HEALTH

1. Introduction

Mental and physical health problems are strongly connected to homelessness. It is best to see homeless people not as constituting a separate category, but as being a group of people who find themselves at the extreme end of the spectrum of social exclusion. Some of the most powerful determinants of health are embedded in conditions of social inequality (Pickett and Wilson, 2009) and these are not usually directly affected by health interventions.

As with other socially-excluded groups, homeless people die earlier and have a higher prevalence of mental and physical illnesses than the general population (Fazel, 2014, Aldridge 2017). Migration, a major source of homelessness, is linked to a range of health problems, including mental health problems (EPRS, 2016). Like other groups at the bottom end of the social-economic scale, they likely to be subject to the "inverse care law" and so less likely to receive the health care that they need (Tudor Hart, 1971).

Psychosis, multiple trauma and addiction are often causes of homelessness, whereas emotional distress, anxiety and depression can be responses to homelessness (Leng, 2007).

Physical health problems can arise directly from the specific dangers of being homeless, from a lack of the normally-assumed social framework for health, or be worsened because of the lack of access to treatment. For example, if you suffer from diabetes, tuberculosis or other illnesses, it is hard to take care of your health in the streets while homeless because:

- You will be more vulnerable to extremes of temperature, more likely to become wet, and more likely to be assaulted.
- You will generally lack control over life to establish and maintain the basic routines to maintain health. These include a healthy diet, clean clothes, adequate rest, security of possessions and privacy. This is also likely to affect your ability to take medication regularly.
- You will often not be able to conform to the arrangements for clinics – many health and social services have limited contact with this population and do not design their services to address such needs adequately.

There have been statements from European bodies concerning healthcare and those who are homeless or socially excluded. In 2016 the European Parliament issued a statement regarding the right to health services for refugees or asylum seekers, with or without papers.

In the same year, Mental Health Europe (MHE, 2016) issued a paper strongly arguing for refugees and asylum seekers to have full access to appropriate health services, particularly where issues of trauma arise.

In spite of these assertions, the PROMO study (Canavan et al., 2012) has demonstrated major issues with access to health care for homeless people in Europe. Their summary comments: "Input from professionally qualified mental health staff was reported as low, as were levels of active outreach and case finding. Out-of-hours service provision appears inadequate and high levels of service exclusion criteria were evident. Prejudice in the services towards homeless people, a lack of co-ordination amongst services, and the difficulties homeless people face in obtaining health insurance were identified as major barriers to service provision."

In addition, there is evidence that, within health services, there can be considerable stigmatisation of certain groups of patients, including homeless people (Jeffrey, 1979).

2. Main ideas

Accessibility

Direct access to care and resources is crucial, especially for undocumented people. Homeless people tend to experience multiple problems simultaneously, so they can easily be perceived as difficult to treat and thereby become "unwanted" by mainstream services. At the same time, homeless people tend to find it hard to deal with bureaucratic barriers, waiting lists and complicated treatment plans. The more rigid and complex a service is, the more likely it is that homeless people will be excluded from that service, or to lose contact with it. Health services should be aware that:

- While general populations have difficulties adhering to treatment plans, homeless people have added difficulties in doing this.
- Services should not make it difficult to access their services – access needs to be as easy and quick as possible (and not just for homeless people).
- Because of myths within services regarding entitlement to those services, homeless people need access to and knowledge of their rights regarding access to healthcare.
- Aftercare and follow up after discharge from hospital presents specific problems. Without a physical home to go to, or a supportive social network,
  one needs to consider that a homeless person may well be being discharged to a hostile and unsupportive environment. It is particularly important that, for a homeless person, a clear and robust aftercare plan is made. Without this, any gains from the hospital admission can easily be lost. However, this is often not done for homeless people before their discharge from the hospital.

Attention to Relationships

It may be that, in some contexts and with some clients, adequate care and treatment can be delivered without needing to pay attention to the relationship between the client/patient and the service provider. This is absolutely not true with homeless people – it is a central, essential part of the work. Effective interventions with homeless people depend on the establishment of a good relationship with an individual – but can also, sometimes, be cultivated in a group setting.

A good relationship and a working alliance with the homeless person is the only way to continuing contact with services and, where necessary, to optimise engagement with treatment or other health interventions.

