

HEALING HANDS



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Mental Illness, Chronic Homelessness: An American Disgrace

It is an outrage that here in America — the wealthiest country on earth in the year 2000 — so many people who suffer from mental illness remain homeless. Although severe mental illness has been documented in less than one-third of our homeless population, these individuals are among the most vulnerable, not only to multiple co-morbidities including substance abuse, but also to stigmatization, exploitation and brutal victimization. Consequently, they are at highest risk for prolonged homelessness.

“The persisting spectacle of homeless people on American streets is a continuing indictment of our collective failure to make the basic ingredients of civilized society accessible to all citizens.”¹

William R. Breakey, MD, psychiatrist
Health Care for the Homeless, Inc.,
Baltimore, Maryland

Over 40 years have passed since many psychiatric institutions in the United States were closed in response to civil rights concerns of the political left and cost-containment imperatives from the right, with the advent of improved therapeutic alternatives for many individuals with severe mental illness. But the promise of creating adequate community-based, outpatient mental health services has not been kept — particularly for many of the sickest and poorest of the mentally ill whose only refuge is the streets.

The past 20 years have seen incremental advances in mental health policy, the development of targeted health care and housing programs, and extensive research confirming the capacity of seriously mentally ill homeless persons to become productive members of the community, with access to comprehensive and integrated health and social services.² Nevertheless, the chronic lack of political will to support adequate health care for this and many other segments of the US population — or even to discuss it seriously in this election year — is appalling.

Forty percent of individuals who suffer from severe mental illness in the United States don't receive the treatment they need, according to **Dr. Christine Yuodelis Flores**, specialist in adult psychiatry with the Health Care for the Homeless (HCH) project at Harborview Medical Center in Seattle, Washington. “There are now twice as many mentally ill persons in jails and prisons than in psychiatric institutions,” she says. “The Los Angeles County jail has been reported to have more mentally ill inmates than the largest inpatient psychiatric unit in the United States.”

Today, few people with serious mental illnesses, homeless or not, require institutionalization. “Advances in the treatment of mental illness have allowed the restoration of health and productivity to almost all who access good care,” writes **Fred Osher, MD, HCH**, Baltimore. “Unfortunately, the vast

majority of people with mental illness experiencing homelessness do not have access to that care.”³

Observers from other industrialized nations call the American system “*capitalisme sauvage*” [savage capitalism] for relegating public health to a lower priority than private profit. Perhaps this suggests a thought disorder far more insidious than the mental illnesses of these “outcasts on Main Street.”⁴

Clinical Challenges:

THOUGHT DISORDERS Clinicians report that among the most difficult challenges they face in caring for severely mentally ill homeless people are the cognitive difficulties intrinsic to their illnesses. “The most serious barrier to treatment is lack of insight,” says Dr. Yuodelis Flores — persons with serious mental illness may not understand that they are ill and need care. Severe and persistent mental illnesses (SPMI) — including schizophrenia, bipolar disorder, major depression and dementia — impair judgment, conceptual understanding and the capacity to make appropriate behavior decisions. People with these disorders typically misinterpret what others say and react with irrational fear or anger, often alienating friends, family and caregivers.

Loss of community exacerbates their mental illness. Dramatic advances in psychotropic drug therapy over the last two decades have made it possible to relieve many of these

symptoms and retard further cognitive impairment. But patients with SPMI often refuse medication.

CO-MORBIDITIES At least one-half of severely mentally ill homeless people are estimated to have a co-occurring substance abuse disorder, according to **Gary Morse, PhD**, Community Alternatives, St. Louis, Missouri. But concurrent, integrated treatment approaches thought to be most effective for dually diagnosed individuals are scarce in actual practice.⁵ “Substance abuse exacerbates cognitive impairment over the long term, making response to traditional addictions treatment very difficult,” says Dr. Yuodelis Flores. It also wreaks havoc with personal finances and significantly increases other health risks — exposure to infectious diseases and violence, social isolation, and other hardships associated with extreme poverty. “Co-occurring mental illness and substance abuse makes it more likely that people will be chronically homeless,” she says. Multiple diagnoses vastly complicate the care of these clients, report HCH clinicians.

FEAR AND MISTRUST OF CARE-GIVERS Paranoia may compound clients’ rational fears of medication side effects or health systems that have failed to serve them well, increasing their resistance to treatment. “Paranoid schizophrenics are adept at concealing their mental illness to remain unmedicated,” notes Yuodelis Flores. “They become fearful whenever increased interest is expressed in them, and frequently travel from shelter to shelter, city to city.” Consequences of lack of treatment include worsening of symptoms, homelessness, incarceration, victimization and suicide. “The longer mental illness goes untreated, the more difficult it is to treat,” she warns. “Optimally, treatment should begin during the first psychotic break. People who receive treatment early in the course of their illness often develop insight into their symptoms and adhere to treatment

better.” Unfortunately, this is more the exception than the rule, according to HCH providers, whose clients may resist treatment for years.

