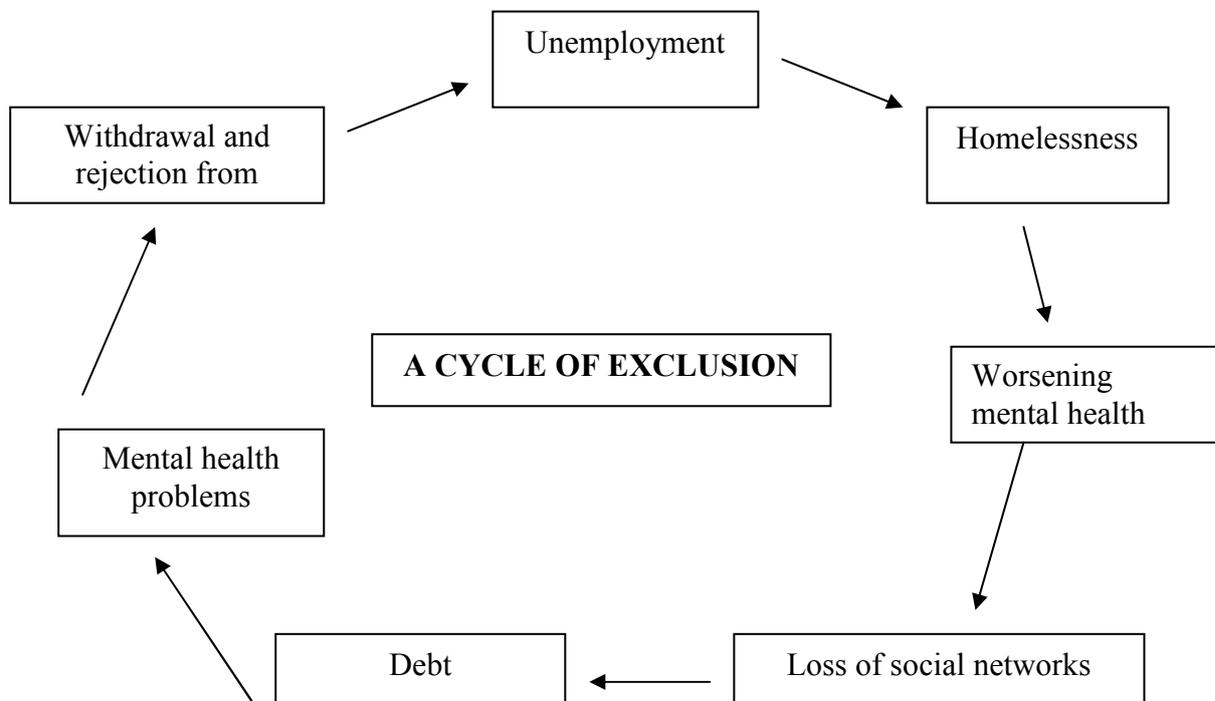
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## Specialist Mental Health Services for Homeless People

*“Few topics are as emotive as the homeless and mental illness, nor more likely to attract broad statements about simple fixes”* - Dr Alex Holmes of the Waratah Area Homeless Outreach Psychiatric Service (WAHOPS), Melbourne’s Specialist Mental Health Service (MHS) for homeless people, in Australasian Psychiatry, March 2005.

The true prevalence of mental illness in the homeless population is unknown and estimates have varied widely. This variation can be understood if one considers the differing definitions of mental illness and homelessness that may be applied, the different settings and methodologies in which research is undertaken. An Irish study 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 a higher prevalence of severe mental illness, (usually taken to mean schizophrenia, schizo-affective disorder, bipolar affective disorder), 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% for schizophrenia, 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 it can be to break the vicious circle. 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 three yearly official census of homeless people in Dublin. The most recent, (Counted in 2008), detected 2,366 people. Advocate and voluntary organisations for homeless people have in general terms accepted this figure, believing it to be more robust methodologically than other measures such as the three yearly 'Housing Needs Assessment' by the Department of the Environment, Heritage and the Gaeltacht (Focus Ireland Press Release, 17<sup>th</sup> 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](http://www.simon.ie)) at any one time.

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).

International evidence suggests 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's 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.

