DISCUSSION PIECE

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Ethical Arguments for Providing Access to Mental Health Care through Longitudinal Relationships

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Abstract

A focus on access to mental health care is critical for beneficent and just care of individuals experiencing homelessness. The delivery of this care is strengthened through building longitudinal relationships between clinicians and persons experiencing homelessness – relationships that are best understood, perhaps, through the lens of attachment theory. In this paper, we look at the prevalence of mental illness among individuals experiencing homelessness and the history of deinstitutionalization of the mentally ill. We then evaluate how three modern-day interventions – street medicine, community health clinics, and supportive housing programs – play integral roles in providing mental health care and constructing a trusting relationship. We conclude with a call for increased funding to support the expansion of these essential mental health care interventions, especially in the aftermath of COVID-19.

Keywords

Homelessness, homeless, mental health, mental health services, mental disorders, psychiatric disorders, public health, supportive housing, street medicine, community health clinics

Introduction

People living with homelessness are among society's most marginalized members. Among the many difficulties they face, mental illness is of serious concern. The global prevalence of mental disorders among individuals experiencing homelessness varies across geographic regions. A review found that most studies conducted in high-income countries reported high prevalence rates of depressive and anxiety disorders, schizophrenia spectrum and psychotic disorders, substance abuse disorders, suicidal behavior, bipolar and mood disorders, neurocognitive disorders, and other mental disorders (Hossain et

al., 2020). Another systematic review on the prevalence of neuropsychiatric disorders among persons experiencing homelessness found that among the various disorders, drug and alcohol dependence were the most common (Fazel et al., 2014). At baseline, many individuals who experience homelessness have a deep distrust of medical systems, due to past experiences, which makes consistent treatment all the more difficult (Kryda & Compton, 2009). Untreated mental illness compounds urban poverty by threatening employment, housing, and social support systems (Anakwenze & Zuberi, 2013).

The COVID-19 pandemic has exacerbated the precarious living of the most vulnerable. Individuals facing homelessness often live in congregate settings that thwart effective quarantine (Tsai & Wilson, 2020). Maintaining good hygiene can be challenging, especially when public restrooms in urban cities are forced to shut down, limiting basic handwashing access. In response, many global governments have increased funding for various interventions, such as temporary housing in hotels and motels (Parsell et al., 2020). The Government of Canada spent \$157.5 million (Canadian Dollars) on Canada's Homelessness Strategy (Government of Canada, 2020). The United States dedicated \$4 billion (United States Dollars) to coronavirus relief efforts among persons experiencing homelessness (U.S. Department of Housing and Urban Development, 2020). A more targeted response includes England's £3.2 million (British Pound Sterling) initiative directed towards temporary housing assistance (Ministry of Housing, Communities & Local Government, 2020). These global efforts exemplify how critical protection and assistance are for the most vulnerable.

The building of trusting, longitudinal relationships between caregivers and the undomiciled is vital to ensuring that persons with mental illness can access essential care, but this can be difficult to achieve. Many individuals experiencing homelessness distrust outreach workers and lack confidence in available services for numerous reasons, including beliefs that outreach workers are largely motivated by paychecks or that they deliver empty promises (Kryda & Compton, 2009). When interviewed, many respondents experiencing homelessness felt that short-term solutions advertised by outreach workers, such as access to shelters, were unsafe, and there was a lack of sufficient, consistent options for long-term solutions (Kryda & Compton, 2009). A paucity of outreach efforts has been described across the United States and Europe (Klop et al., 2018; Kryda & Compton, 2009).

Not only does the goal of long-term clinical relationships demonstrate the ethical principle of beneficence—that is, of doing good on behalf of this marginalized population—but it also shows a commitment to justice. When put into practice, the principle of justice seeks to make right what

is wrong and making mental health care a reality for individuals experiencing homelessness exemplifies justice.

Integral to our discussion of the relationship between clinician and the undomiciled is the idea of Attachment Theory. British psychologist, John Bowlby, developed the original theory, which was later expanded by Mary Ainsworth's empirical research (Bretherton, 1992). He defined it as a psychological connectedness between human beings, as commonly observed among children and their primary caregivers (Bowlby, 1969). The behavioral attachment system is an innate protective system that is activated when an individual feeling threatened seeks the closeness of a caregiver in order to reestablish emotional security (Bowlby, 1969).

Attachment theory crystallized into three major attachment styles: anxious attachment, avoidant attachment, secure attachment (Pietromonaco et al., 2013). First, individuals with an anxious attachment style are in a state of heightened distress when they are separated from their attachment figure and seek proximity and reassurance to mitigate the effects of isolation. Second, persons with an avoidant attachment style disengage with threats and become overly self-reliant (Pietromonaco et al., 2013). Finally, secure attachment style depicts a combination of low anxiety and low avoidance where an individual feels comfortable with closeness and trusts that a partner will be responsive when in a threatening situation (Pietromonaco et al., 2013). These three attachment styles can form a base for explaining how the relationship between care seeker and caregiver varies greatly depending on individual levels of anxious and avoidant behavior – both common in persons experiencing homelessness. It is also important to note the myriad of poor health outcomes that can be exacerbated when a person's attachment system is hyperactive or deactivated (Pietromonaco et al., 2013).