FEW WILLING AND ABLE

PROVIDERS HCH clinicians struggle to establish reliable referral networks that meet the human as well as medical needs of their mentally ill homeless clients. Projects that are affiliated with academic medical centers

easily adhere to treatment, which brings relief from symptoms that interfere with social and cognitive functioning. Thus residential stability is an important element of any therapeutic strategy for the homeless mentally ill.

RECOVERY MODEL OF CARE

Effective care for SPMI homeless clients should follow a recovery model similar to that used in the treatment of addiction disorders [See box], says Dr. Yuodelis Flores, who advocates a harm reduction approach. “Treatment must be individualized and proceed in steps. First, make clients feel safe in your presence. Use tact and diplomacy to establish rapport; don’t ask for all information at once. Help clients connect with other providers to address co-occurring illnesses. Use a team approach to case management, and group therapy including persons who have had positive experiences with medication to assist other clients in accepting treatment. Consumer-driven

care is important. Begin with extremely low doses of medication to minimize side effects. Most important, be patient; building trust and fostering treatment adherence may take a long time.”

INTEGRATED SERVICES Homeless service providers agree that fundamental changes in mainstream health care delivery systems must be made to meet the needs of persons with thought, mood and behavior disorders that undermine their capacity to advocate for themselves or even seek the care they need. “Homeless mentally ill people have multiple needs and require multiple services which must be provided over the long term,” explains Dr. Osher. “For those with severe mental disabilities, outreach, integrated case management, safe havens, treatment, income support and benefits, vocational training, supported employment, and safe and affordable housing must all be woven together to end the cycle of homelessness.”³ ■

Mental Health Outreach to Homeless Individuals: WHAT WORKS⁶

- Intensive, personalized case management over a period of time
- Flexible service planning and delivery, addressing clients’ basic needs and priorities first
- Overlapping, individualized phases of treatment:
 1. Case finding/client identification
 2. Engagement/assessment and planning
 3. Active resource and service assistance (housing, entitlements, clothing, transportation); direct psychotherapeutic interventions
 4. Transition and relapse prevention — psychiatric medication management; concurrent, personalized case management

Gary Morse, PhD,

Community Alternatives: Innovations in Behavioral Care, St. Louis, Missouri

are more likely to have established relationships with mental health professionals and other specialists. Unfortunately, many clinicians outside targeted homeless programs lack the experience, skills, and often the desire to engage and successfully treat the serious and complex health problems that distinguish severely mentally ill persons who are homeless from those who are housed.

Effective Responses:

HOUSING AS HEALTH CARE

Experienced mental health practitioners understand that permanently re-housing homeless mentally ill persons is not a simple matter easily solved by inexpensive, quick fixes. But they also know that treatment of serious mental illness is difficult or impossible without some measure of residential stability.² “Patients with severe mental illnesses who are housed have fewer complications, and are much less likely to have co-occurring disorders that exacerbate their illness,” explains Dr. Yuodelis Flores. As a result, they more

Controlling Symptoms, Learning to Cope

Once a therapeutic relationship has been initiated, homeless care providers and their clients are faced with another thorny set of challenges — applying for benefits, examining therapeutic alternatives, and managing multiple diagnoses. The same panel of experts, from Alaska and Washington State to Maryland and Virginia, was consulted on these topics.

DOCUMENTING DISABILITY All persons with SPMI should be eligible for health coverage under SSI-Medicaid or SSDI-Medicare, but obtaining benefits depends on the client's willingness to apply and confirmation by a mental health provider of a functional disability as defined by the Social Security Administration. Easier said than done for many severely mentally impaired homeless clients, say HCH clinicians. What do our experts say?

"You can't be pushy, and you can't set the agenda, warns psychiatric nurse **Carol Moriarty, BSN, RN**, of Anchorage. "The *client* has to set the agenda, and you have to follow it." Every HCH project should have a close, collaborative relationship with a psychiatrist who is knowledgeable about the homeless population, declares **Christine Yuodelis Flores, MD**, of Seattle. Case managers and psychiatrists must work hand-in-hand to document functional disabilities appropriately, she says.

