
Experiences of Frontline Workers' Engagement with Mental Health Services for Homeless Adults in Ireland

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- **Abstract_** *Ireland is experiencing a deepening homeless crisis with few sustainable solutions identified. This study explores front-line service providers' experiences in their engagement with mental health services for adult service users who are homeless within the South-East Region of Ireland. Strauss and Corbin's Grounded Theory approach was used to guide twenty in-depth interviews with front line service providers. Five key service gaps emerged: (1) inter-agency communication and collaboration; (2) assertive community recovery-orientated care; (3) training, information sharing and up-skilling; (4) building and sustaining trust, and (5) discharge planning and resource constraints. The findings suggest that the provision of bespoke tailored Mental Health Services, improved inter-agency collaboration and the development of relevant staff educational programmes are required. Further research to inform targeted service provision, policy and practice development is recommended.*
- **Keywords_** *Homelessness, mental illness, front-line staff, barriers, challenges, Ireland*

Introduction

Ireland is experiencing a deepening homeless crisis (Government of Ireland, 2018), which is at the centre of political and social debate, with few sustainable solutions identified (Houses of the Oireachtas, 2018). Various approaches have been used to study groups of homeless people, for example, Kuhn and Culhane, (1998) identify three distinct clusters of homeless individuals: (1) transitional, (2) episodic and (3) chronic. Indeed, a recent Irish study found that an average of eighty percent of people who experience transitional forms of homelessness remain homeless for just a short period of time and this experience is not repeated. This situation is comparable to similar studies conducted in America, Canada and Denmark (Waldron *et al.*, 2019).

Homelessness has a human cost encompassing emotional distress from intense social isolation, stigma and loneliness (McGrath *et al.*, 2015; Pleace, 2015; Abiri *et al.*, 2016). People experiencing homelessness are often exposed to trauma (FEANSTA, 2017), such as street violence, victimisation and entrapment within street sub-culture (Hopper *et al.*, 2010; Davies and Allen, 2017), with their physical and emotional health deteriorating as they become entrenched in long term repeated homelessness (Murphy *et al.*, 2017; McMordie, 2018; Singh *et al.*, 2019). Socio-economic influences such as poverty, stigmatization and marginalization compound the difficulties a homeless person with mental health issues may experience, which negatively impacts their engagement with local mental health supports (Montgomery *et al.*, 2013).

The prevalence of mental illness amongst people experiencing chronic and episodic forms of homelessness averages at sixty percent compared to fifteen percent in the general population (Murphy *et al.*, 2017). In terms of serious mental illness, it is argued that socioeconomic deprivation combined with living with a serious mental illness is more likely to account for a risk for homelessness rather than just the prevalence of the illness itself. This highlights the importance for more intense secondary and tertiary mental health service provision (Montgomery *et al.*, 2013). Admissions to Irish psychiatric hospitals between 2005 and 2014 indicate that nearly sixty per cent of homeless people have a mental or behavioural diagnosis with evidence of deliberate self-harm (Barrett *et al.*, 2017), which is an increase of fifty per cent over this period (Glynn *et al.*, 2017). Dual diagnosis, for example, depression with an underlying substance misuse disorder, is more prevalent among homeless people than in the general population (Millier *et al.*, 2014; Glynn *et al.*, 2017) with an upward trend in suicidal behaviour (Edidin *et al.*, 2012; Department of Health, 2015; Office of National Statistics, 2019). Homelessness has also significantly increased among drug users in Ireland (Fazel *et al.*, 2014; O'Brien *et al.*, 2015) with the Central Methadone Treatment lists showing a rise in attendees from 5 500 to 11 500 during this period (HSE, 2016).

