ABC of mental health

Mental health on the margins

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Mental illness and homelessness

People with mental illness have always been marginalised and economically disadvantaged, and deprived inner city areas have excessive rates of severe mental illness. Homelessness is the most marginalised end of the spectrum of poverty, and here are found disproportionate numbers of mentally ill people.

Homeless people do not constitute a homogenous population: disparate groups have widely differing needs. The mental health needs of people living in "traditional" homeless lifestyles have elicited particular concern. We focus on the situation in Britain, but similar problems exist in most Western industrialised nations.

Size of the problem

Reliable estimates of the numbers of homeless people are notoriously difficult to come by. The 1991 census concluded that about 3000 people were sleeping out and 20000 were living in hostels for the homeless, but these figures are now recognised to have been underestimates. In addition, 169966 households were registered as statutorily homeless in 1992.

Although the absolute numbers are small, homeless people place disproportionately large demands on services. Compared with the general population, at least twice as many homeless people have some kind of important mental health problem.

Nature of the problem

There are no mental illnesses or emotional problems unique to homeless people. They suffer from the same disorders as the general population, but there are three main differences.

Prevalence of all mental disorders is higher. Psychosis is overrepresented by a factor of 20 or 30 in hostel populations.

Social support and resources that are necessary for health, and taken for granted by most people, simply do not exist.

Contact with helping services, including primary care, is likely to have been lost, and homeless people are unlikely to be receiving treatment.

Specific problems

Major mental illness

The closure of long stay mental hospitals has not been responsible for the large number of homeless people who are mentally ill. Excessive rates of psychosis among homeless people have been reported since the 1950s. Few of the current homeless population have had long term hospital admissions, but most of those with psychiatric problems have had multiple brief admissions with poor follow up.

Shelter for many of these vulnerable people has been provided by hostels or reception centres. Although these institutions are supposed to provide only temporary accommodation, many people with chronic psychotic illnesses have lived in them for years. This may be because they are tolerant environments where, traditionally, little "rehabilitation pressure" is placed on residents. They have become de facto institutions, affording sanctuary but providing little adequate treatment and producing the same institutional deficits as did the old asylums.

Pathways to homelessness

- Unemployment
- Problem drinking among middle aged men
- Drug misuse among teenagers
- Lack of low rent housing
- Marital break up
- Clashes with family or friends
- Leaving local authority care
- Leaving the armed forces
- Leaving prison
- Episode of mental illness
- Children of homeless families

Very few people choose to have no home

Spectrum of housing needs

- People living in existing households in very unsatisfactory conditions
- Households sharing accommodation involuntarily
- Imminent release from institutional accommodation (prison, local authority)
- Insecure tenure (holiday letting, tied accommodation, mortgage default)
- Accommodation for homeless people (hostels, night shelters, bed and breakfast)
- No shelter ("roofless," "sleeping out" on streets or in parks or car parks)

Many homeless people show signs of mental illness

Homelessness is often a consequence of severe mental illness

Anxiety and depression

Both anxiety and depression are common in homeless people. These may result from the stresses of living without a home, and they can be disabling, so trapping people in homelessness. Low level support is often all that is needed and can produce dramatic improvements. Referral for psychotherapy or counselling should be made as appropriate on clinical grounds.

Substance misuse

Alcohol has been the traditional substance of misuse for homeless men (women are less likely to have an alcohol problem), often having been the cause of homelessness in the first place. Hence the stigmatising stereotype that identifies all homeless people as alcoholics, despite the fact that in most British studies psychosis is at least as common as alcoholism. Alcohol accounts for the small but highly noticeable number of homeless people with severe cognitive problems.

Drug misuse is an increasing problem among the growing proportion of young homeless people. Opiate addiction has always been a minority problem, with the main drugs of misuse being amphetamines and benzodiazepines. The most common picture is of opportunistic misuse of multiple drugs, often with alcohol as well.

Dual diagnosis—Alcohol or drug misuse and psychosis are found increasingly in the same individual (“dual diagnosis”). Such patients are particularly difficult to help, not only because of the multiplying effect of the disruption caused by each problem, but also because they tend to fall between mainstream alcohol and psychiatric services.

