

Conference report

Homelessness, outreach and advocacy Current themes in North American community psychiatry

GRAHAM THORNICROFT, Psychiatric Registrar, The Maudsley Hospital, Denmark Hill, London SE5

With the process of closing psychiatric hospitals and establishing community-based alternatives more than 20 years old in the United States, psychiatric practice there is in the post-deinstitutionalisation age.¹ In Britain we are now starting on this same path. Against this background, I attended the annual conference convened by the journal *Hospital and Community Psychiatry* in October 1987. Held in Boston, in the same week that Major Koch of New York sanctioned the compulsory reinstitutionalisation of homeless mentally ill people from the streets of Manhattan, the conference emphasised four themes: homelessness, outreach programmes, systems of case management, and compulsory out-patient treatment.

In his keynote address, Dr G. Pollock, President of the American Psychiatric Association, gave an historical description of how the indigent have been treated within Western societies, a process largely characterised by segregation and exclusion. Indeed a main theme of the congress was the question of the homeless mentally ill.² Dr Stephen Goldfinger, from San Francisco General Hospital, proposed that although society is sensitive to homelessness, we are insensitive to homeless people. His experience leads him to believe that provisions for these people can only be effective when they are based upon the stated needs of the patients, and not upon an assumed norm set by psychiatric professionals. Dr Ezra Susser provides a psychiatric service to those in shelters for the homeless in New York City. Most of these patients have dual diagnoses being both psychotic and drug or alcohol dependent. He proposes that psychiatric staff adopt an advocacy role in acting on the patient's behalf to gain welfare entitlements, and in an educational role in teaching what he calls 'constructive sociopathy', or the skills necessary for the patients to act to establish such benefits on their own behalf.

Several practitioners presented work describing outreach services to the chronically mentally ill who are under-served by hospital-based facilities. Dr W. Breakey, Director of the Community Psychiatry Program at Johns Hopkins Hospital in Baltimore,

described these patients as those who are unresponsive to treatment, who make inappropriate use of services or who are 'system misfits' in not being served by traditional services. He referred to the work of Dr L. Stein and his associates in Madison, Wisconsin³ showing that the re-admission of chronic patients is primarily due to deficits of coping skills, so that life events easily provoke relapse. The Training in Community Living model at Madison show that such techniques are best taught not in hospital, but *in vivo* at home. Extending this theme, Dr T. Witheridge presented the work of the Thresholds Bridge Program in Chicago, which has provided outreach services to 350 members for the last 10 years. The treatment team takes those patients who are at highest risk of relapse, and have had frequent previous admissions, with poor treatment compliance. Patients are seen almost entirely at home, usually two or three times a week, and initial engagement is made gradually and with great care, often orientated around a concrete problem identified by the patient. Evaluation is conducted pragmatically, and interventions are made only if they can be justified as increasing the patient's quality of life, and reducing the risk of rehospitalisation. Staff, mainly psychologists and social workers, accompany patients to psychiatric consultations, and the programme acts as payee in managing the money of about half the patients seen. A team rather than individual case management system is used, both to provide continuity of care during staff absences, and to provoke frequent staff meetings, for an hour at the end of each day. One explicit function of these meetings is to give staff time away from direct patient contact, to reduce staff exhaustion.

Dr Annette Primm reported the work of COSTAR, a programme in Baltimore which she directs. Within a socially deprived catchment area of 75,000 in East Baltimore, this treatment team provides a home-based service for 93 chronically mentally ill patients. Those taken on by the team are 'treatment drop-outs' with poor medication compliance, frequent previous hospital stays, and misuse of psychiatric emergency

services. Two thirds of the patients have a diagnosis of schizophrenia. The staff-patients ratio is 1:10 and at each home visit staff make a mental state examination and often take in medications on a daily basis. If patients are reluctant to comply, assertive means are used to encourage medication use, for example the use of outings or food as a reward. Staff help most patients to open a bank account, with access by automated teller machines, and encourage the patient's family to regulate spending. There is an explicit policy of 'nursing the care giver' in providing support to family members.