People experiencing homelessness often experience a paradox in their care provision, occurring because their health needs become more complex and the availability of services to meet their growing needs becomes restricted (Dunne *et al.*, 2012; Dear and Wolch, 2014). For example, those with a dual diagnosis of active drug/alcohol dependency, coupled with an underlying mental illness may experience exclusion from mainstream mental health services. This occurs because many times addiction services do not have the capacity or expertise in the wider field of mental health care (Canavan *et al.*, 2012; Fazel *et al.*, 2014). Furthermore, people who are experiencing chronic forms of homelessness often have limited knowledge of the range of mental health services available to them (Krausz *et al.*, 2013; Chant *et al.*, 2014) 2014). Those who do have a chaotic lifestyle and poor engagement with services challenge mental health providers in their efforts to provide optimum care (Canavan *et al.*, 2012) with a need for the provision of more tailored interventions (Tyler *et al.*, 2019).

Australian homeless policy has integrated an assertive outreach model for managing homelessness, which is adapted from UK and USA best practice guidelines integrating focused interventions into service delivery (Parsell *et al.*, 2013). A review of Emergency Department presentations by homeless people with addiction issues suggest that psycho-social interventions such as assertive outreach is a valuable support for their recovery (Parkman *et al.*, 2017). In Ireland, mental health care for homeless people is limited, complicated by this population being unable to positively engage with most support services (Simon Communities of Ireland, 2011; 2018). Delivering quality mental health care is further impacted by factors such as staff shortages and increased economic challenges (Cullen *et al.*, 2017; HSE, 2020). Emergency Departments often become the de-facto primary and acute care provider for mental health service users (The Royal College of Psychiatrists, 2010) and are often the only out-of-hours mental health supports available for homeless people in crisis (Ceannt *et al.*, 2016; Farrell *et al.*, 2016; Murphy *et al.*, 2017), with limited engagement from the homeless person to the care offered (Lam *et al.*, 2016). Arguably bespoke mental health services could mitigate against protracted hospital admissions and unnecessary presentations to Emergency Departments (Pleace, 2015).

Front-line service providers working with homeless adults face many challenges in their work with mental health services (Canavan *et al.*, 2012; Kennedy *et al.*, 2017). Safetynet, an innovative free Dublin based primary health care service (Keogh *et al.*, 2015) targeting the health care needs of homeless people, has reported significant increases in GP attendance, health diagnoses and reduced hospital presentations. Ongoing training and up-skilling of key hospital and community front-line staff is recommended so that evidence-based recovery-orientated mental health care which is culturally and human rights sensitive is offered (WHO, 2013; Jones

and Radford, 2015). There is limited research that explores the challenges faced by front-line workers and homeless people who are mentally unwell and solutions required to meet their needs. Therefore, this paper presents the findings of a study that explores the challenges that front-line staff experience within the South-East Region of Ireland.

Methodology and Approach

A qualitative methodology using Strauss and Corbin's Grounded Theory approach was used. Initially, data collection was guided by purposive sampling with the principle of selection directed by the researcher's judgement as to the 'typicality' of the group (Robson, 2002). As initial coding and concepts emerged from the data, this led to a theoretical sampling approach guiding and developing the sample (n=20). Homeless Action Team (HAT) members were recruited and consisted of sixteen females and four males ranging in ages from thirty to sixty years. They work across a range of local homeless services, Department of Justice, youth and addiction services, community health and hospitality sectors. Interviews ranged from 30 to 70 minutes and permission to audio-record interviews was granted. A topic guide used to steer discussion and data, was entered into a qualitative data analysis computer package – NVivo 11. This software package was used to facilitate data storage and management only. Data analysis followed Strauss and Corbin's (1998) three levels for coding (1) open coding to find categories and their properties; (2) axial coding to identify interconnections between categories and (3) selective coding and moving to a more abstract level to establish the core category or in the case of this study five key processes. The method of constant comparison was used as well as memo writing. Ethical approval was granted by the HSE South East and Waterford Institute of Technology, Ireland.

Findings

Five key processes emerged: (1) inter-agency communication and collaboration; (2) assertive community recovery-orientated care; (3) training, information sharing and up-skilling; (4) building and sustaining trust, and (5) discharge planning and resource constraints.

