The Education of Psychiatry – Caring for Patients Experiencing Homelessness

Malia E. Haddock, MS, PMHNP-BC

Although trainees incidentally care for patients experiencing homelessness throughout residency and beyond, intentional didactic and clinical experiences with homelessness create unique opportunities to increase interest, confidence and ability among resident psychiatrists in the care of underserved patients.

It is well known that individuals with unstable housing have disproportionally high rates of severe psychiatric and substance use disorders compared to their housed counterparts. Indeed, untreated psychiatric and substance use disorders are cited as primary causes of homelessness, and once homeless, psychiatrically-symptomatic individuals face additional barriers to accessing psychiatric care. Common obstacles include lack of affordable or reliable transportation, variable access to telephone/internet, and systems barriers such as scheduled appointments and attendance policies. **However, intangible barriers such as provider discomfort with homelessness may further distance patients from psychiatric care.**

HPATHI

The Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI) is a validated 19-item instrument designed to **"assess medical students' and physicians' attitudes towards homeless persons and to measure their level of interest and confidence in their ability to deliver health-care services to the homeless population"** (Buck et al., 2005). The impetus for this inventory traces back to a 1985 publication on access to care among individuals with unstable housing. The report's author, Elvy, writes, "The disinclination of the homeless to seek care may be due in part to the ways in which many health-care workers respond to them. A less investigated but possibly equally important circumstance is the attitudes that health-care professionals have toward the homeless" (as cited in Buck et al., 2005, p. 2). More contemporaneous academic discussions also play a role in HPATHI's inception, particularly those involving the role of humanism and Social Determinants of Health curricula in undergraduate and graduate medical education (Buck et al., 2005).

Opportunities for Psychiatry

In "A Survey of American Psychiatric Residency Programs Concerning Education in Homelessness" McQuistion et al. found that while 60% of programs offered **optional** clinical and/or didactic experiences, only 11% of programs reported **mandatory** rotations in the care of patients experiencing homelessness. Lack of widespread mandatory

programming was attributed to several factors, most notably lack of attending psychiatrists with expertise in caring for patients experiencing homelessness; lack of funding and/or logistical support to create programming; and perceived lack of homelessness in suburban and rural areas (2004).
Given the prevalence of severe psychiatric illness and substance use disorder among individuals experiencing homelessness, psychiatry trainees have much to gain from intentional exposure and training in this area. Over time, measurable improvements in interest, confidence and ability among learners may result in more accessible and culturally attuned care for this population.

Why HPATHI in Medical Education?

- Acknowledges the impact of provider attitudes and behaviors on engagement with underserved patients
- Raises awareness among educators and learners of the unique needs of patients with unstable housing
- Establishes baseline data on attitudes, interest, confidence and ability in caring for patients experiencing homelessness
- Uncovers experience and knowledge gaps that can be specifically addressed through curriculum development
- Over time may lead to structural changes in both educational practice and care delivery to meet the needs of learners and underserved patients

References

Buck, D.S., Monteiro, F., Kneuper, S. *et al.* Design and validation of the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI). *BMC Med Educ* **5,** 2 (2005). https://doi.org/10.1186/1472-6920-5-2

McQuistion HL, Ranz JM, Gillig PM. A survey of American psychiatric residency programs concerning education in homelessness. Acad Psychiatry. 2004 Summer;28(2):116-21. doi: 10.1176/appi.ap.28.2.116. PMID: 15298863.

Acad Psychiatry (2014) 38:246–247
DOI 10.1007/s40596-014-0071-5

FEATURE: LETTER TO THE EDITOR

Street Psychiatry as a Community Rotation for Residents: The UNC Homeless Support Program

Sheryl B. Fleisch · Anne C. Kelly

Received: 27 August 2013 / Accepted: 24 February 2014 / Published online: 12 March 2014
© Academic Psychiatry 2014

To the editor:

Homelessness is a unique problem with serious public health concerns due to increased rates of mental health diagnoses, untreated medical comorbidities, and mortality rates that exceed that of the general population [1]. On a single night in January 2012, there were 633,782 homeless individuals in the USA based on the U.S. Department of Housing and Urban Development's yearly "point-in-time" count [2]. This yearly count also identified 13,602 persons experiencing homelessness in North Carolina [3].

