Getting Homeless to Engage Key

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health care services, the fundamental elements of the mental health homes being developed in Jacksonville include psychiatric street outreach, coordination of and increased access to comprehensive care, and the integration of medical, psychiatric care, and addiction services, Dr. Richard C. Christensen said at the meeting.

Two days a week, Dr. Christensen hits the road with an outreach nurse and case managers with expertise in the areas of housing and addiction services to attempt to bring the city's street-dwellers into the health care fold – a monumental challenge considering city census data estimate that, on any given night, there are 2,900-3,000 homeless people in Jacksonville "and there are only 600 shelter beds available," he said. "That leaves 2,300-2,400 persons who are unsheltered and outside the realm of any kind of treatment or attachment to any kind of medical system."

The outreach team is described as transdisciplinary rather than multidisciplinary, because the members do not work independently, but rather they integrate their skills and knowledge and share in clinical decision making, according to Dr. Christensen, professor and chief of the division of public psychiatry at the University of Florida, Gainesville, and director of behavioral health services at the Sulzbacher Center.

Just as the medical home is most beneficial to individuals with difficult-to-treat illnesses, a history of nonadherence, and limited access to consistent, comprehensive care, the mental health home is potentially of greatest value to "the most highly underserved members in our community: persons who are literally and systemically homeless," he said. The corollary, however, is that those who stand to gain the most from the integrated model of treatment are often the most difficult to engage and retain. In particular, the unsheltered homeless – those who chronically live on the streets, rather than in a temporary shelter – tend to have the high rates of severe mental illness and are the least likely to receive services, Dr. Christensen said in an interview.

A recent report by the U.S. Conference of Mayors estimated that 26%-28% of the homeless people in this country have a serious mental illness, and other estimates place that percentage over 30%, with the highest rates being seen among the unsheltered homeless, Dr. Christensen said. Additionally, "unsheltered homeless persons with mental illness have high rates of co-occurring substance use disorders, making them a particularly difficult population to engage."

Exacerbating the engagement challenge is the fact that these individuals have a pervasive mistrust of outreach workers and the public mental health care system. "There is a fundamental difference between the unsheltered homeless and those within a shelter system or service program who are open to receiving help," according to Dr. Christensen. "The people we are targeting are not the ones who come looking for treatment. We are going to them, and they're often not interested." Thus, engaging the clients is often an arduous task that can take days, weeks, and even months and requires adapting communication styles and expectations and, often, a fair degree of bargaining on the part of the outreach team. "We are fortunate because [through the Sulzbacher Center] we are able to offer emergency shelter, which is sometimes the hook that gets people in, but it can take weeks and weeks to even get that point," he said.

For this reason, the goals of the program are not lofty. While there are some remarkable success stories – Dr. Christensen tells of one client with psychosis who, after months of refusing the outreach team members' dogged efforts, eventually accepted their offer of safe housing and has since become "an active participant in her own recovery – most gains are more modest. "The success of psychiatric street outreach cannot be evaluated with the same outcome measures as those used in clinical practice," he said. Certainly, the ideal progression is to engage the client to the point where he or she is willing to accept a shelter bed, food, water, clothing, and medical and psychiatric care, followed by the development of a diagnosis and treatment plan. However, he noted, the realistic goal is to simply get the homeless individual to agree to interact with any member of the team. "When that happens, we consider it a success," he said.

Because of this, evidence-based medicine with measurable clinical outcomes takes a back seat to relationship building, intuition, and tolerance, according to Dr. Christensen. The concept of recovery is impossible without establishing a respectful relationship with each client, he said, noting that "my goal is to get them to talk to me. That's it. We don't discuss medication or treatment plans." By building a trusting relationship, the outreach team can begin to help each client establish social, medical, and mental health connections through "open and welcoming doors" via ongoing street outreach, easily accessible walk-in clinics, and extreme tolerance of nonadherence and missed appointments, he said.

Once clients have established a connection to a caring, compassionate community, they can begin to take steps toward healing and recovery, including participating in their own psychiatric care, entering substance-abuse treatment, reestablishing family and social connections, and, ultimately, finding stable housing, Dr. Christensen said.