Inter-agency communication and collaboration

Front-line workers recognise that quality mental health services are offered for homeless people; however, such services are not consistent in terms of communication and collaboration across the relevant community agencies and care departments. The inter-agency shared care and case management framework is viewed

as inadequate, leading to front-line workers feeling ill-equipped to effectively case manage. Many workers expressed concerns relating to insufficient information regarding the homeless person's mental health not being provided from the relevant treating teams. Concerns were reported that standards of communication between relevant departments within mental health services and the front-line staff supporting the homeless person were inadequate. Staff were uneasy about *'weak and disjointed interactions... with connections... missing between all services... a kind of a block'* (P16) that compromised recovery. There is a lack of transparency and communication of treatment plans due to limited *'background information on a [homeless] person's mental health status'* (P6).

There is a view that mental health services do not adequately facilitate inter-agency shared care arrangements for homeless people. As one front-line worker stated *'... mental health services don't really tell me anything because of confidentiality, so I just try to handle the lads [service users] myself the best I can'* (P7). This leads to front-line workers feeling *'abandoned'* in terms of shared care planning and worry about the potential risk posed to service users. Furthermore, service user's recovery is compromised as a result of a limited approach to the implementation of a recovery model of care, within a dominant medicalised mental health care system. Such services are reported as being reactive, which results in high levels of *'frustration'* among many front-line staff. They suggest that, frequently, homeless people have no choice but to access mental health service through very often overcrowded Emergency Departments particularly during out-of-hours time frames.

A lack of follow-up care for homeless people is a concern expressed by many front-line workers. Limited awareness by care and administration staff regarding the transient nature of homeless people leads to appointments being sent to incorrect or out-of-date addresses. Other challenges as a result of not having proof of address include; claiming welfare benefits, difficulty in registering with a primary care practice and processing medical cards. As one front-line worker states *'the medical card issue is huge and then not having a General Practitioner or a mental health outreach worker... affects their mental health care'* (P14).

General Practitioners are often regarded as gatekeepers to mental health services and front-line workers feel that they are at times *'unwilling to refer homeless people for expert mental health care'* (P18). In addition, front-line staff report that homeless people lack knowledge regarding where services are located or the nature of care and supports offered by these services. It is felt that homeless people do not prioritise their mental health care and /or their attendance to services. This can often be due to a denial or poor insight of their mental health problems, living chaotic lives, poor self-confidence, underlying social phobias or feeling embarrassed about their appearance due to sleeping rough in squats or open spaces.

There is a need for mental health professionals to have stronger links with hostels for homeless people. Front-line staff feel the need for community clinics to be provided, where primary care services, housing advice, welfare supports, befriending and peer support services can be offered. A policy requirement by voluntary housing providers of not housing tenants in supported long-term accommodation unless they have comprehensive mental health supports in place, such as counselling and medication management is challenging, as assertive outreach mental health services are not available in many catchment areas. This leads to marginalisation and further isolation for the homeless person in need of care.

Assertive community recovery orientated care

Tailored outreach and in-reach assertive community recovery orientated care services are required. Such services are viewed as '*helpful*' due to homeless people being reluctant to engage with mainstream services as a result of their '*chaotic lifestyles*'. Homeless people do not prioritise their recovery due to their '*struggles with isolation and inability to cope*' with the many challenges that confront them, further compromised due to limited availability of relevant mental health supports in their areas.

Women's refuge centres are unable to accept homeless women engaged in active addictions, highlighting the need for separate homeless women's emergency accommodation. Furthermore there is no hospital diagnostic coding system to track hospital care and the complex '*accommodation needs of homeless people*' (P3) challenges robust discharge care planning.

