Opening Doors
Project Guidance

The Queen's Nursing Institute

Mental Health and Homelessness

Guidance for Practitioners

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Contents

Introduction

The multiple health problems encountered by homeless people are of increasing concern, and the plight of those with mental health problems is particularly problematic. Homeless people face great inequalities in accessing mental health services, yet paradoxically their mental health often suffers from their being homeless.

Moreover, poor mental health may well have caused homelessness in the first place. Homelessness is an extreme form of social exclusion with huge health problems, yet homeless people have great difficulty accessing and utilising health care.

This guidance is not targeted at experts in mental health, but rather nurses and allied health professionals who are working in homelessness. It may also be of use to other statutory and voluntary agencies working in the same field. The aim of the guide is to briefly examine existing models of good practice and, more significantly, to look at various interventions in areas where there may be a lack of resource for this growing client group, which can go some way to meet the needs of homeless people with mental health difficulties.

This guidance is focused primarily on homeless adults, although mental health problems have also been reported in homeless children and young people.

Mental Health Problems Among Homeless People

There is a strong body of evidence that points to markedly higher rates of mental health problems in populations of homeless adults than among the securely domiciled. Most studies support the finding that unusually high rates of psychosis and substance misuse are a common feature of homeless populations. The difficulties of addressing combined substance misuse and mental illness (dual diagnosis), which exists in this group, has long been acknowledged (Veitch P & Wigmore J., 2003). Several commentators suggest that as many as half of the homeless population suffer from some form of mental illness. Nationally, the prevalence of co-morbid substance misuse dependency among the homeless mentally ill can be as high as 50-60 per cent and is up to 5 times higher than that for the general population (Melvin P, 2004). Homeless people, many of whom were young adults, experience twice the rate of neurotic disorder that that of the general population, including include anxiety, depression and mental distress. The study also indicated that homeless individuals suffering from primary health issues displaying these symptoms were more likely to become hospital in-patients than to be treated on an out-patient basis for their mental health problems.

Homelessness & Access to Mental Health Care

One in four of the general population will experience some form of mental disorder at some point in their lives (ONS, 2001) and the majority of patients will be treated by primary care services. Homeless people who sleep rough, are moving in and out of insecure accommodation or are placed in homeless hostels may not be registered with a local primary care practice or find it difficult to do so. Despite the publication of guidance on access to primary care for homeless by the Royal Collage of General Practitioners in 2002, many homeless people still have difficulties registering with a GP. Historically, due to the difficulties experienced accessing primary care, homeless people have used A&E departments for health care which is expensive and inappropriate. Homeless Link (2011) reported that 41% of homeless people had attended A&E departments during a 6 month audit period. Access to primary care is paramount for effective health care and homelessness workers/practitioners have an important role to play in helping homeless people break down these barriers, advocating for equity of access to primary care services.

Access to secondary mental health care can be even more difficult for homeless people suffering from serious mental illness such as schizophrenia, bi-polar affective disorder or serious depression, especially if there are no specialist mental health practitioners working in your area of responsibility. The general rule of thumb is that access to secondary care is difficult if the client is not registered with primary care. Direct access to secondary mental health care without a referral from primary care can be extremely difficult unless there is a specialist mental health practitioner available to enable access.

Helping Homeless People with Mental Health Difficulties

As in many other aspects of working with homeless people, engagement can be crucial to a successful outcome, and should be a priority when working with the homeless. Social isolation, stigma and a perception of being displaced from society make it difficult for this client group to canvas for better services. Smith (2006) recommends that advocacy is a key skill in enabling homeless people to enhance their quality of life. Workers coming into contact with homeless people who disclose that they have mental health problems, or workers who suspect that they may have mental health difficulties, should attempt to engage with these people with a view to enabling GP registration as a matter of priority. If necessary and appropriate, accompany them to the first consultation with the GP as advocate and express your concerns. Some homeless people have had poor experiences with Mental Health Services, and may be reluctant to disclose any mental health issues due to a fear of being sectioned under the Mental Health Act.

The following sections aim to guide readers in how best to assist homeless people suffering from mental health problems. Descriptions, symptoms and advice about how to best help those suffering from specific disorders can be found below.

Psychosis/schizophrenia

Psychosis/schizophrenia is diagnosed by the presence and duration of specific symptoms. which are divided into two categories, positive and negative symptoms, although a person can present with a combination of the two.