It thus behooves clinicians to develop trusting relationships—to strengthen attachments in healthy ways—with persons experiencing homelessness by providing nurture through consistent care. This fosters a sense of security among persons experiencing homelessness and increases the likelihood that their clinical concerns are addressed (Tsai et al., 2019). In order for services to have a chance at

succeeding, this patient-centered, trusting relationship must be at the core of all approaches.

History of Deinstitutionalization

Mental illness treatment in the United States has taken many shapes. Since the expansion of asylums throughout the 19th century until the 1960s, most chronically mentally ill patients lived in state hospitals (Lamb, 1984). Negative and unjust depictions of understaffed, abusive psychiatric hospitals motivated the patient rights movements of the 1960s to fight for the closure of these institutions and to release mentally ill patients back to their families and communities. This movement was rooted in the argument that mental hospitals were inhumane, costly, and the rise of new antipsychotic drugs offered more effective treatments (Yohanna, 2013). Deinstitutionalization became the norm by the 1980s (National Academies of Sciences, Engineering, and Medicine, 2018). State hospitals significantly reduced the number of beds from 535,000 in 1960 to 137,000 in 1980 (National Academies of Sciences, Engineering, and Medicine, 2018).

The goals of the deinstitutionalization movement in the United States fell short, however. Many chronic mentally ill patients were displaced to the streets or locked up in prison due to a lack of robust community rehabilitative alternatives (Lamb & Weinberger, 2005). Additionally, on the heels of the 1980 recession, the US Department of Housing and Urban Development (HUD) budget was severely cut, resulting in reduced public assistance (Jones, 2015). This, in turn, led to a massive housing problem for those facing unemployment and those with mental illness (Lamb, 1984). This significant change in mental illness treatment explains the current situation: individuals experiencing chronic homelessness who would benefit from intensive treatment instead receive ad hoc care through community services.

In what follows, we explore possibilities for exercising beneficence and justice by building longitudinal relationships through present-day methods, including street medicine, community health clinics, and supportive housing programs.

Street Medicine Improves Access to Mental Health Care

The undomiciled carry a heavy burden of medical and psychiatric illnesses and use acute health care services, such as the emergency department, at high rates (Kushel et al., 2002; Martinez & Burt, 2006). Seeking primary care in the emergency department may be due to the high prevalence of substance use disorders and mental illness, in addition to reduced access to primary and preventive care services (Kushel et al., 2002). Without effective treatment, patients experiencing both homelessness and mental health challenges will be at risk for further mental deterioration. Research suggests that untreated mental illness leads to increased morbidity and mortality risk within the general population due to neglected medical conditions (Fagiolini & Goracci, 2009). As noted in a Swedish study, because risk factors for chronic mental and medical illnesses are higher among individuals experiencing homelessness than the general population, the undomiciled experience a lower health-related quality of life (Sun et al., 2012).

One solution to address this issue and foster longitudinal relationships is through the implementation of street medicine. Street medicine is defined as providing direct health care in settings acceptable to individuals who experience homelessness, such as under bridges or on park benches (Feldman et al., 2020; Withers, 2011). Dr. Jim Withers, one of the pioneers of street medicine in the 1990s, and Founder of the Street Medicine Institute, suggest that although street medicine is less than ideal, it must be considered an essential service until housing is available for the undomiciled (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). Street medicine acts proactively, saves on health care spending, and breaks down barriers to health care by providing patients with preventive care, including mental health care, thereby thwarting the reliance on emergency departments (SAMHSA, 2019). In Seattle, mental health street practitioners see the building of long-term, trusting relationships as a critical goal (Howe et al., 2009). Additionally, Boston Health Care for the Homeless Program built longitudinal relationships by following a cohort of individuals experiencing homelessness over ten years from streets to the hospital to

housing and established primary and preventive care programs (O'Connell et al., 2010). Ongoing relationships enable undomiciled patients to regain trust in the medical establishment and receive mental health care.

COVID-19 brought another barrier to clinicians providing care on the streets as many urban centers locked down and mandated strict stay-at-home orders. Clinicians providing health care through street medicine programs did not shy away, but rather took to the streets in solidarity with the most vulnerable. Withers released a statement in March 2020 advocating for continued care despite pandemic risks. In reflecting on a similar situation during the HIV epidemic, when fear of treating patients was prevalent throughout the medical community, he states:

What a sacred privilege to be there for those whom others were rejecting. Yes, there was a risk, but this is what I had prepared myself for all my life. To be able to help others in times of crisis – especially those whom others forget – is the soul of healthcare (Street Medicine Institute, 2020).

This devotion to a long-term person-centered approach by Withers and others for persons experiencing homelessness strengthens attachments. While mindful of public health protocols, ongoing care helps individuals experiencing homelessness feel remembered and cared for, especially during times of crisis.