The value and support offered by liaison mental health services designated to care for homeless people with mental illness is widely acknowledged. However, limitations to their role are noted, particularly in relation to covering large geographical areas and related responsibilities. Front-line workers report that homeless service users often feel '*abandoned*' by their mental health teams and are '*scared*' to approach services. A designated community outreach case manager, such as a nurse or social worker is required to aid continuity of care for service users with advanced skills in counselling and addiction issues who would be attached to each treating team. This is viewed as a means to building therapeutic relationships between homeless people, mental health care teams and front-line workers. As suggested by one front-line worker that '*it's very hard to expect a homeless person to fit into a system designed for those in stable housing, they have different priorities*' (P7).

Most front-line workers feel '*isolated*', expressing concerns that they are often unable to access mental health teams or other multi-disciplinary staff who are skilled in counselling and challenges related to dual diagnoses. Front-line workers suggest that

homeless people are '*...lone ranger[s] in the community... there is no recovery orientated care... no team...no staff member to call to see them from mental health teams who know about addictions and have counselling skills...*' (P12).

The lack of assertive in-reach care to where the person is living was also highlighted. Bespoke mental health services are required to help meet the specific needs of people who were previously homeless who are now housed. This is because they are at risk of losing their new home due to potential deterioration in their mental health and being unable to manage their tenancy. As one worker suggested '*... when the supports from here are gone and they [homeless person], are on their own, that's when they are really vulnerable, and things break down and they lose their home*' (P10).

Training, information sharing and up-skilling

Inter-agency collaboration, shared care and case management practices are limited and front-line workers acknowledge they have limited training in the areas of '*risk assessment*'... , '*therapeutic interventions... behaviour management techniques*' (P12), '*mental health and managing substance misuse issues*' (P3). Front-line workers have concerns regarding their ability to manage a mental health or substance misuse crisis and subsequent case management issues. They worry that they do not have the skills to support a homeless person's recovery from mental illness and live a meaningful life. Advanced training in medication management could minimise crises occurring and as one front-line worker suggests that they cope by '*... learning on the job... nobody is here to support us from the treating teams, I google everything in relation to medications*', (P6). Risks minimisation through enhanced mental health care and case management is argued for. A greater understanding of professional roles and responsibilities particularly in relation to nursing and social worker roles is required as such roles are often unclear. Referral pathways and assertive outreach practices, such as interventions by community pharmacies could act as a central point for providing relevant supports. Mental health service updates could include mental health service professionals contact details, '*service update emails... directory of services... and service information days*' (P5).

Building and sustaining trust

Front-line workers describe a limited understanding of how mental health services are configured and the supports available, with a notable lack of trust and respect evident between homeless people and service providers that affect the therapeutic relationship. Front-line workers feel isolated from statutory health services, which results in poor information sharing. This is further reinforced by a perceived stigma of homeless people by service providers. Consequently, front-line workers suggest

that the homeless person may feel ‘... *threatened... unsupported and judged by them* [mental health service providers]’ (P5), with breaches of confidentiality often reported to front-line workers. As a result, homeless people are reluctant to consent to share information with services.

Front-line staff report that many homeless people are frustrated by long waiting lists for mental health and homeless services. Homeless people are discouraged by the mental health system as they are repeatedly asked to deal with their substance misuse and alcohol related problems. As one front-line worker states:

‘What they [homeless people] experience is constantly being asked to give up substances, when they are actually looking for something to help them deal with their anxiety and depression’ (P1).

Many front-line workers report that service users prefer the use of non-pharmacological therapy such as counselling interventions, but the emphasis appears to be mainly on medication therapy. Some report that homeless people can be intimidated by the perceived authoritative nature of care services. However, efforts by mental health service providers and the bespoke services available are acknowledged by front-line workers in their efforts to engage homeless people prior to discharge from services.

Discharge planning and resource constraints

The absence of a discharge policy for homeless people has a significant impact for planning and managing after-care and recovery. This is further complicated as homeless people report to front-line workers that discharge planning is not ‘*person-centred*’. ‘*We [front line workers] seem to be working in isolation... there is no discharge policy with clear responsibilities... for staff to know what to do when discharging the [homeless] person...*’ (P13).