Psychiatric street outreach and the establishment of comprehensive, coordinated mental health homes for unsheltered homeless individuals is a complex, often arduous endeavor, as is the establishment and maintenance of funding needed to keep such efforts alive.

"The financial aspect can be complicated. Our funding comes from many different streams, mostly in the form of grants from various sources for specific services," Dr. Christensen said. As such, the availability of services necessarily expands and contracts along with the financial support for those services, he said.

Working with homeless populations has been Dr. Christensen's passion since medical school – in fact, he said, he went to medical school expressly to be able to provide care to the homeless. However, "even if you're not doing this as full-time work, psychiatrists have many opportunities to link people to services by virtue of our credentials and training," he said. There are many things psychiatrists can do to not only provide direct care to these individuals, he said, "but also to be advocates."

Dr. Christensen had no conflicts of interest to report. ■

Mental Health Courts Lead to Fewer Arrests, Days in Jail

BY JANE ANDERSON

FROM THE ARCHIVES OF GENERAL PSYCHIATRY

Inmates who participate in mental health courts that are designed to facilitate treatment and reduce incarceration experience lower posttreatment arrest rates and fewer days in jail, according to a study in the journal.

The study found that the mental health court participants with the best outcomes included those with fewer arrests and incarceration days in the 18 months prior to their participation in the mental health court.

In addition, higher rates of mental health treatment in the 6 months prior to participation in the court led to better outcomes, as did a diagnosis of bipolar disorder, the study said (Arch. Gen. Psychiatry 2010 [doi:10.1001/archgenpsychiatry.2010.134])

Meanwhile, diagnoses of schizophrenia or depression and illegal substance use in the 30 days prior to court participation led to worse outcomes in inmates, Henry J. Steadman, Ph.D., who works public policy in a group practice in Delmar, N.Y., and his colleagues found.

About 250 mental health courts operate across the country with the goal of moving people with serious mental illness out of the criminal justice system and into community treatment without sacrificing public safety, Dr. Steadman and his colleagues reported. They called their investigation the first prospective, multisite study of mental health courts.

This is how mental health courts work: Potential clients are referred by jail staff, after which the court holds a hearing. Individuals then have the option of entering a guilty plea and agreeing to the terms established by the court, which usually includes treatment.

Individuals who agree to the terms usually are released into the community under mental health court supervision. The court holds subsequent hearings repeatedly, and can sanction individuals who violate the terms of their agreements through bench warrants, temporary reincarceration, and agreement revocation. The court also facilitates treatment options for these individuals.

VITALS

Major Finding: The use of mental health courts for some defendants results in fewer posttreatment arrests and days of incarceration.

Data Source: A prospective, longitudinal, quasiexperimental study of 447 people enrolled in mental health courts and 600 controls.

Disclosures: The study was supported by the Research Network on Mandated Community Treatment of the John D. and Catherine T. MacArthur Foundation. No financial disclosures were reported.

The study looked at 447 individuals enrolled in four mental health courts in three states: California, Minnesota, and Indiana. A total of 600 individuals served as controls.

In the pre-court period, almost all the individuals in both groups had at least two arrests. However, in the 18-month postarrest period, 49% of the group that attended mental health court had an additional arrest, compared with 58% of the treatment-as-usual control group.

Both groups showed a decline in their annual arrest rates, but, overall, the mental health court group's annual arrest rates declined more than did the control group's rate.

When days of incarceration were measured, the study found that the mental health court group saw a 12% increase during the 18 months following their court participation, from 73 days to 82 days. However, those in the control group saw their incarceration days shoot up by 105%, from 74 days to 152 days, when those same two 18-month periods were compared.

"The average number of jail days increased for both samples," the investigators wrote. "However, the small increase of 9 days for [mental health court] is not statistically significant and is unlikely to have practical implications."

When the study compared the group attending the mental health court vs. the treatment-as-usual group, it was clear that the mental health court participants did much better in the follow-up period. "It appears that mental health courts are diversion programs for justice-involved persons with mental illness and, usually, co-occurring substance abuse disorders that warrant public policy support," Dr. Steadman and his colleagues wrote. ■