Community Health Clinics Improve Access to Mental Health Care

Perhaps the most basic source of mental health care for individuals facing homelessness is provided by community clinics. The best clinics are staffed by dedicated clinicians who recognize the complex needs of the undomiciled and treat physical and psychiatric ailments. An organization called Care for the Homeless, for example, has been providing essential medical, mental health, and behavioral health care in 26 clinics across New York City for 35 years (Care for the Homeless, n.d.). Care for the Homeless and similar institutions use an outreach-based approach that embeds clinical services in shelters, soup kitchens, and drop-in centers. This design allows clinicians and staff to forge strong attachments with patients experiencing

homelessness who regularly seek their services. Unfortunately, the COVID-19 pandemic resulted in the closure of many of these clinics and halted access to these vital services (Liu & Hwang, 2021).

Empirical data shows that through outreach community efforts and orientation to clinics, the undomiciled experience improved access and retention in primary and mental health care compared to individuals who are unaware of these services (O'Toole et al., 2015). Additional evidence suggests that tailored care through community health clinic interventions, with emphasis on location, immediate services, and integration of mental health and substance abuse services, greatly improves a patient's own perceptions of the care they are receiving (Chrystal et al., 2015).

Although clinics have the potential to provide long-standing partnerships between clinicians and individuals experiencing homelessness, the potential for burnout among health professionals is strong. Psychologist Herbert Freudenberger, who coined the term "burnout" in the 1970s while working in free health clinics, draws a connection between practitioners who feel the need to help marginalized patients and the burnout they experience (Freudenberger, 1974). In order to foster healthy, longitudinal relationships, there also needs to be greater resources invested in support clinicians' mental health (Brabson et al., 2020).

Supportive Housing Improves Access to Mental Health Care

Some groups serving persons experiencing homelessness go beyond street interventions and clinical care to provide housing. Debate surrounds the question of which intervention should come first – housing or treatment. The discussion of housing as a fundamental human right brings about a "Housing First" model, pioneered by Dr. Sam Tsemberis in New York City and has had global influence, most notably throughout Europe. This model provides individuals experiencing homelessness and mental health or addiction disorders with immediate access to permanent supportive housing on a voluntary basis (Tsemberis et al., 2004). It is important to note that how long an individual remains without housing plays a

significant role in long-term recurrent homelessness. Critical Time Intervention (CTI) is a time-limited intervention that provides support to individuals experiencing homelessness during transitional times, such as upon discharge from shelters or prison (de Vet et al., 2017). This practice focuses on a continuum of care during critical periods—precisely what is required for favorable outcomes.

In New York City, for example, the Center for Urban Community Services (CUCS) has a three-pronged approach to reducing street homelessness: housing, mental health, and medical services (Center for Urban Community Services [CUCS], 2019). Their housing programs are based on a supportive housing model that provides individuals with transitional housing, psychiatric care, counselling, support, and access to social workers, psychiatrists, and nurses. By embedding services of care in the physical housing units of patients experiencing homelessness with mental illness, practitioners are able to see and provide treatment to patients on a consistent basis, thereby forging stronger attachments. As a result, patients experiencing homelessness are able to form trusting relationships with their practitioners (Kerman et al., 2019).

Evidence shows that greater funding for this style of supportive housing decreases overall healthcare costs. A five-year randomized controlled trial performed by the Corporation for Supportive Housing (CSH) evaluated whether a supportive housing model of embedding psychiatric and other long-term services within a housing complex would significantly decrease healthcare costs (Corporation for Supportive Housing, 2017). The results suggested that the supportive housing model improved healthcare for individuals experiencing homelessness who had been highly utilizing emergency room care by increasing their access to care. The supportive housing model resulted in a decrease in the overall cost of healthcare, most notably in emergency care and hospitalizations.

According to the recovery model, a focus on services, like supportive housing mentioned above, helps to address immediate needs and informs treatment decisions for people with mental illness (Warner, 2010). Through the building of strong relationships between caregivers in the supportive housing model and

individuals experiencing homelessness, caregivers are able to offer tools for self-empowerment and thereby equipping individuals on their road to recovery (Warner, 2010).

The idea of combining consistent mental and physical health care with housing is comprehensive and ideally would reach every person living with homelessness (Withers, 2011). However, due to funding limitations, such interventions reach a slim minority. In 2019, CUCS could provide their programming only to about 400 individuals (CUCS, 2019). An increase in funding for supportive housing could substantially improve the mental health of many undomiciled people.

Conclusion

As demonstrated above, a variety of models increase support of the undomiciled leading to improved mental health. Most important, perhaps, is the establishment over time of trusting relationships between individuals experiencing homelessness and their clinicians (Kryda & Compton, 2009). The forging of such relationships—the strengthening of attachments—is undergirded by the ethical principles of beneficence and justice. Those who care for individuals facing homelessness, including health professionals, can work toward the good of the marginalized and seek to counter injustices.

The coronavirus pandemic has created new challenges that will affect individuals facing and fighting homelessness for years to come. Unemployment, increased illicit drug use, and mental illness rose significantly in 2020. As a result, we should expect to see a surge of undomiciled individuals in need of good mental health care. Rather than curbing spending for these services, the efforts outlined above require ongoing financial support and the injection of additional resources to facilitate their expansion.

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