Homeless people are often poorly informed about their discharge plan and can be discharged with a prescription for medication and often not registered with a primary care service to follow this up. Front-line workers receive little or no notice of discharges, resulting in poor follow-up in the community. The practice of discharge for non-attendance following two missed outpatient appointments is also challenging as quite often appointments are sent to incorrect addresses.

Front line workers feel isolated in their work with homeless people as ‘*there is often no follow through when someone is discharged... they just turn up at your door and that’s it... we feel abandoned*’ (P2). This is further complicated by a lack of out-of-hours mental health and social work services, which negatively impacts meaningful engagement with services during crises periods. Services required include a

women's emergency shelter, a damp house, which is a space where homeless people can drink in a controlled way, and the provision of short and long-term supported accommodation options that will optimise recovery.

Discussion

The Mental Health Commission in Ireland recommend that statutory services should work more closely with non-health stakeholders to identify and address gaps in mental health care (Mental Health Commission, 2016), with a greater emphasis for improving quality care for homeless people (Partnership for Health Equality, 2015; Murphy *et al.*, 2017). Findings from this study are consistent with previous research that suggests that care agencies should improve their partnership with each other to facilitate effective services (Maher and Allen, 2014; Casey and Farrelly, 2016; Tyler *et al.*, 2019). The provision of integrated care between hospital and community agencies for the homeless is complex and requires greater efforts by all care agencies to ensure quality care (Stergiopoulos *et al.*, 2015; Mental Health Foundation, 2015). However, there is little consensus regarding how integrated care should be configured and implemented (Burrows *et al.*, 2013; Kaehne, 2015; Tyler *et al.*, 2019). Developing integrated services that minimise barriers and retains the ability for communities to respond to political and financial sensitive environments is required (Shaw *et al.*, 2011; Anderson *et al.*, 2012). The introduction of the Irish Mental Health Service Providers Self-Auditing Guidelines (Health Service Executive, 2017) has potential whereby care providers can compare service delivery against international best practice frameworks (Almond and Esbester, 2018).

Promoting mental health recovery for homeless people requires strong inter-agency collaboration and agreed shared care protocols (Stergiopoulos *et al.*, 2010; Kelly *et al.*, 2011). A shared understanding of the roles and responsibilities by the various professionals and agencies working with homeless people is required in order to galvanise cohesive working arrangements (Royal College of Nursing, 2011; Bee *et al.*, 2015). Similar findings were expressed by front-line workers in this study with role ambiguity affecting shared care and inter-agency collaboration (Kelly *et al.*, 2011). For example, there are no clear job descriptions detailing responsibilities for the accommodation needs of homeless service users (Manthorpe *et al.*, 2013; Manktelow *et al.*, 2016) and very often the role of the social worker tends to be dominated by issues relating to child protection and probation matters (Maddock, 2015). Too often a blurring of professional roles and boundaries can negatively impact the division of work within mental health teams, particularly in the area of social work and addressing the housing needs of homeless people (Maddock, 2015; Thompson, 2015) leading to poor discharge planning (Mental Health Commission, 2010). This absence of an agreed discharge policy is a barrier for

positive mental health outcomes (Gonçalves-Bradley *et al.*, 2016; Lamann *et al.*, 2018). The National Homeless Discharge Guidelines were introduced to address such issues (Health Service Executive, 2016) with political will to implement now required (Tyler *et al.*, 2019).

Findings from this study suggest that assertive outreach mental health services are a positive means to incentivise proactive engagement of homeless people with appropriate health services. Such services can be delivered through existing mainstream community care or through the provision of targeted mental health outreach services that recognise the unique needs of homeless people (Canavan *et al.*, 2012). In-reach care provision for those in temporary accommodation prevents illness relapse and subsequent loss of tenancy (Irish Psychiatry, 2011) with outreach and shelter-based care being central to the delivery of mental health care for the homeless (Phillips and Parsell, 2012; Nazari and Raistrick, 2014; Pauly, 2014).