The case manager helps gather medical history information from other places. Some Masters-level social workers document clients' disabilities extremely well, she says. A psychiatrist has only to review and approve their reports. "I review all data from the case manager and the medical history, together with information obtained from my interview with the patient before arriving at a diagnosis," she explains. "It may take more than one interview. Some patients are reluctant to reveal any information — but that tells you something too."

CONSIDERING THERAPEUTIC ALTERNATIVES Clinicians must weigh the pros and cons of prescribing older versus newer (atypical) anti-psychotic drugs. "Although older medications (fluphenazine,

haloperidol) are very effective for reducing auditory hallucinations, delusions and paranoia, they are not so effective at helping with social or behavioral symptoms of schizophrenia," says Dr. Yuodelis Flores. "But they can have bad side effects including Tardive Dyskinesia (involuntary muscle spasms) and Parkinson-like symptoms."

"Atypical anti-psychotics (olanzepine, clozapine, risperidone) are much better for treating negative behavioral symptoms and verbal/cognitive deficits, and have significantly fewer side effects," she says. The down side is that these newer drugs are very expensive, and can only be administered orally. For patients with extreme difficulty adhering to treatment, injections may be the only realistic option, initially. Only the older drugs are currently available in injectable form.

"Newer anti-psychotics are among the safest drugs available. You can't overdose on them and they don't have many serious side effects or require blood monitoring. They are also easy to use in treatment — a single dose at bedtime or during the day (which may be preferable for street dwellers afraid of taking medications that induce deep sleep at night, when they are more likely to be victimized)."

Christine Yuodelis Flores, MD, Seattle, Washington

Although the mental health professionals interviewed for this article reported no difficulty obtaining atypical psychotropic medications free or at reduced prices from drug companies, others say cost is a serious barrier to obtaining these drugs for uninsured persons. The cost of a one-month supply of olanzepine is \$504.17 for the most common dose (20 mg), reports Moriarty. "Don't be fooled into thinking there are no adverse effects from the newer psychotropic drugs," she warns. "Tremendous weight gain (25–120 lbs) can occur in patients taking olanzepine, and risperidone can cause stiffness and lactation in both women and men."

Resistance or lack of adherence to treatment is a serious concern, as already mentioned. Patients frequently relapse during the course of treatment and must be re-engaged. Laws varying from state to state prohibit involuntary treatment except under specific circumstances. In Alaska, for example, a court order

for involuntary treatment can be obtained if clients present a danger to themselves or others, or are gravely disabled — i.e., unable to meet their own basic needs or lack of treatment would cause them unnecessary suffering — reports Moriarty.

"As long as unmedicated clients are nonviolent, they are welcome to participate in any aspect of our program," she says. "But sometimes we pray they will get bad enough that we can take them to court to approve involuntary medication."

Dr. Yuodelis Flores admits her frustration with the delicate balance that must be maintained between protecting civil rights and getting clients the treatment they so desperately need. One of her patients flew to Switzerland and applied for asylum, fearing

pursuit by witches in the US government. He listed the psychiatrist's name on his passport as next-of-kin. Admitted involuntarily to an inpatient psychiatric unit for over a month, he got the best care he had ever received, she reports, because Switzerland's laws controlling involuntary treatment are far more lenient than King County, Washington's, and because he wasn't discharged prematurely for financial reasons, as in the United States.

Although psychotropic drugs may be necessary to control disruptive symptoms, they are not sufficient to enable patients to cope with the life-long challenges presented by severe mental illnesses. Individual and group therapy, life skills training, and ongoing support groups are also recommended to enable these persons to maintain stable housing, regain control of their lives, and re-enter the community, PATH Exemplary Program practitioners remind us.

First Steps in a Long-term Relationship

Outreach and engagement, crisis intervention, dealing with grief and tracking clients throughout the referral system are important first steps in establishing an ongoing therapeutic alliance with mentally ill homeless persons, say experts in homeless health care from Las Vegas, Nevada; Los Angeles, California; Anchorage, Alaska; and Fairfax County, Virginia.



Salvation Army Outreach team, Las Vegas, Nevada

CONSUMER OUTREACH Outreach is essential to effective mental health care for homeless people who do not seek services despite their multiple disorders and needs.⁵ To help overcome their suspicions, resistance and prior negative experiences with the mental health system, The Salvation Army in Las Vegas, Nevada, uses outreach workers who are homeless or formerly homeless themselves. Their work has been so successful, that the program was honored in June as one of seven Projects for Assistance in Transition from Homelessness (PATH) Exemplary Programs by the Center for Mental Health Services.