- Hallucinations of any of the 5 senses – touch, taste, visual, smell and auditory. Auditory hallucinations are the most common; sufferers may experience hearing voices which can be derogatory in nature and/or command hallucinations where the client is told what to do by voices (i.e. harm himself or others).

- Delusions where the client has a false belief that is inconsistent with his or her culture or background (e.g. a belief that people are persecuting or out to get them; a grandiose belief that they are someone they are not like Jesus, a great doctor etc.) They can believe that they are being controlled by others or are in control of others.

- Thought disorder can affect the fluency and flow of speech where the sufferers sounds disorganised, is not making much sense, and sometimes making up non-existing words.

Positive symptoms are easier to identifiy and tend to have a better response to anti-psychotic medication.

Some of the negative symptoms you may observe are:

- Self neglect
- Social withdrawal
- Apathy
- Poverty of speech
- Lack of motivation
- Retarded movement
- Inability to function
- Low mood
- Lack of insight

Negative symptoms are more difficult to identify and can be mistaken for laziness or depression. They don't respond well to medication, with people often requiring on-going support to function and attend to basic needs. Negative symptoms can often lead to eviction and homelessness.

What helps?

It has long been established that high levels of expressed emotion by carers can increase the risk of relapse for a person with schizophrenia, indeed, some commentators advocate that avoiding high expressed emotion is as important as continuing to take medication in terms of avoiding a relapse expressed emotion includes emotional over involvement, critical remarks, hostility towards the sufferer, over-protectiveness and high expectations of close contact. This is particularly relevant within a hostel or day centre environment. Other helpful strategies in working with people with schizophrenia are:

- Concordance with prescribed medication
- Minimise stress
- Avoid alcohol and substance misuse where possible
- Adequate sleep
- Healthy diet and regular exercise
- Regular social contact and positive relationships
- Employment
- Adequate finances and housing
- Engagement with a Community Mental Health Team (CMHT)

It is acknowledged that not all of the listed help strategies recommended throughout this guide will be practicable when working with homeless people, however it is important for workers to have an awareness and understanding of what helps. As and when the circumstances of our clients change (i.e., moving from rough sleeping to hostels) there may be an opportunity to provide guidance commensurate with the client's new environment.

NICE Guidelines Link: http://www.nice.org.uk/nicemedia/live/11786/43610/43610.pdf

Bipolar Disorder

Bipolar Disorder is a cyclical disorder characterised by mood disturbance with episodes of either mania, depression (for more information on depression, see the next section), or mixed episodes. During the manic episode, judgement is impaired causing disruption in social and occupational functioning. Not only is the individual at risk of ruining his or her reputation with inappropriate and often bizarre behaviour, but he or she is also at risk of causing serious financial, legal or physical harm. This can be particularly difficult for sufferers living in shared hostels or temporary accommodation, where eviction is a real risk. Some of the symptoms of mania include:

Mania

- Elevated mood (sometimes accompanied by irritability)
- Grandiose ideas and inflated self esteem
- Increased energy and activity
- Rapid, pressurised speech which may be unintelligible
- Inappropriate sexual activity (e.g. promiscuity, removing clothes in public)
- Decreased need for sleep
- Psychotic symptoms such as delusions or hallucinations

What helps?

- Decreased stimulation
- Calm environment
- Low expressed emotion
- Non confrontational
- Distraction techniques
- Protect dignity
- Engagement with CMHT

NICE Guidelines Link: http://www.nice.org.uk/nicemedia/live/10990/30191/30191.pdf

Depression

Depression is a mood state that is characterised by significantly lowered mood and a loss of interest or pleasure in activities that are normally enjoyable. Such depressed mood is a common experience in the population. However, a major depressive episode is distinguishable by its severity, persistence, duration and presence of characteristic symptoms:

- Markedly depressed mood
- Loss of interest or enjoyment
- Reduced self esteem and self confidence
- Feelings of guilt and worthlessness
- Disturbed sleep/appetite
- Decreased libido
- Diminished concentration
- Ideas or acts of self harm or suicide

What Helps?