While they have no characteristics, homelessness excepted, setting them apart from the domiciled mentally disordered, on average homeless people have higher rates of childhood and adult adversity, challenging behaviour, substance and alcohol misuse, poor educational and occupational achievement and co-morbid physical illness.

In mental health, sectorised services delivered on the basis of address 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 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 for homeless people can be effective (Power & Attenborough 2003, Holmes 2006).

### **Specialist Mental Health Services for homeless people in the Republic of Ireland**

The **Programme for the Homeless** at St. Brendan's Hospital in north, inner Dublin, is the oldest Specialist Mental Health Service for Homeless People in Ireland. We are unaware of any older Consultant Psychiatrist-led service in the world. It was set up in 1979, initially under the leadership of Dr J. Fernandez, until his retirement in 2004. The service was set up in recognition of unmet needs for the patients of St. Brendan's Hospital, who had a high prevalence of homelessness. The service early on in its history had acute and continuing inpatient care, on-campus day centre and supported community residence components. There was, until a decade ago, availability of 'lodging' beds in the hospital Assessment Unit. All these units have been decommissioned over time. The male day centre moved off-campus in 1997 to Usher's Island, Dublin. The service has gradually increased the assertive outreach component and is more orientated to the community now than it was in 1979, echoing the changes in Mental Health Service 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 a social worker.

In 2004, funding was made available for a Consultant Psychiatrist-led team to provide additional service to homeless people with mental illness in south Dublin. This **ACCES** team works as an assertive community outreach team. The team consists of a Consultant Psychiatrist 0.7 WTE, two Community Mental Health Nurses (CMHNs) 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 **Cork Adult Homeless Integrated Service (CAHIS)**, established in 2002, was the second such service nationally. This team uniquely comprises mental health professionals (Community Mental Health Nurse, Psychiatrist and Psychologist) working side by side with a General Practitioner and Public Health Nurse/Registered General Nurse and an Addiction Counsellor. The mental health component uses an assertive outreach model as advocated in 'A Vision for Change'. The team has been incorporated into Cork City Central Primary Care network. This is consistent with the recommendation of 'The Way Home: A Homeless Strategy' to address Adult Homelessness in Ireland 2008-2013', that 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 Mental Health Services. 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.

There are also Specialist Mental Health Services for homeless people based in Limerick, Waterford and Galway, comprising one Mental Health Nurse each. In Galway, the nurse is employed by a voluntary agency working with homeless people. These clinicians employ an assertive outreach approach, in a liaison role, interfacing with general Mental Health Services and Primary Care in different ways in each location.

The assumption by local services of the duty to provide a designated identifiable team with responsibility for the delivery of Mental Health Services to homeless people, as outlined in 'A Vision for Change', has not happened in any service of which we are aware.

There is a complex range of statutory and voluntary 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.

### **Criteria for acceptance from general Mental Health Services to the Specialist Mental Health Services for homeless people in Dublin**

The criteria for acceptance of referrals to Dublin Specialist Mental Health Services for homeless people by general Mental Health Services 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 Mental Health Services for homeless people 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 Mental Health Services in Dublin manage some homeless people with mental health needs.

### **Mental Healthcare Services for homeless people 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 Mental Health Services for homeless people, 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).

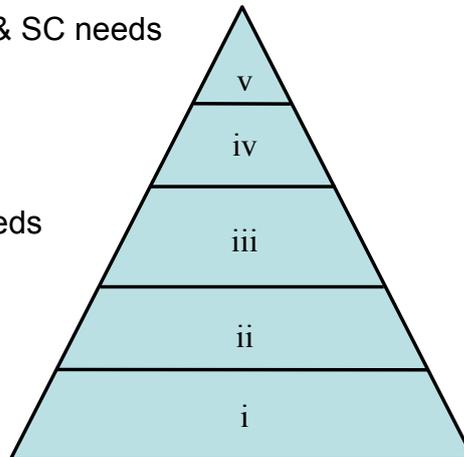
### **Mental Health in the WHO European Region**

FEANTSA ([www.feantsa.org](http://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.

MH= Mental Health  
SC= Social Care

## 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 +/- substance misuse
- v) social care needs & severe and complex mental health needs +/- substance misuse

As currently configured, the Dublin Specialist Mental Health Services for homeless people deliver services to the top tier, as well as a proportion of the second from top tier. General Mental Health Services 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 Mental Health Services 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 Mental Health Services 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 Mental Health Services is something which varies widely. It has a significant impact on the structure and function of Specialist Mental Health Services for homeless people. In terms of the conceptualisation above, this will influence the size of the pyramid (the number of people represented by it).