David Norment, certified addictions counselor and coordinator of the Salvation Army's Safe Haven and PATH programs, supervises the outreach team that also works in the Day Resource Center. About 20–25% of outreach staff are consumers. Safe Haven is an emergency shelter for persons with serious mental illness that opened in April 2000. Residents must be alcohol and drug-free. Referrals are provided for detoxification, mental health assessment, and dual diagnosis treatment. Clients who want more help are transferred to the PATH program where they can obtain peer counseling, life skills classes, transportation to clinic appointments, vocational rehabilitation and substance abuse counseling. Of the 4,000 homeless clients served this year, 528 were admitted to the PATH program.

“Harness the talents of your consumers,” advises Norment. “Don’t assume that clients can’t function just because they have a mental illness, and don’t try to do everything for them.” Empowerment is an important element of recovery, he insists. Once clients are stabilized, he recommends involving them in life skills classes taught by other consumers. “Many of our clients are professionals — professors and computer specialists, for example — who lost their jobs and became

homeless because of mental illness.” Including these individuals as part of the service team is an effective way to engage other clients and reinforce their own progress.

DEALING WITH DIFFICULT CLIENTS Eve Rubell, MPH, director of training and education at Homeless Health Care Los Angeles, teaches HCH service providers how to deal with difficult clients, including those with mental disorders that cause them to be either disruptive or very fearful and anxious in a clinic setting. She uses the nonviolent crisis intervention method developed by the Crisis Prevention Institute (CPI) in Brookfield, Wisconsin.⁷ [For a list of HCH clinicians who participated in CPI training sponsored by the Network, contact Brenda Proffitt at bproffitt@nhchc.org, 505 872-1151.]

“Clinics need to develop and implement policies and procedures for dealing with emergency situations,” says Rubell. “They should form an emergency team and be sure that all staff understand and practice the fundamentals of nonviolent crisis intervention.” In a nutshell, here is what she recommends to help prevent or de-escalate acting out behaviors:

Tips For Dealing With Difficult Clients

- **Try to understand why the person is angry or upset.** Use active listening and an empathic, non-judgmental approach to alleviate anxiety.
- **Try to prevent acting out behavior by being proactive.** Approach apparently anxious clients with respect; address problems immediately, before they escalate.
- **Remain calm and professional; don't take acting out personally.** Don't let your own behavior escalate. Take a break; get help from others who have better rapport with the client.
- **In an escalating situation, isolate the difficult person.** Separation from others often allows clients to save face and calm down.
- **Respect personal space; watch your body language.** Remain 3-4 feet from the client — in front and slightly turned. Avoid challenging gestures, stance and facial expressions.
- **Tone of voice is important; don't sound harsh.** Be respectful. Don't communicate stress or negative expectations through your manner.
- **Speak clearly, slowly and simply.** Don't use jargon or large words. Avoid jokes and arguments about what the person is seeing, feeling or experiencing.
- **Set limits that are clear, simple, reasonable and enforceable.** Ask something the client is capable of doing. Emphasize the positive. Be understanding of the need just to “vent.”
- **After an incident, sit down with staff and debrief.** Discuss what worked and what didn't to be better prepared next time.
- **The teachable moment is when the client has calmed down.** Remind client how to avoid anxious situations in the future-but not in the middle of crisis.

**Eve Rubell, MPH, Homeless Health Care,
Los Angeles, California**

WHO WERE YOU BEFORE YOU GOT SICK? Just listening to **Carol Moriarty, BSN, RN**, is enough to lower one's blood pressure a few notches. This psychiatric nurse, case manager and clinical associate for the Crossover House Project in Anchorage, Alaska, exudes compassion and gentle humor. Her project has also been recognized as an exemplary PATH program for its aggressive community outreach and skillful engagement of homeless persons with psychotic disorders.

"Our number one engagement tool is hanging out," says Moriarty. "We go into shelters and soup kitchens, get to know people who appear to be mentally ill, and give them an opportunity to know us. An introduction from someone they know is helpful. Most don't want anything to do with us and run." Outreach may take as long as 15 years, she says. "Sometimes it's hard to tell whether hallucinations are secondary to a substance abuse disorder or a pre-existing mental illness. Substance abusers may act like schizophrenics. Over time, we'll see that they aren't."

Moriarty and her colleagues try to lure people into their center with lunch, coffee, clothing and bus tokens (so they don't have to accept a ride in someone's car). The facility is extremely attractive, with free showers, free laundry and fairly loose rules. Clients can lie down on the couch and take a nap. "They don't sleep well outside when it's below zero," she explains. Clients can read the newspaper or magazines there. "It's a safe, comforting place to hang out."