Paying attention to interpersonal and relational aspects is as important as other, more obviously "technical" concerns. Although these are often referred to as "soft" skills, they are capable of being learnt, communicated and measured, so should be seen as "hard" skills as much as any more obviously physical and technical skills.

The ability to create and maintain a helping relationship should be seen as a technical concern in its own right. Group interventions can also be effective as they foster a sense of belonging and enable shared non-hierarchical learning.

Outreach

The notion of going to meet with potential patients or clients, sometimes without any invitation, rather than waiting for them to come and see you.

Given the almost-universal medical tradition of responding to a health need clearly expressed by an individual, how can this be justified in ethical terms? Are we not in danger of offering unwanted treatment in a paternalistic fashion? The traditional model of offering medical assistance is based on two assumptions. One is that the doctor/nurse is available; the other is that the potential patient is not impaired by any sort of intoxication or brain disorder. Both practical experience and research into homeless populations show that neither of these assumptions holds true for much of the time for many homeless people. They are either unable to access appropriate services for practical or cultural reasons or are so impaired by physical or mental illness or intoxication, that they are unable to access the services to which they have a right.

So, outreach can be both a strategy for:

- Case detection.
- Follow up and continuing care (further material concerning this will be found in the separate "Outreach" chapter).

In health, it is an approach that can be applied to the assessment and treatment of both mental and physical health problems.

There is a range of outreach styles, from proactive/assertive approaches to more gradual, participative and receptive styles. These styles are influenced by national cultural attitudes, economic circumstances, specific ideologies of mental illness and homelessness – and the legal structures that control some aspects of psychiatric treatment.

As a result, there can be no universally-applicable "prescription" for the practicalities of outreach. However, there are probably universal principles that can be applied to most situations - see the section dedicated to outreach

Structurally, health outreach can involve a range of professionals and non-professionals, including:

- Mobile clinics.
- Dedicated clinics in existing health establishments.
- Visiting clinics in existing homeless settings such as hostels, shelters or day facilities.
- Consultation settings with non-medical homeless organisations.
- Visits by individual health workers.
- Peer support, peer educators, working 1:1 or in groups.

The intensity and frequency of such interventions will depend both on the resources available and the attitude of the staff – see the section on hospital admission. An assertive outreach approach (Coldwell & Bender, 2007) has been shown to be an effective model of care for homeless people with mental health problems.

Networking

This is essential because, usually, a homeless person will face multiple health and social problems at a single point in time. If only a health problem is addressed, it is often the case that other active issues will undermine any gains from an otherwise effective health intervention. And, in this population, multi-morbidity should be assumed to be the norm rather than the exception. This can include both a range of physical disorders, mental disorders and drug or alcohol problems, all of which need to be considered for each homeless person.

So - no single professional, or non-professional group can, on its own, provide adequate care and support when they first encounter a homeless person. Even most multi-disciplinary teams do not have the full range of resources within their team to address the full range of possible issues. Clearly, not every issue needs to be addressed at the same time – one must be guided by the patient's priorities and by what is practical – or bearable – for the individual patient. But the critical set of skills and resources may not be available when they are needed by the patient.

Active networking can go some way towards resolving this problem by connecting up dispersed resources in such a way that they can be activated/engaged when needed. By establishing an active network, a person or facility working with homeless people with mental health problems should be able to offer the most comprehensive service possible.

Facilities such as hostels, shelters, soup kitchens, day centres and shower facilities, should have the capacity to be involved in active person-centred networks, using both formal agreements between organisations and informal communications between practitioners.

In terms of continuing, planned work, networking and collaboration with other professionals and services are needed to construct a comprehensive (or at least multi-faceted) service plan involving the provision of basic needs and a plausible plan for the future.

All professionals and other people working with homeless persons would benefit from training in how to create and maintain networks and active collaborations (see section on Networking).

Communication

Phone or email communications are clearly vital – but personal meetings can engender a sense of personal trust between services that can make things work much more smoothly.

Accompanying/bridge-building

Many homeless people have had poor experiences with health systems – in common with many other marginalised groups – or may be disabled by mental illness, illiteracy or dependence problems. Advocacy and emotional support through interactions with various health and social systems, therefore, have an important part to play in services for homeless people. It can also play a part in establishing and reinforcing a therapeutic relationship, with an individual worker or with a team.

