Homelessness in 2009
Outline

• Overview
  – Homelessness, mental illness and trauma

• Trauma and PTSD among Homeless Adults in Sydney
  – Challenges of treatment implications

• Overcoming Practical Challenges
  – Policy changes and a new model of intervention

• Overcoming Clinical Challenges
  – Working with this client group
Overview

Homelessness, mental illness and trauma
Homelessness

- Inadequate access to safe and secure housing
- Living below a minimum standard
- Levels
  - Primary
  - Secondary
  - Tertiary
- 105,000 in Australia
Mental Illness

• High prevalence established but figures vary
  – Differences in definitions and sampling
• “Down and Out in Sydney”
Hodder, Teesson and Buhrich (1998)
  – Assessed schizophrenia, substance use, mood and anxiety ($N = 210$)
  – Found 75% met criteria for at least one mental disorder in previous 12 months
  – This compares to 18% in the Australian general population
Role of Trauma

• Goodman, Saxe and Harvey (1991)
  – Homelessness itself is traumatic and it precipitates or exacerbates post-traumatic symptoms and mental disorders

• Hodder, Teesson and Buhrich (1998)
  – Trauma experience precipitates or exacerbates mental disorders in people who are homeless
Trauma and PTSD among Homeless Adults in Sydney

Kathryn Taylor and Louise Sharpe
The University of Sydney
Study: Trauma and PTSD

• Aims
  – Investigate trauma and PTSD
  – Explore the role of cognitions in PTSD

• References
Background

- Incidence of trauma
  - Australia: 93% at least one trauma (Buhrich, Hodder & Teesson, 2000)
    - General population: 57% (Rosenman, 2002)

- Prevalence of PTSD (adults)
  - US: 18% of 600 men & 34% of 300 women lifetime diagnosis (North & Smith, 1992)
    - General population: 0.9% male; 3.1% female
  - Australia: Unknown
    - General population: 1.5% (Rosenman, 2002)
Method and Sample Demographics

- 56 homeless adults
- 8 homeless services
- Structured clinical interview (90 min)
  - Composite International Diagnostic Interview (WHO, 1997)
- Sample
  - 71% male
  - 18 - 73 years, average age 39
  - Average age first homeless 26
  - 82% first homeless because they had to leave family or friends
Trauma Experience

- 98.2% at least one lifetime trauma
- 92.8% more than one lifetime trauma
- 6 traumas on average
- 12 years mean age of first trauma
- 71.4% trauma at less than 16 years
PTSD Co-morbidity

- Psychosis
- Depression
- Anxiety
- Stress
- Gambling
- Alcohol Use
- Drug Use

The diagram shows the percentage of co-morbidity for various conditions related to PTSD.
PTSD Onset

- 70.5% onset preceded or coincided with the first homeless episode
  - 59.1% onset before age first homeless
  - 11.4% onset at age first homeless

- Mean onset 5 years before first homeless
  - SD 14; range 33 before to 41 years after
• Current PTSD group scored significantly higher on:
  – Impact of Event Scale Revised
    • Intrusion, avoidance, and hyper-arousal
  – Post-traumatic Cognitions Inventory
    • Negative thoughts about the self and world
  – Young’s Schema Questionnaire
    • Disconnection and rejection
    • Impaired autonomy and performance
    • Overvigilance and inhibition
Mediatational Model

Control: trauma and mental health care

Mediator
Post-traumatic Cognitions

Control: trauma and mental health care

Independent Variable
Early Maladaptive Schemas

Dependent Variable
PTSD Symptom Severity
Conclusions and Implications

• High rates of trauma and PTSD
  – When working with homeless people obtain a trauma history and assess for PTSD

• PTSD typically precedes homelessness
  – When working with a person who has a complicated trauma history and PTSD be aware of the risk of homelessness
Conclusions and Implications

• Importance of cognitions and schemas in the development and maintenance of PTSD
  – Support for cognitive models of PTSD
    • Ehlers and Clark (2000); Foa and Rothbaum (1998)
  – Cognitive therapy and exposure therapy

• Prevalence of schemas that centre on the world being entirely dangerous and the self being totally inept
  – Address in cognitive restructuring
Challenges of Treatment Implications

- **Practical**
  - Treatment is not readily available
  - Clients have multiple needs

- **Clinical**
  - Cognitive therapy challenging for therapist
  - Contraindications for exposure therapy
  - Multiple traumas and co-morbidity
    - Substance misuse and depression
Overcoming Practical Challenges
Policy changes and a new model of intervention
White Paper