- Increase stimulation
- Encourage activity and routine
- Frequent support sessions
- Initiate diary planner
- Set achievable goals
- Concordance with antidepressant medication

NICE Guideline Link: http://www.nice.org.uk/nicemedia/live/12329/45890/45890.pdf

Anxiety

The experience of anxiety is a normal part of being human. Everyone experiences anxiety in varying degrees and it is usually a transient response to a threat or danger. We have all experienced the feelings and thoughts prior to an exam or driving test. People suffering from an anxiety disorder, however, can experience high levels of anxiety that do not diminish easily and can have a serious impact on their lives. According to Muir-Cochrane (2003), between 8% and 12% of the population experience a pervasive level of anxiety that impedes their daily lives. Many homeless people recovering from long term drug or alcohol abuse invariably experience some form of anxiety disorder, characterised by difficulty going out alone, avoidance of busy shops or areas where people gather, paranoid thoughts that people are watching them or talking about them, tendency to stay in and avoiding contact with others. Other symptoms include:

- Palpitations
- Dry mouth
- "Butterflies" in stomach
- Sweating
- Altered breathing
- Overall feeling of impending doom
- Tight feeling across the chest

What Helps?

- Adequate sleep
- Good diet
- Learning to relax
- Recognition of the signs
- Plan to challenge negative thoughts
- Distraction
- Controlled breathing
- Self help books

NICE Guidelines Link: http://www.nice.org.uk/nicemedia/live/13314/52601/52601.pdf

Anxiety is very treatable; a combination of antidepressant therapy, coupled with cognitive-behaviour therapy has show to be effective (Gelder, Mayou and Cowen, 2001). Access to psychological therapy can be difficult and may vary in different areas of the country. Homeless people will generally need help in accessing these services as well as motivation and support in sustaining a series of therapy sessions. Serious anxiety can be extremely debilitating (Barker and Kerr, 2001):

Self Harm

Cutting as a form of self harm is something that people working with the homeless are likely to come into contact with. Cutting of arms, or any other part of the body for that matter, can be misunderstood by professional carers to the detriment of the client. Injury to self, including cutting are not suicidal behaviours and are not associated with serious danger (Gerson & Stanley, 2005). The purpose of cutting is to relieve negative emotions (Linahan, 2002). Cutting provides short term relief from intense negative emotion by substituting physical for mental suffering by acting as a distraction.

Carers may relieve their own disappointment and frustration with the client by stigmatising them as bad, attention seeking or manipulative, terms which have no explanatory value but subtly devalue the client's distress and can sometimes be used to justify either harsh or indifferent treatment. Interestingly, the factors which can predispose a repeat of self harm behaviour are:

- Have a personality disorder
- Have been in psychiatric treatment
- Unemployement
- Social class V – unskilled workers
- The possession of a criminal record
- Aged between 24 and 35
- Single, divorced or separated
- Misuse of drugs and/or alcohol

As many of our homeless clients fall into some or all of the above categories, it is easy to appreciate why self harming behaviour is common among our homeless clients.

What Helps?

- Understanding why people self harm
- Agree to some one-to-one time to enable the client to talk
- Have a calm objective approach
- Offer support on a regular basis
- Provide a safe and supportive environment
- Enable client to offload his/her distressing thoughts

NICE Guidelines Link: http://www.nice.org.uk/nicemedia/live/10946/29422/29422.pdf

Personality Disorder

Personality disorder is too complex to summarise in just a few paragraphs, and as such we have decided it best to omit from this particular guidance. It may be addressed in future work, but in the meantime, we recommend you visit http://www.mind.org.uk/help/diagnoses_and_conditions/personality_disorders to learn more about the condition.

Conclusion

People working in the field of homelessness will be aware that the prevalence of mental health problems amongst the homeless population is high and that mental health service provision is difficult for this group to access. The majority of mental illness is treated within primary care, therefore GP registration is paramount. Historically, GP registration has been difficult for homeless people and, unfortunately, in some areas of the country, there is still an advocacy role to be played by homeless workers in enabling GP registration and helping/encouraging homeless people to stay engaged with primary care treatment. In areas where there are no specialist mental health practitioners available, access to secondary mental health services is very difficult and GP registration will be necessary for access, as will support in helping clients to attend appointments and stay engaged.