Emergency services

Emergency services (such as Accident and Emergency departments/Emergency rooms)- are crucial points of entry into the health system for homeless people. However, if a homeless person does try to use a hospital emergency department, he or she can be looked upon with suspicion, as if they are only looking for a meal or bed (Jeffery, 1979). This prejudice can lead hospital staff to overlook the very real health needs of that homeless person.

On the other hand, a homeless person can arrive at the emergency room after a long period of involvement with community services and outreach teams, who have worked hard to make this attendance happen. Staff working in emergency services need to know that these services exist, and should prioritise communications with them.

They also need to be aware of the services network that can be activated and enlisted to help these clients — having the involvement of a social worker or social nurse right from the start can facilitate the recruitment of these community services.

Information

Good recording of social and clinical information is clearly necessary for sustained and coherent clinical activity, and professional accountability. However, it is also vital in terms of being able to describe and evaluate the service that is being provided.

The usual professional standards apply to work with homeless people, so all activities and socio-demographic data should be carefully recorded. If interactions and interventions are restricted by the environment, then this should be documented. It is clear that the situations in which one can

meet many homeless people are not ideal, and that one can often not do as much as would be possible in a clinical environment.

Attention should be given to how information is shared between different parts of the system – e.g. between hospital wards, outpatient services and community services. Again, the same confidentiality standards apply to homeless people as do to anyone else.

It may be helpful to have a "tagging" or "alerting" system of some sort to ensure that everybody who needs to know is alerted when a homeless person comes into the hospital.

Hospital admission:

Most work with homeless people is best accomplished by working collaboratively in the community. However, hospitalisation can be needed when an individual:

- Has health needs that cannot be met with outpatient/outreach treatment.
- Has lost the capacity to make informed decisions about their health care and is neglecting their self-care or attention to safety.
- (rarely) poses an immediate risk to themselves or others.

In certain circumstances, an involuntary/compulsory admission to hospital may be needed.

It may be helpful to have a standard protocol for admission, agreed between the in-patient wards, community services and local homeless services.

To be effective, in-patient treatment must fully take into account the conditions a homeless person is likely to face if they return to the street if it is to discharge the person in a way that allows them to continue their recovery. Discharge to the streets should never happen.

To achieve this, community services and professionals in homeless services, who have been involved with the individual, must take the initiative in communicating with and sharing information with, in-patient staff. This can be termed "inreach".

In such a context, discharge from hospital can happen without joint working with the community services, resulting in inappropriate treatment, lack of treatment or inappropriate discharge from the hospital. A meeting between in-patient and community staff should always happen before a homeless patient is discharged from the hospital.

Homeless services need to "inreach" to in-patient staff while one of their clients is in hospital.

To optimise a hospital admission:

- Keep an "accumulative history" for the patient, that will allow the Ward staff to quickly grasp the essentials of your clients' predicament.

- Use an “admission plan” protocol to succinctly set out the reasons for admission, what has and has not worked in the past, and what the anticipated outcome for the admission would be.
- Have regular joint meetings between the homeless team and mainstream teams.
- Maintain the intensity of your input during hospital admission.
- See your client on the Ward within 24 hours of admission. This can be reassuring for them, but can also help you to ensure that the ward staff understand the case.
- View the admission as not just as an opportunity for safeguarding and treatment, but also as an opportunity for change.
- Be very clear about your clients’ capacity to make important decisions – like whether to stay in hospital or not or to consent to or refuse medication. Wrongly-assumed capacity can be used as a reason to discharge the patient inappropriately, or not to provide treatment.

Outpatient services

Easy access to such services is essential. Good examples are the “Open psychotherapeutic group” and “Open consultation” models that work regularly, every week without an appointment.

Coordination / joint work with social services

Collaboration with social services is essential. Even if the system is over-loaded, homeless people have the same rights of access to it as anyone else. Social services need, and appreciate, collaborative work to help to deal with their most difficult cases with mental health problems. On the other hand, mental health services need to collaborate with social services to create appropriate arrangements after hospital discharge.