• The Road Home: A National Approach toReducingHomelessness
  December 2008
The Road Home

• Goals
  – Halve overall homelessness by 2020
  – Offer supported accommodation to all rough sleepers who need it by 2020

• $7.3 billion over 5 years provided by the National Affordable Housing Agreement
The Road Home

• Three strategies
  – Turning off the tap
  – Improving and expanding services
  – Breaking the cycle

• Initiatives
  – No exits into homelessness
  – No wrong doors
  – Wrap-around services
The Michael Project

• In 2007 Mission Australia was selected by a private benefactor to enter into a significant three year collaboration to deliver a range of initiatives for men who are homeless in greater metropolitan Sydney

• Aim
  – To improve the social inclusion of homeless men through enhanced, timely and integrated service delivery
The Michael Project

- Objectives
  - To improve the health and wellbeing, social participation and economic participation of homeless men
  - To improve access to stable, secure and long term accommodation for homeless men
  - To articulate and implement a new model of support for homeless men
  - To provide an evidence base for policy and programme development in the delivery of services to homeless men
The Michael Project – New Service Model

- Supported Accommodation
- Assistance Program

- + Intensive Case Management
- + Specialist Service
- + Specialist Service
- + Specialist Service

Mission Australia | TRANSFORM
The Michael Project – New Service Model

• Run in seven existing services across Sydney
• Case workers provide intensive case management
• Eleven specialist service providers:
  – Psychologist, alcohol and other drugs counsellor
  – Outreach nurse, dentist, podiatrist, barber
  – Occupational therapist, recreational officer
  – Numeracy, literacy, and computer literacy tutors
  – Aboriginal and Torres Straight Islander outreach worker
The Michael Project – Key Features

• Focus on outcomes beyond accommodation
• Facilitated access to a range of support services otherwise not available or accessible
• Homeless sector delivers services
• Services are mobile and delivered in-house
• Suite of services provided across Sydney metro
  – Not site specific
• Case manager facilitates continuity and consistency
The Michael Project – Principles

- Individualised
- Integrated
- Intense
- Appropriate
- Timely
- Direct
- Continuous
The Michael Project – Rationale

• Homeless people often have:
  – Poorer health, education, family relationships

• Homeless men often struggle to follow through on referrals

• Current homeless services limit the continuum of care
  – There is limited access to a diversity of services
  – Not all services are available when needed
  – Service delivery is often discrete (not integrated)
  – Long waiting lists
Michael Project Research Study

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Overcoming Clinical Challenges

Working with this client group
Cognitive Therapy and Exposure

• Engagement and psycho-education

• Cognitive restructuring

• Imaginal and in vivo exposure
  – Contra-indications for exposure
    • Ongoing trauma or threat
    • Current suicidal ideation, self-harming behaviour
    • Actively psychotic
    • Extreme dissociation
Multiple Traumas

• Modified approach to exposure

• Discuss the various traumas with the client
  – Create a list of traumas
  – Ask the client to monitor their re-experiencing symptoms for several weeks
  – Assess the frequency and intensity of their re-experiencing symptoms
Multiple Traumas

• Create a hierarchy with the client
  – Discuss the client’s subjective perception of the “worst trauma”
    • Don’t rely on an objective appraisal
    • The “worst trauma” tends to be a trauma with a personal meaning
  – Consider the content of the re-experiencing symptoms
  – Structure the hierarchy based on SUDS ratings
Multiple Traumas

• Work on the hierarchy
  – Begin with the worst and work down the list
    • Exceptions (depression, poor distress tolerance)
  – May not need exposure for each trauma
    • Due to generalisation

• During imaginal exposure another trauma may intrude
  – Normalise
  – Focus on original trauma
Co-morbid Depression

• Treat primary disorder or the disorder that causes significant interference then re-assess

• Screen for suicidal ideation and self-harm
  – Consider exposure when suicidal ideation subsides

• Antidepressant medication (SSRIs)
Co-morbid Depression

• Prior to exposure identify and challenge core cognitions around perceived helplessness

• During imaginal exposure identify “hot cognitions” that may contribute to depressed mood, negative self-view, or unhelpful interpretations of trauma

• Following exposure watch carefully for rumination
Useful References


Acknowledgements

Mission Australia

Murdoch University

NDARC

St Vincent de Paul Society

NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE

TRAUMATIC STRESS CLINIC

SAAP