"There are tremendous losses that must be grieved. Ask clients to tell the story of their loss without labeling it as loss — 'Tell me what things were like before you got sick.'"

Carol Moriarty, BSN, RN, Anchorage, Alaska

"Don't insist that clients acknowledge their mental illness," she advises. "It doesn't really matter. Try to get them to take medication to make them feel better. Don't label the illness 'mental.' Accept the client's explanation for not feeling well." Most people are aware that they are sick; they may or may not notice stigmatization by others, which often occurs. Moriarty deals with stigma by addressing it from a perspective of grief and loss. She offers an eight-week session on grieving, loosely adapting Elizabeth Kubler-Ross' principles. "The breakthrough is the identity part — when clients reveal who they were before they got sick. Then we grieve together for the person who was."

NO BURNED BRIDGES For the past decade, Fairfax-Falls Church Community Services Board (CSB), Fairfax County, Virginia, has placed full-time outreach therapists in two county shelters and a community mental health center, as the centerpiece of their exemplary PATH program. Drop-in groups of social workers and licensed therapists provide direct service at each of these three sites, functioning primarily as evaluation and referral clearinghouses for street-dwelling homeless people.

Four of these mental health practitioners graciously devoted part of a

staff meeting to tell us about their work with Mental Health Homeless Services, a subsidiary of the mental health adult residential services unit of the county mental health services agency. They explained that their outreach is based on four basic principles:

- **Maintaining a consistent presence** in places where homeless people congregate;
- **Focusing on long-term goals** including access to housing and social services, and establishing a relationship with a mental health counselor;
- **Flexibility in service provision**, proceeding at the individual client's pace; and
- **Ongoing education** of clients and other providers to assure that homeless people with mental disorders are never inappropriately discharged from care.

"We base our outreach on a one-stop-shopping model, meeting homeless clients where they are with a package of services," explains mental health manager **Whitney Henry, MS** (clinical psychology). "Needs are addressed as they arise, with no appointments necessary," adds **Cliftemma Allen, MA** (counseling), mental health supervisor for the Northwest region's homeless services. "We receive referrals from hospitals, county agencies, the police, community-based organizations, citizens and shelters — where clients are also referred for services. It's a two-way street."

"We practice 'car therapy' and 'fast food therapy' — developing relationships with our clients while driving to pick up food stamps or talking at McDonald's over lunch — whatever it takes," says **Nella Leppo, BS** (physiological psychology) mental health therapist for the Mt. Vernon region. Outreach and shelter-based workers follow clients through the referral system within and beyond Fairfax County. "We respond to the transience of our homeless clients by remaining in close contact with providers in neighboring jurisdictions — in effect, by being transient ourselves," remarks **Dale Davidson, MA** (neuropsychology), mental health supervisor for the Woodburn region. "We don't allow clients to burn their bridges. It may take years and various engagement efforts, but we never give up on them." ■

Reminders for Clinicians who Care for the Homeless Mentally III

- Relationship is the most important element of healing.
- Don't give up on anyone — provide services and be their advocate.
- Be open and receptive to second chances.
- Allow time; expect this to be a long-term relationship.
- Set attainable, client-centered goals.
- Build up formal and informal community resources.
- Maintain a consistent presence.
- Remember — you can't equate success with the number of people served or the number of services provided.

Mental Health Homeless Services, Fairfax County, Virginia

MANAGING MULTIPLE DIAGNOSES

One HCH clinician reports a case illustrating the quandary many clinicians face in deciding how to handle severely mentally ill patients with multiple diagnoses. A client with schizophrenia and a self-reported gender identity disorder repeatedly obtains Premarin (estrogen) from area physicians not associated with the HCH project. The hormone therapy exacerbates his asthma and a serious cardiac condition. He has been homeless for 17 years, intermittently hospitalized, with

fragmented discharge planning. The client smells bad, is extremely abusive to clinicians, and chronically misses appointments, sometimes returning years later. When HCH providers objected to his misuse of medications and suggested that a representative payee assume responsibility for his finances, he left again. The good news is, he is reported to have engaged with another case management program to which they referred him.

“An increasing part of our job is making sure

that clients with multiple diagnoses show up for clinic appointments and get proper medical care,” says outreach therapist **Dale Davidson, MA**, Fairfax County, Virginia. “Educating clients and other providers is an essential part of this work. We accompany clients to pick up supplies, advocate for them when they are inappropriately discharged, and do everything we can to keep them in housing. For clients who are resistant to care, it’s important just to be there, with very frequent contacts.” ■

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