Coordination with Health Authorities - compulsory treatment

Compulsory treatment is always (or should be) a complex and difficult process. Pro-active collaboration with health authorities can make this process more effectively, and more helpfully for the individual concerned. Once mainstream health services understand the benefits and effectiveness of treating homeless patients, they are likely to be much more positive about working with homeless services.

Research, training and case discussion

These need to be incorporated into the regular life of any team, not just as occasional events. They not only enable homeless services to demonstrate what they are doing but are also be fulfilling and motivating for team members.

3. Difficulties

“Hard to engage”

Homeless people can be seen by mainstream services as difficult to engage – but this will usually have much to do with access to basic rights, social security and language barriers.

Overlap of physical, mental health and drug/alcohol problems

Mainstream services often have separate and strictly demarcated services for mental illness and alcohol/substance issues. Many homeless people will often have problems in both these areas – but then this is increasingly the case in the domiciled population as well.

Street Assessments

A street assessment can clearly be sub-optimal in terms of confidentiality, comfort and quietness, and the time available. However, it is absolutely justifiable when the alternative is no access to services at all.

There are difficulties inherent in conducting a health assessment on the street:

- Lack of privacy.
- Lack of control of the environment.
- Difficulty in persuading the person to stay.
- Lack of recognition by other agencies (e.g. police) of the individual's mental health needs.
- Communication difficulties in a noisy environment.
- Sometimes, sheer physical discomfort!

So, it is particularly important that experienced health professionals, able to evaluate these complex situations, should be carrying out such street assessments.

Compulsory Assessments

Mental assessment for compulsory admission is a difficult and complex process. Professionals working within the health system, and those outside it, can often have very different and contradictory perspectives. For example, there can be a great concern in the community about the health situation of a homeless person – but, at the same time, this person can be seen in the emergency room (or on an in-patient ward) as having no significant mental health problem.

A person can be disabled by their symptoms, yet not obviously unwell. If the focus of an assessment is purely directed towards symptoms, the person's impairments may be overlooked. It is, therefore, advisable to perform a formal assessment of a person's capacity (Pathway, 2016) to make important decisions for themselves. This will often be clearly impaired, even when symptoms of mental illness are not disclosed to the interviewer.

Communication

A focus only on health or only on social needs tends to foster a lack of communication between professionals, statutory services and charity/NGO services. If doctors only talk to doctors, or social workers only to social workers, misunderstandings, lack of necessary information, duplication of

effort and poor results will follow. The same applies to the medical domain to in-patient and community services.

Cultural differences

Many homeless people are immigrants or refugees, from different parts of the world. Different cultural expectations, ways of behaving, and thinking can complicate mental health assessments, behaviour, treatment and symptoms.

Multiple – or so-called "revolving door" admissions are not necessarily a problem as they can be part of the relationship-building process. The crucial element is that lessons should be learnt from each hospital admission so that the persons care and treatment can be enriched and become more effective.

4. Good practices

Outreach

Outreach work is fundamental to working with people who have often avoided health and services or people who have experienced such services as inaccessible and unhelpful. It must address social, mental and physical health needs.

Access to mainstream services

At the same time, mainstream services should increase access for homeless people. Open door services without an appointment or waiting lists are good ways to achieve this.

Hospitalisation

There should be clear, well-established and agreed on protocols for compulsory admissions, which include:

- Sending assessment and reports of the person prior to admission.
- Actively and negotiating a bed to be used, not just relying on the emergency department.
- The homeless team should maintain regular contact with hospital staff during the admission.
- Pre-discharge meetings should be arranged towards the end of any hospital admission (mental or medical). These will involve the hospital team and the homeless team (with a social worker) to plan future accommodation, and organise a discharge / follow up plan.
- Staff should be trained in cultural aspects of mental health, particularly how non-European people may view mental health issues and how they might be dealt with.

Work with our professional colleagues

Advocacy, good information and marketing about homeless people and issues are vital to helping other professionals become less suspicious/pessimistic about homeless people, and thus more likely to make their services accessible to homeless people.

We need not to meet our colleagues as though we are asking for favours from them – we honestly see this (from both sides) as a way of improving everybody's life and, most importantly, the life of the patient – a win-win scenario.

Having said this, there can still be a stigma regarding both homeless people and specialist homeless services which may need to be addressed.