Physical illness

Compared with the general population, homeless people suffer from considerably more untreated disease. Chronic chest, skin, and dental problems predominate and may exacerbate anxiety and depression.

Barriers to care

Professional attitudes

Stereotyping—Health workers are not immune to the popular stereotypes that portray homeless people as being alcoholic, with personality disorder, feckless, and as having chosen their lifestyle. They often expect homeless patients to be both awkward and highly mobile: the myth of the “tramp.”

“What difference can I make?”—Patients who are both homeless and mentally ill have a multiplicity of needs. Doctors’ usual interventions assume the presence of the social factors (housing, adequate nutrition, and a social network) that make possible both health and treatment. Doctors may feel that they have nothing to offer when the absence of these factors seems to defeat any medical or psychiatric intervention.

Organisation of services

Communication—The multiple needs of homeless people who are mentally ill require help from several agencies—health, social, and housing—in addition to a specifically psychiatric input. This requires substantial communication between agencies, which, in spite of legislation on community care, is still the exception rather than the norm.

Psychiatric “No fixed abode” rotas—Many psychiatric units have a “No fixed abode” rota, which allocates homeless patients to a duty psychiatric team. Unless this also confers continuing responsibility for such patients, their care will be unnecessarily fragmented.

Hostel accommodation is usually basic and often lacks privacy. However, hostels may be tolerant and undemanding environments for homeless people with chronic mental illness

Physical disorders in homeless people

Offer to treat

- Chest infections
- Skin problems
- Other conditions amenable to a short course of treatment

Offer advice on

- Contraception
- Diet
- Smoking and alcohol consumption

Offer referral for

- Dental problems
- Alcohol and drug misuse

The difficulty in treating homeless people can produce a therapeutic nihilism that may not only prevent professionals from doing what they can but may even serve as a justification for neglect

Desirable characteristics of a service for homeless people

- “Out there”
- Rapid response
- Informal
- Flexible
- Prepared to deal with a range of social as well as medical needs
- Collaborative, part of a wider service network
- Responsive to changing circumstances

Philosophies of care—Different agencies have differing philosophies of care: some operate non-interventionist policies that may prevent or delay referral. Most mental health services would consider that patients are unable to make informed choices when in the throes of a relapse of a severe mental illness. Many housing organisations take the view that people are always fully responsible for their choices and actions. This can lead to eviction if a disturbed or distressed patient is deemed, by his or her difficult behaviour, to have made a choice. To be fair, the inaccessibility of psychiatric help has often made it difficult for housing agencies to respond in any other way.

Homeless lifestyles

Priorities—Both physical and psychiatric care rank low in homeless people's list of priorities. The demands of securing immediate needs for survival—food, shelter, money—are more pressing than appointments with doctors or nurses.

Poor access to services—General practitioners are both gatekeepers and guides to most sources of psychiatric or psychological help. Homeless people with no regular general practitioner will often have to find their own way to these services, perhaps via an accident and emergency department. For obvious reasons, these departments are orientated towards brief intervention rather than continued involvement and advocacy.

Mobility—Mobility is as often forced on homeless people as it is chosen. Although much of this movement is relatively local, crossing the boundaries of catchment areas may lead to problems of both primary and secondary care services denying responsibility.

Alienation—Homeless people have often been disappointed by statutory services. Their predicament makes demands that these agencies cannot meet, often provoking inadequate or even punitive responses. Hospitals and general practitioners are reluctant to take them on, benefits regulations seem specially designed to penalise them, council housing departments are interested only in homeless families and the most vulnerable people, and the police may move them on or arrest them for drunkenness. It is not surprising that homeless people are often suspicious and distrustful of services that like to see themselves as caring and helping.

Providing services

Improving access

Conventional clinic times will not do for homeless patients. It is more realistic to arrange meetings at times that fit in with their often irregular timetables. Even better is a drop-in service at a hostel or day centre where people can be seen quickly without appointment.