Front-line workers identified a training need for case management and further education in the Stepped Model and Trauma Informed Care approaches as trauma is often experienced by homeless people (Huckshorn and LeBel, 2013). Previous research identifies a need for enhanced educational supports and skills development with regards to crisis management (Dowds and McCluskey, 2011; Kelly *et al.*, 2011; WHO, 2013; Welsh *et al.*, 2016) and this is reinforced by a lack of out-of-hours mental health crisis teams (Henwood *et al.*, 2015; Maddock, 2015; Ceannt *et al.*, 2016). Front-line workers identified effective case management, coupled with agreed inter-agency protocols as central to supporting homeless people to positively engage with services (Maher and Allen, 2014). Further research is required to assess the specific health needs of homeless people within a person-centred model of care (Mills *et al.*, 2015; Hippl *et al.*, 2016).

Historically, Irish mental health services have been poorly resourced, which has had a negative effect on the care of homeless people and their limited capacity to engage with the necessary services (Partnership for Health Equality, 2015; Murphy *et al.*, 2017). However, targeted primary mental health services have demonstrated effectiveness in engaging homeless people within mainstream health care delivery locally and nationally (Keogh *et al.*, 2015; Partnership for Health Equality, 2015). A lack of supported accommodation hinders positive engagement with mental health services (National Disability Authority, 2013) resulting in delayed interventions (Partnership for Health Equality 2015).

Front-line workers identified a range of accommodation options required for homeless people, which include a women's emergency hostel (Simon Communities of Ireland, 2015), mental health day care centres with a specific focus on homelessness and the provision of high support residential units (Fazel *et al.*, 2014). They suggest that Irish homeless services are predominantly modelled on a 'male experi-

ence' which are unsuitable for women leading to further marginalisation, trauma and distress (Simon Communities of Ireland, 2015). Consequently, gender-sensitive strategies to incentivise homeless women to engage with services are required, whereby specific targeted interventions such as trauma informed care are offered (Machtlinger *et al.*, 2015) which respects the autonomy and dignity of women (Mayock and Bretherton, 2016).

Arguably, mental health facilities should be co-located and integrated within wider mainstream community services. Such targeted service provisions could include multi-disciplinary specialised primary care services with user-friendly referral routes, both to and from mainstream primary and secondary care (Irish Psychiatry, 2011; HSE, 2020). Self-explanatory information leaflets detailing treatment options, along with the development of a housing clinic and expanding mental health clinics are identified as potential resources for meeting the complex mental health needs of homeless people (Tam, 2010). Furthermore, a directory of mental health services with updated service lists are required (Health Service Executive 2010; Health Service Executive, 2011; Dowds and McCluskey, 2011; Health Service Executive, 2016).

Homeless people face great difficulty in securing medical cards which negatively impacts their engagement with both primary and secondary mental health services (Simon Communities of Ireland 2013; The Journal.ie, 2018). The following service provisions are required; designated primary care services, a more simplified medical care application process, the availability of a homeless services generic medical card (Canavan *et al.*, 2012; Simon Communities of Ireland, 2013; Bonevski *et al.*, 2014), and improved intra and inter-agency collaborative care protocols (Downey, 2011; Kaehne, 2015) to enhance the care of homeless people with mental health problems. This would require tailored staff training with agreed discharge policies, guided by the Stepped Model of Care (Simon Communities of Ireland, 2018) and Trauma Informed Care approaches. (Lambert *et al.*, 2017) In addition, hospital in-patient diagnostic coding is required to assist in monitoring incidents of homelessness and this would in turn reduce hospital costs, as protracted admissions and readmissions would be reduced. (Hwang *et al.*, 2011). To conclude, findings from this study suggest that the provision of bespoke tailored mental health services, improved inter-agency collaboration, tailored community services and the development of relevant staff educational programmes are required. Further research targeting dedicated service provision, policy and practice development is recommended to optimise recovery and quality of care for homeless people.

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