Homeless persons experience mental illness at rates significantly higher than the general population with approximately one-third to one-half with serious mental illness and approximately two-thirds struggling with substance use disorders with numbers greater in chronic homelessness [4]. Homeless persons are also more likely to develop suicidal ideation and attempt suicide. In a large sample of homeless persons with mental illness, approximately two-thirds had suicidal ideation with one-half reporting history of suicide attempt [5]. Homeless individuals disproportionately utilize emergency services, visiting the emergency room four times more often than non-homeless individuals with longer emergency room stays and lower hospital admission rates [6]. During training, psychiatry residents are most likely to encounter homeless persons in emergency rooms or on inpatient units that are typically not equipped to evaluate and meet the complex needs of the homeless. Despite these inevitable clinical encounters and homeless persons representing a vulnerable and underserved population, only 60 % of residency programs have curricula, through didactics or clinical rotations, addressing homelessness, and only 11 % require it [7].

One model for meeting the health needs of homeless persons is street medicine, which delivers health care services in locations where unsheltered homeless individuals are found, whether it be a park bench, a street corner, or in the woods. Street medicine has existed as a field since the early 1990s [8, 9]. Few psychiatrists participate in "street work" despite the increasing availability of street medicine programs nationality, and the development of the Street Medicine Institute in 2005, an annual symposium to discuss best practices [10]. Psychiatrists generally serve as adjunct clinicians to existing street medicine programs. To our knowledge, there are no data on the number of psychiatrists who participate as adjunct faculty in street medicine programs, nor data on psychiatry-specific street outreach programs due to a dearth of literature on this topic. It is our opinion that there is an important role for psychiatrists in street medicine as homeless persons with severe mental illness, and particularly those with psychotic disorders, are often difficult to engage, but can, through psychiatric outreach and assertive engagement, be connected to social services and higher levels of care at rates similar to those without severe mental illness [11].

In 2012, as fellows at University of North Carolina (UNC) at Chapel Hill in psychosomatic medicine and community psychiatry, we developed and implemented the UNC Homeless Support Program (HSP), a psychiatry-specific street outreach program with the goal of honing our own assertive engagement techniques while developing a rotation for future UNC psychiatry residents. As a model for our program, we looked at Project HOPE (Homeless Outreach to Promote Empowerment), a city-funded mobile outreach initiative based in Jacksonville, FL lead by an attending psychiatrist [12] and a psychiatric street outreach program at Western Psychiatric Institute and Clinic developed by a resident [13]. We combined the interdisciplinary and educational features of

S. B. Fleisch (✉)
Department of Psychiatry, Vanderbilt University,
Nashville, TN, USA
e-mail: sheryl.b.fleisch@vanderbilt.edu

A. C. Kelly
Department of Psychiatry, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA

these models with street outreach approaches of earlier street medicine models [8, 9].

We partnered with the nonprofit Housing for New Hope's (HNH) Projects for Assistance in Transition from Homelessness (PATH) program and with the UNC Center for Excellence in Community Mental Health's Critical Time Intervention (CTI) team. CTI is a SAMHSA evidence-based practice model that focuses on decreasing homelessness among persons with severe mental illness through time-limited intensive case management [14]. Our goal was to rapidly connect street homeless persons with intensive case management services through CTI. In order to ensure the longevity of the program, we applied for and were granted designation as a North Carolina Area Health Education Center (AHEC) site. We designed the rotation for one second-year and one fourth-year psychiatry resident to fulfill their ACGME community psychiatry requirement. Residents complete the validated Attitudes Towards the Homeless Questionnaire [15] both before and after their rotation to measure if the experience has changed their view toward homeless individuals.