Providing information

Voluntary agencies provide most of the social care and support for homeless people. These commonly include hostels, day centres, sources of cheap or free food and clothing, alcohol counselling services, and advice centres. Each health authority or hospital trust should obtain or create a directory that is concise enough to be of use in a busy ward, general practice, or accident and emergency department.

Referral

Referral to the local authority social services or housing department (homeless persons unit) may lead to a considerable

Entrance to a hostel for the homeless. Many homeless people use the same hostel—or a small number of hostels—on a regular basis. Thus, they may provide a reasonably reliable point of contact

Providing homeless people with mental health services

- Initially, this may seem daunting, but it is relatively straightforward if it is a coordinated part of more general housing and social provision
 - Don't do what you can't do, but make sure that you know someone who can
 - Homeless people are rewarding to treat and grateful to those who treat them with respect
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Useful addresses and voluntary organisations

Message Home

- A national freecall helpline for those who have left home or run away and wish to send a message
- Free helpline 0500 700 740

Shelter

- National Campaign for Homeless People, 88 Old Street, London EC1V 9HU
 - Telephone 0171 505 2000
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improvement in a patient's accommodation but will often require the involvement of an advocate of some sort.

Finding a key worker or advocate—Treatment plans for homeless patients often fail because it is assumed that there is no carer with whom contact can be maintained. In fact, there is nearly always a person or organisation with whom they maintain contact and who should be informed. This might be a worker at a hostel or day centre, an alcohol counsellor, a minister of religion, a social worker, or a probation officer—the list is surprisingly long. Issues of confidentiality may arise, but these can be overcome by obtaining patients' written permission or by producing an edited, portable version of documents such as discharge summaries.

Treatment

Whatever the temptation to prescribe benzodiazepines for someone who is obviously distressed—don't do it. Although most homeless patients use their medication responsibly, it should not be forgotten that drugs such as the benzodiazepines, chlormethiazole, and procyclidine have a substantial and tempting street value.

Offer advice and treatment (including referral) for dental and other physical disorders.

Lack of supervision makes it unwise to attempt alcohol detoxification outside a well organised hostel sick bay, hospital, or alcohol unit. Paradoxically, hostels for the homeless can be good places to prescribe antipsychotic drugs. Since there is often little pressure to achieve quick results, it is possible to start with low doses and increase slowly. This usually avoids troublesome side effects and so reduces resistance to treatment.

Compulsory admission under the Mental Health Act is occasionally necessary, usually to treat an acute psychotic episode in which a patient becomes suicidal, violent, or dangerous in other ways (such as setting fires). Prompt intervention and treatment may mean that a hostel is prepared to accept a patient back when he or she is discharged from hospital.

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Corrections

ABC of mental health: Mental health emergencies

An editorial error occurred in this article by Zerrin Atakan and Teifion Davies (14 June, pp 1740-2). In the flow chart for rapid tranquillisation of an acutely disturbed patient (p 1742) it was wrongly stated that zuclopenthixol acetate is given intravenously. This drug should be given by deep intramuscular injection only.

ABC of mental health: Addiction and dependence—I: Illicit drugs

An author error occurred in this article by Claire Gerada and Mark Ashworth (2 August, pp 297-300). In the last paragraph, on legal aspects of prescribing opioids (p 300), it was stated that the chief medical officer maintains an index of addicts at the Home Office, which must be notified of addicted patients. This index ceased to exist with effect from 1 May 1997, and doctors should instead notify their Regional Drugs Misuse Database. Further information is available from the Home Office Drugs Inspectorate (tel 0171 273 3000).

Maintaining continuity of care for homeless patients

- Obtain, or create, a directory of local services for homeless people
- Get to know the hostels that a patient uses—there may be several in a relatively small locality
- Get to know the hostel workers and other people with whom patients may keep in contact
- Be prepared to offer short term courses of treatment
- Use simple treatment regimens (single drugs, once daily doses)
- Allow for patients' mobility—prepare a brief case summary for patients to carry with them or to be sent on request to other agencies
- Be prepared to accept patients back into your care and to restart treatment
- Build up trust—be accessible, flexible, and sensitive to patients' priorities

Do not prescribe drugs that may be misused

Further reading

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