Opinions differ regarding what populations (tiers of the pyramid) should be targeted by Specialist Mental Health Services for homeless people. We believe that the need to care for the top tier on an ongoing basis is the paramount priority for Specialist Mental Health Services for homeless people 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 Mental Health Services for homeless people intend that the following principles will guide future services:

- Recovery and social inclusion oriented
- Incorporate a multi-agency approach throughout the inner city, close liaison with primary care, homeless and social care providers and other mental health services.
- Employ an assertive outreach approach and have a clear pathway of care.
- As set out in 'A Vision for Change', set up a Crisis House which will be available to homeless mentally ill patients thus reducing their need for inappropriate admissions to psychiatric units.
- Community mental health teams should adopt practices to help prevent service users becoming homeless.
- Interaction and co-ordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged. The importance of this recommendation needs to be emphasised.

Outside Dublin, 'A Vision for Change' has not been 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 health 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 by the Department of Environment, Heritage and the Gaeltacht (housing) and Department of Health (social inclusion), 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 health services into Primary Care Teams dovetails with the view of supporting specialist mental health teams in 'A Vision for Change'. Some of the Community Mental Health Nurses involved in homeless services around the country, like the Cork Adult Homeless Integrated Service, are funded by Community Care from its social inclusion budget. In such services, the Homeless Strategy is the document whose objectives have been seen as paramount.

## **Primary Care**

In Dublin, in recent years, improvements have occurred with the commencement of the SafetyNet Primary Care Initiative and with increases in the percentage of homeless people holding medical cards. These developments need to be built on. Liaison by Specialist Mental Health Services for homeless people 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 Specialist Mental Health Services 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 Specialist Mental Health Services 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 Specialist Mental Health Services for homeless people for a period, to ensure a secure transition as the patient is re-establishing a domicile. 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 Mental Health Services and Specialist Mental Health Services for homeless people. 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 ill.

## **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 health services, including Mental Health Services.

This paper, like many other health and social policy documents in Ireland over several decades, restates the right of mentally ill homeless people to have their needs robustly addressed by mainstream health and social care services. Given that general Mental Health Services are delivered on the basis of address, such services must often make a greater effort to address the needs of such patients. Such Mental Health Services must take the lead role in the prevention of homelessness in the mentally ill. 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 Mental Health Services in urban areas with a higher prevalence of homelessness. In these areas of high prevalence, Specialist Mental Health Services for homeless people make sense and are effective.

Within Dublin, the Specialist Mental Health Services for homeless people should be aligned more closely with what is envisaged in 'A Vision for Change', This incorporates two 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 Mental Health Services for homeless people response will be required, with either individual mental health professionals or Multi Disciplinary Teams 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 Mental Health Services, offering mutual information, support and education, to underpin best practice in such services throughout the country.

### **Key Recommendations**

A. In all areas without Specialist Mental Health Services for homeless people, the recommendations of national mental health policy, 'A Vision for Change' (2006), should be implemented: "that a range of practices should be adopted by all mental health services and teams to prevent service users becoming homeless". Adequate data collection on this issue should be arranged locally. A robust, local Mental Health Services and inter-agency response should be made to the needs of mentally ill people who are homeless or vulnerable to homelessness. 'A Vision for Change' recommends the designation of a Community Mental Health Team with responsibility and accountability for the homeless population in each catchment area. We suggest designation of an individual with responsibility for this issue as a possible first step in this regard. In addition to this, investment made locally in Community Mental Health Teams with assertive outreach capacity and in Psychiatric Rehabilitation Teams, will reduce the likelihood of individuals with severe mental illness becoming homeless.

B. In areas of high prevalence of homelessness, namely inner urban areas, Specialist Mental Health Services for homeless people make sense and are effective.

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 House be established as recommended in 'A Vision For Change'.

D. Outside Dublin, in inner urban centres, variable types of Specialist Mental Health Services configurations will be required, with either individual mental health professionals

or multi-disciplinary teams, 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.** Establish 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.

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