The role of the case manager was a widely debated issue at the conference, and many variants were described varying from that of a 'broker' who liaises the various services received by the patient, often by telephone with little necessary patients contact, to the role of primary case worker, with frequent meetings relating to the treatment, material social and emotional needs of the patient.⁴ Repeatedly speakers emphasised the central co-ordinating role of the case manager in community-based services, especially for the chronically mentally ill. Ms M. Harris, co-director of Community Directions, an outreach service in Washington DC, described a programme in which each patient receives 2.5 hours of service contact on average per week, and is in touch with the treatment team on average of 15 times each month.⁵ The mean time spent in hospital by each patient during the last year is less than three days. Ms Harris and her colleagues studied the patterns of patient contacts and formulated five initial hypotheses. Each of these was rejected by their study findings. Contrary to their expectations, the outcome variables of rehospitalisation rate and duration of in-patient stay was not greater in those patients with more previous admissions. The young rather than the old patients took more staff time. Patients new to the system did not reduce their demand for services as expected. The assumption that it is easier to see patients at the treatment centre rather than at the patient's home was not borne out by the findings, and finally it was found to be a better investment of staff time to work directly with the patients' families and with their anxieties rather than with the patient alone. Further, the gender, experience and training of the case manager were not related to patient outcome. Ms Harris suggested that the characteristics of the patient and case manager should be matched carefully for a therapeutic effect, and that pathological combinations should be avoided: for example the over-responsible case-manager with the over-dependent patient.

A concern of the conference that bears directly upon a current issue in British psychiatric practice is the issue of compulsory out-patient treatment. Dr Paul Appelbaum, of Worcester, Massachusetts, gave an overview of the current legal provisions in the

United States. Six states now have statutes that explicitly permit such forms of mandatory treatment. Twenty states have no such codes, and in several states lawyers and psychiatrist have elaborated 'creative' *de facto* systems. The eligibility for such commitment in these different states is either the same as for in-patient commitment, that is dangerousness, or has been extended to include the probability of dangerousness. Procedurally, such an order must be made at a court hearing (as must all in-patient commitments in the United States), and there are differing approaches to whether the out-patient order should be separate from or consequent to in-patient treatment. The major hurdle encountered to date has been in the enforcement of such orders where the committed patient continues to refuse treatment. In practice, Dr Appelbaum reported that in many cases the patient's appearance in court is itself usually sufficient to ensure continuing treatment compliance.

Several states have employed 'extra-legal' methods to this effect. In Rhode Island, an *ad hoc* order binds the patient to out-patient follow-up, failing which admission is arranged automatically. In Wisconsin a lawyer intervenes to draw up a treatment contract which the patient signs, and in W. Massachusetts, a judge can find the patient 'incompetent' to consent to treatment, and so order treatment until competence is re-established. Dr Appelbaum set out the criticisms of compulsory community treatment. It can be seen as the extension of coercive control in the patient's area of privacy, and may degenerate into a probation system with infrequent and inadequate staff-patient contact. Medico-legal liability of staff for assessed patients who then commit assaults may encourage psychiatric practitioners to proceed directly to in-patient commitment, while the area of legal suits by such patients asserting their right to the least restrictive form of treatment is as yet largely untested.⁶ Dr J. Geller, from Worcester, extended the argument in interpreting such orders as committing both the patient to treatment and the psychiatrist to the continuing care of the patient. His experience of state laws in practice, however, is that his recommended treatment plan, if endorsed by the court, then committed him to a continuation of the specified drug and within a pre-established narrow dosage range. He reported that the forthcoming model statute of the American Psychiatric Association recommends coercion only for those patients deemed incompetent.

Dr Geller reported five cases of long-term psychotic patients with multiple hospitalisations, who had been compulsorily treated in Massachusetts, and who had avoided readmission during these periods.⁷ Despite this evidence, however, in his view such legal provisions are probably not necessary where the local psychiatric service adequately provide

continuity of care and assertive treatment by the care givers. Dr Goldfinger concurred with this view and proposed that where community services are adequately provided, legal provisions become redundant. There remains open, however, the fraught ethical question of 'false positives', or patients mistakenly deprived of their right to refuse treatment.

The echoes of this conference may augur future concerns for British psychiatry in the last decade of the 20th century: how to fund, staff, organise and integrate a comprehensive range of accommodation and community based services for the mentally ill, with a recognition of the continuing requirement for asylum, if not asylums, for the most disabled.

References

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