Professional training

Offering trainees training opportunities in homeless services, whether medical, addictions, housing or social support. Most medical, nursing or social work students find such placements extremely rewarding and are likely to become more sensitive to the needs of homeless people – and to become more skilled in helping them.

Support for staff

Not all stories end happily – so burnout is always a possibility in homeless services. Staff welfare and effectiveness cannot be taken for granted. Planned supervision and staff care are needed for good practice to be maintained. (See section on staff care.)

Prevention

Prevention is generally described in three ways (WHO). The involvement of health services in preventing homelessness can be:

Primary

"improving the overall health of the population"

Most of the primary drivers of homelessness fall outside the remit of health or social services – although it can be argued that work to improve the treatment of and follow up of, mental disorders by such services could reduce homelessness.

Secondary

"Improving detection of disorders"

In the UK, the recent Prevention of Homelessness Act (2017) has placed an obligation on both social and health services to take preventative action if a person in contact with their service is in danger of becoming homeless. For some reason, this does not apply to out-patient or community services, but it certainly encourages a more assertive approach to maintaining accommodation for vulnerable people. Prior to this, some local council housing services had formal liaison arrangements with local mental health services, which would allow extra input to people who were in danger of losing their accommodation.

Tertiary

“Improving treatment and recovery”

The provision of specialist mental health services for homeless people can be seen as a way of reducing the impact of health problems that have precipitated, or continue to perpetuate, homelessness, thereby leading to a resolution of the homeless situation

This is a more contentious area - tertiary prevention can be taken to represent a continuing service to minimise the impact of a condition – or homelessness – on a person’s well-being, while not aiming at any final resolution of the problem. Are we really happy to view our services as merely helping our clients/patients to survive homelessness, rather than as being part of a way for them to escape homelessness?

5. Case profile

Case Profile: Rita

A 54th-year-old Finnish woman who left Finland in 2017, after the death of close family members, and came to Barcelona on her own. Her father, her half-sister, her son and her daughter lived in Helsinki, but she stopped contacting them a year before coming to Barcelona.

She said that she had been a nursing assistant and worked in France and Sweden, but had not worked for a long time. She said she could speak eight languages and enjoyed travelling, reading and music.

Mental health problems:

Paranoid schizophrenia /schizoaffective disorder with multiple psychiatric admissions in several EU countries over the last 15 years due to her psychotic symptoms.

Mental and behavioural disorder due to Alcohol, dependence type

Past substance abuse:

- *IV heroin from ages 17-27, with periods in detoxification units and programs with methadone and buprenorphine.*
- *Past abuse of IV cocaine from ages 15 to 27, occasional current use.*
- *Consumption of LSD and amphetamines in youth.*
  Currently a heavy smoker

Other health problem: Cor pulmonale, asthma, diabetes, HBV and positive HCV. Epileptic seizures in the context of brain neoplasia years ago, and a diagnosis of narcolepsy.

***December. 2017:** She was referred to our team from a shelter with ideas of self-harm but, before our first visit, she had to be referred to the A&E department due to an opiate overdose. From intensive care, she was discharged again to the shelter (she wasn't admitted to a psychiatric ward).*

From the shelter, she was admitted to a respiratory medicine ward and again referred back to the shelter where we continued to follow her up.

***February 2018**: From the shelter, she was referred to a medium stay psychiatric unit without our knowledge, due to plans made during her admission for her chronic obstructive pulmonary disease. She was again discharged, without any plans for her accommodation. She had lost her place at the medium stay unit and the shelter, so an emergency hostel had to be organised with the help of a social worker after an urgent referral by our team.*

***March 2018**: In hostel (although an inadequate placement for her breathing problems).*

***April 2018**: Admitted to a medium stay psychiatric unit where she overdosed with heroin, possibly wishing to harm herself. She was admitted to an intensive care unit and then to a psychiatric ward.*

***June 2018:** Discharged and placed in the same shelter as before (no other placement would accept her). Our team then started to work to return her to Finland, her country of origin.*

September 2018: *Another admission to a respiratory medicine ward. On discharge, we managed to place her in a convalescent unit where her pulmonary condition could stabilise for her return trip to Helsinki.*

October 2018*: Returns to Helsinki, a trip organised by our team.*

We can see from the case a person with serious physical and mental health conditions who was willing to accept help but whose support was interrupted several times by her medical and psychiatric situation. This required urgent action, but also a long-term plan for her recovery and it wasn't always possible.
The effort by staff to provide a long term follow-up independent of her placement meant that her care and support could continue in spite of changes in her accommodation.
On the other hand difficulties and inefficiency in the coordination between different professionals was constant despite many emails, phone calls and meetings.