The current residents participate in the rotation every Thursday with a typical day beginning with the CTI multidisciplinary treatment team meeting. The team reviews individual treatment plans and events from the previous week. After the meeting, residents provide office-based psychiatric care. In the afternoon, they meet at the University United Methodist Church located in the heart of downtown Chapel Hill where the HNH office is located. They review the plan for the afternoon with the PATH outreach worker, which typically includes psychiatric care provided at the church office along with spending the last two hours of the day completing "street rounds." They carry backpacks with hygiene packs, socks, water bottles, snacks, and seasonal items such as winter hats. They walk to areas where homeless persons congregate and begin conversations with an offer to meet an immediate need through the supplies in their backpacks. Over multiple conversations, trust is developed which often results in an understanding of mental health and social needs and allows for facilitation of connection to community resources that can begin to rapidly target those needs to further maintain engagement.

Our goal has been to afford residents the training to navigate multiple public systems from the perspective of a person experiencing homelessness. Given the large percentage of homeless with mental illness and substance use disorders and the many barriers they face in accessing traditional health care and social services, it is important that as psychiatrists, we train our residents in alternative models of care. We believe that continued opportunities that bring residents outside of the hospital and into the lives of the individuals they serve, will assist them in better understanding the complex needs of such patients. We hope to spread the word about our efforts so that other training programs might consider adding street psychiatry to their curriculum. Psychiatry residents will encounter individuals who experience homelessness in almost all environments in which they train, and it is important to teach residents how to engage homeless persons in order to interrupt the cycle of homelessness.

Disclosure On behalf of all authors, the corresponding author states that there is no conflict of interest.

References

1. Baggett TP, Hwang SW, O'Connell JJ, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Intern Med. 2013;173:189–95.
2. U.S. Department of Housing and Urban Development. Press release 2012. Available at http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2012/HUDNo.12-191.
3. North Carolina Point-In-Time Count Data. Available at http://www.ncceh.org/PITdata/.
4. McQuistion HL, Finnerty M, Hirschowitz J, et al. Challenges for psychiatry in serving homeless people with psychiatric disorders. Psychiatr Serv. 2003;54:669–76.
5. Desai R, Liu-Mares W, Dausey D, et al. Suicidal ideation and suicide attempts in a sample of homeless people with mental illness. J Nerv Ment Dis. 2003;191:363–71.
6. Pearson DA, Bruggman AR, Haukoos JS. Out-of-hospital and emergency department utilization by adult homeless patients. Ann Emerg Med. 2007;50:646–52.
7. McQuistion HL, Ranz JM, Gillig PM. A survey of American psychiatric residency programs concerning education in homelessness. Acad Psychiatry. 2004;28:116–21.
8. Boston's Health Care for the Homeless Program. Available at http://www.bhchp.org/.
9. Operation Safety Net. Available at http://www.pmhs.org/operation-safety-net/.
10. Howe EC, Buck DS, Withers J. Delivering health care on the streets: challenges and opportunities for quality management. Qual Manag Health Care. 2009;18:239–46.
11. Lam JA, Rosenheck R. Street outreach for homeless persons with serious mental illness: is it effective? Med Care. 1999;37:894–907.
12. Christenson RC. Community psychiatry education through homeless outreach. Psychiatr Serv. 2004;55:942.
13. Fleisch SB, Sengupta S, Hafeman DM, et al. Personal accounts: bowling for socks: residents are reminded that giving is receiving. Psychiatr Serv. 2012;63:529–30.
14. Herman D, Conover S, Felix A, et al. Critical time intervention: an empirically supported model for preventing homelessness in high risk groups. J Prim Prev. 2007;28:295–312.
15. Lester HE, Pattison HM. Development and validation of the Attitudes Towards the Homeless Questionnaire. Med Educ. 2000;34:266–8.