Not all sufferers of mental illness will wish to engage with services. The focus of this practice guide is to help homelessness workers to understand some of the difficulties experienced by homeless mentally ill people and to help them feel more confident in working with clients who struggle with mental health problems. If it is felt that an urgent mental health assessment is required, (when a risk to themselves or others is evident), find out the local procedures for handling such situations. Many sufferers of mental illness feel lonely and isolated and can benefit from a friendly listening ear. Mental health training is not a prerequisite to listening and talking to someone in distress. It is hoped that this practice guide goes some way in allaying the fears and trepidations held by some working in our field.

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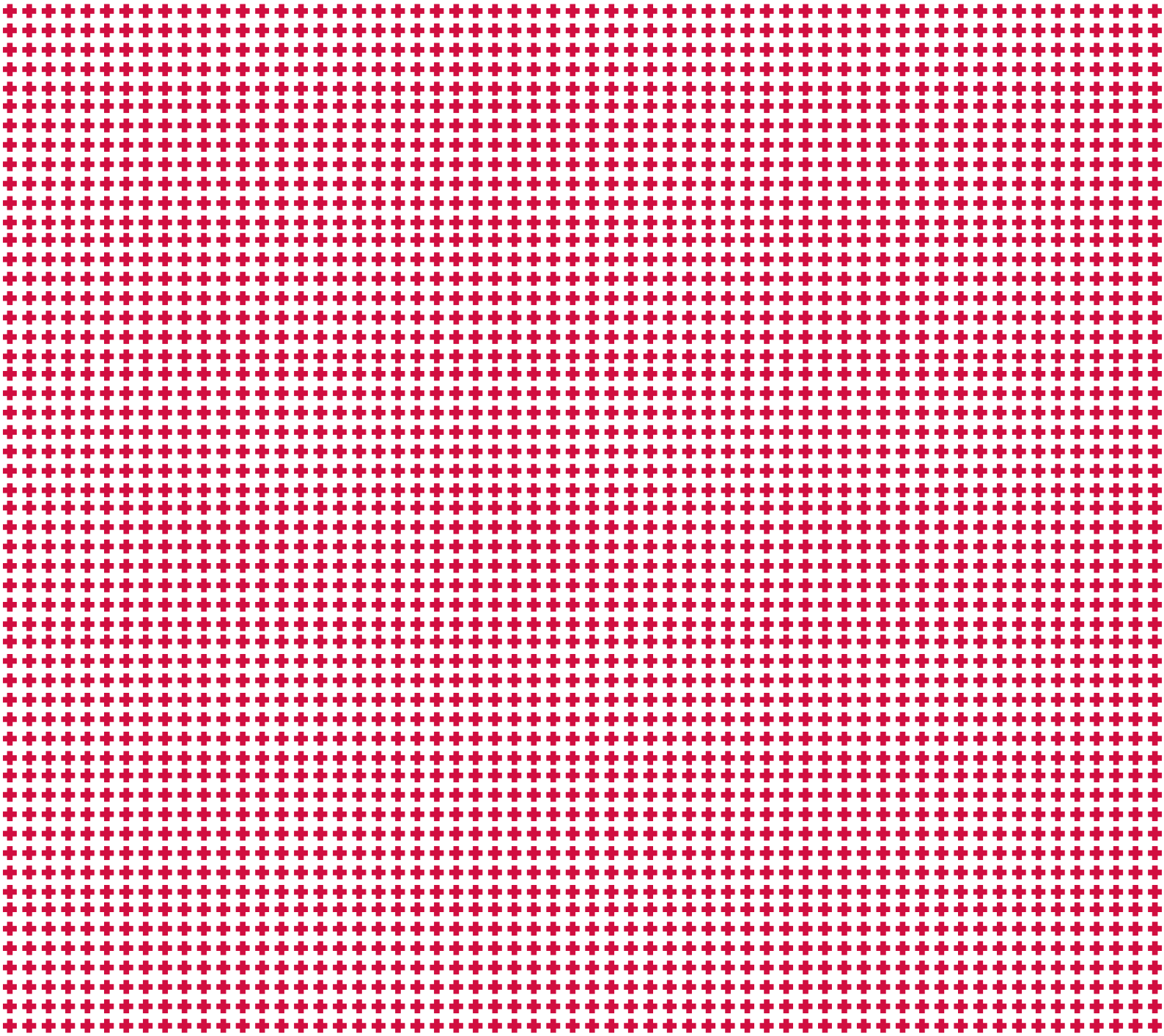

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