Questions:
- Which strengths and risk factors do you identify in this client?
- Which were the critical moments in the process?
- Which professional interventions would you like to underline as positive and which as negative and which were missing?

Case profile: Alan

A 38-year-old English man who had lived for several years in a large night-shelter for homeless men in South London. He had been allocated a bed but chose, instead, to sleep on a wide window-ledge in a large dormitory on the first floor, using rags that he gathered from the street rather than blankets offered by the shelter staff. He had a national insurance number and so was eligible for benefits. His shelter fees were paid automatically from his benefits, but he never claimed his other financial entitlements.

He never spoke and avoided contact with both staff and residents. When he was not asleep on the window ledge, he went out early in the morning, returning late at night. He was dressed in scavenged clothes which he never washed. He would never shower, and the skin of his face and hands were covered in ingrained dirt. He never ate in the shelter, and it was unclear where he found his food. As the years wore on, the staff had become increasingly concerned over his extreme social isolation, apparent self-neglect and loss of weight. They, therefore, referred him to the START team, a mental health outreach team for homeless people.

We first approached him early one morning – his response was to get up and leave the shelter, without talking to us at all. We noticed that, under the dirt, he looked extremely pale and that his bedding was infested with lice. We tried three more times, and each time he just got up and left the hostel.

Given his extreme self-neglect and weight loss, it seemed likely that he was suffering from some sort of mental disorder, probably a psychosis. We, therefore, arranged for him to be assessed under the Mental Health Act and he was admitted to a psychiatric ward. In initial physical examination showed that he was both covered in insect bites, presumably from lice, and that his haemoglobin level was 3g/dl (compared to a normal of 13-17 g/dl). This meant that he was in danger of becoming blind through his extreme anaemia. He had a blood transfusion and was subsequently treated for psychotic illness, eventually being able to live in supported accommodation.

Points to highlight:

- This man never asked for help – and, in fact, actively avoided it.
- His severe mental illness had never been identified, over many years.
- Although he was extremely socially isolated, his predicament was well-known to the NGO/voluntary sector staff who ran the night shelter.
- While never being an immediate danger to himself or others, his self-neglect gradually created a significant danger to his physical health - and his infestation created a problem for other residents of the hostel.
- Although he was entitled to his benefits, his mental state meant that he was unable to use them.
- The outreach team made several attempts to engage with him before arranging the compulsory assessment.
- The mental health team worked closely with the people who knew Alan best – the staff of the night shelter.

- The action of outreaching to this man meant that he received a service which he had not had over the preceding decades.

Glossary

- **Accessibility**
  Direct access to care and resources.
- **Networking**
  Essential due to the multiple health and social problems, multi-morbidity.
- **Continuing care**
  (See outreach chapter)
- **Bridge building**
  Advocacy and emotional support through various health and social systems have an important role.
- **"Soft" skills**
  Paying attention to interpersonal and relational aspects.
- **Inreach**
  Community services and professionals must take the initiative in communicating with and sharing information with in-patient staff.
- **Admission plan**
  Succinctly setting out the reasons for admission, what has worked in the past and what the anticipated outcome for the admission could be.
- **Street assessments**
  Assessments carried out in the street
- **Compulsory assessments**
  Carrying out an assessment to evaluate a possible compulsory admission to hospital
- **"Hard to engage."**
  Homeless people can be seen by mainstream services as difficult to engage, but this will usually have much to do with access to basic rights, social security and language barriers
- **Revolving door**
  Multiple admissions to hospital
- **Open door services**
  Mainstream services should increase access for homeless people, therefore without an appointment or waiting lists are good ways to achieve this.
- **Pre-discharge meetings**
  Involving the hospital team and the homeless team (with a social worker) to plan future accommodation, and organise a discharge / follow up plan.
- **Prevention**
  Primary: Improving the overall health of the population.
  Secondary: Improving the detection of disorders.
  Tertiary: Improving treatment and recovery.

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