# Health Group - workshop synthesis

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## 1. Why this pillar?

Mental and physical health problems are strongly connected to homeless. Homeless people die earlier and have a higher prevalence of mental and physical illnesses than general population. (bibliog)

Psychosis, multiple trauma and addiction are often causes of homeless, whereas emotional distress, anxiety and depression can be a response to homeless. (bibliog)

Physical health problems can arise directly from the rigours of being homeless, or be worsened because of lack of conditions for treatment. For example, if you suffer from diabetes, tuberculosis or other illnesses, it is hard to take care of health in the streets because:

A homeless person is likely to lack the control over their 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 impact on a person's ability to take medication regularly.

On the other hand, health and social services tend to have limited contact with this population. Many cases of poor health in homeless people are not addressed adequately by mainstream health services.

## 2. Main ideas to highlight

**Accessibility**

The importance of direct access to care and resources, especially for people who are undocumented, **or at least possible stablished routes.** Homeless people tend to struggle with a multiple problems simultaneously, making them to be easily perceived as difficult and become unwanted in the services. At the same time, homeless tend to have difficulty to deal with bureaucratic barriers, waiting lists and

complicated treatment plans. The more rigid a service is, the more likely that homeless people are likely to be excluded from that service, or to lose contact with it.

Health services should be aware that, although general populations have difficulties adhering to treatment plans, homeless people have added difficulties in doing this.

Services should not erect barriers to access to their services. They should make access to services easier and quicker.

Access to and knowledge of rights regarding access to healthcare.

Aftercare/follow up after discharge from hospital. It is extremely important, especially when a person is discharged to a hostile environment, that a clear and robust aftercare plan is made. However, this is often not done for homeless people before their discharge from hospital.

**Outreach**

Can be both a strategy for:

- Detection
- Follow up and continuing care ( more content regarding this style of approach will be produced as a separate chapter).

It is an approach that can be applied to both mental and physical health medical assessment and treatment. The use of mobile health units was mentioned as a specific type of outreach.

The idea of outreach styles was discussed – proactive/assertive approaches versus more receptive styles. We understand that these styles are influenced by national cultural attitudes, economic circumstances, specific ideologies of mental illness and homelessness – and legal structures that control some aspects of psychiatric treatment.

Follow up techniques and interventions should be briefly described, e.g: intensity, frequency - basically a brief description of specific practices, which have been described in some of the summaries available.

**Networking**

Essential because homeless people present multiple problems at a single point in time – so no one service can provide adequate care and support. All services working with homeless people with mental health problems should actively network to ensure that they can 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-centered networks, using both formal and informal communications.

**Attention to Relationships**

It may be that, in some contexts and with some clients you can deliver adequate care and treatment without paying attention to the relationship, this is absolutely not true with homeless people – it is a central, essential part of the work. A good relationship and working alliance with the homeless person is the only way to establish adherence to treatment and collaboration with the services. Paying attention to the interpersonal and relational aspects is as important as other, more obviously "technical" concerns. Indeed, it should be seen as a technical concern in its own right.

**Emergency services**

Emergency services (such as A&E 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 is often looked upon with suspicion, as if only looking for a meal or bed. 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. Staff working in emergency services need to know that these services exist, and need to 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 make a difference.

**Information**

Good recording of all kinds of information is indispensable and empowering. All activity should be carefully recorded.
In-patient treatment, outpatient consultations, emergency consultations, sociodemographic and diagnostic data should all be registered. Attention should be given to information-sharing between different sectors – hospital, out-patients.

**Hospitalisation:**

Most work with homeless people is best accomplished by working in a collaborative way in the community. However, hospitalisation is sometimes necessary when an individual:

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

It may, in certain circumstances, have to be an involuntary / compulsory admission to hospital.

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 improve the person's condition. Discharge to the streets should never happen.

To achieve this, it is imperative that community services and professionals, who have been involved with the individual, take the initiative in communicating with and sharing information with in-patient staff. A meeting between in-patient and community staff should always happen before a homeless patient is discharged from hospital.

**Outpatient services**

Easy access to such serivesis fundamental. Good examples are the "Open psychotherapeutic group" and "Open consultation" models that work regularly, every week without appointment.

**Coordination / joint work with social services**

Collaboration with social services is necessary and nothing to be defensive about. Once again there is no risk of homeless patients over-loading the system. 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 effective collaboration with social services to find appropriate responses after hospital discharge.

**Coordination with Health Authorities re. 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 ae likely to be much more posisitve about working with homeless services.

**Research, training and case discussion**

These should all be invested in and allowed time for them in any team. They not only enable homeless services to demonstrate what they are doing but can also be fulfilling and motivating for team members.

## 3. Difficulties expected, barriers

**Street Assessments**

There are difficulties inherent to 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 (eg 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 often complex situations, should be doing 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 an alarm 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.

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 hospital.

**Communication**

A focus only on health or only on social needs tends to foster 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 within the medical domain to in-patient and community services.

**Cultural differences**

Many homeless people are not 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.

Concept of revolving door homeless person. Revolving door in relation to any type of resources.

## 4. Good practices

**Outreach**

Outreach work is fundamental with this population that often avoid services. It must include consideration of social, mental and physical health needs.

**Access to mainstream services**

At the same time, services should try to adapt and make access easy to homeless. Open services, without appointment and waiting lists are good practices.

**Focus on relationship-building**

Effective interventions with homeless people is dependent on the establishment of a good relationship on an individual basis.  Group interventions can also be very

effective as they foster a sense of belonging and enable shared, non-hierarchical learning.

### Networking

Networking and collaboration with other professionals and services is essential to provide a comprehensive (or at least multi-faceted) service plan involving the provision of basic needs and a plausible plan for the future. Phone or email communications are clearly vital – but personal meetings can engender as sense of personal trust between services that can make things work much more smoothly.

All professionals and other people working with persons in situation of homeliness would benefit to have training in collaboration.

### Hospitalisation

Clear, well-established and agreed protocols for compulsory admissions

- 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.
- Homeless team maintain regular contact with hospital staff during the admission.
- Pre-discharge meetings for any type of hospital admission (mental or medical) invovling the hospital team and the homeless team (with a social worker) to plan future accommodation, and organize a discharge / follow up plan.
- Training staff 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 help other professionals become less suspicious / pessimistic about homeless people, and thus more likely to make their services accessible to homeless people.

## Professional training

Offering trainees training opportunities in homeless services. Most students find such placements extremely rewarding and are likely to become more sensitive to the needs of homeless people – and more skilled in helping them.

## Support for staff

Staff welfare and effectiveness cannot be taken for granted. Planned supervision and staff care are needed for good practice to be maintained.