

**PREVENTING HOMELESSNESS
AMONG PERSONS
DIAGNOSED WITH SCHIZOPHRENIA
(by introducing alternatives at first break)**

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Adversity predates first episode of psychosis(FEP)

- Parental Loss/Separation
- Parental Death
- Mental Illness among a parent
- Childhood abuse (physical, sexual)
- Poverty
- Migration
- Residential instability
- Foster care
- Other violence

Premorbid adversities

1. May have etiological significance
2. May influence timing and appearance of first episode
3. Definite impact on course and outcome
4. Comorbidities (e.g. substance abuse)
5. Social outcomes (lack of familial support, homelessness, institutionalization)

Treatment/Interventions

- Can intervene, modify or correct premorbid adversities

BUT INSTEAD

Often aggravates/reinforces them by fostering

1. Stigmatization
2. Medication side effects
3. Trauma/retraumatization
4. Institutional dependency
5. Family disruption
6. Social isolation/ghettoization

Alternative interventions

- Promote early recovery
- Engage family support
- Reinforce self-determination/treatment choices
- Sustain/reinforce community ties
- Turn disaster into opportunity
- Salutogenic
- Teach skills (including social & vocational)

What is homelessness?

Federal definition:

- an individual who lacks a fixed, regular, and adequate nighttime residence; and
- an individual who has a primary nighttime residence that is —
- - a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
- an institution that provides a temporary residence for individuals intended to be institutionalized; or
- a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings

United States Code Title 42, Chapter 119, Subchapter I

My definition:

**Not living in a parental home
(before age 18)**

**Or not living in a home of one's
choosing**

Why talk about schizophrenia?

“The paradigm shift from schizophrenia as a disease entity to a paradigm of domains of schizophrenia pathologies is now becoming widely accepted and influential.”

William Carpenter Jr.

Schizophrenia: disease, syndrome, or dimensions?

Family Process. 2007 Jun;46(2):199-206.

Antecedents of homelessness/institutionalization

- Parental loss more common among long-term institutionalized patients (Stastny et al. 1984)

We also found that:

Family burden remains high in spite of l/t institutionalization

Family perception of patient behavior explains most of the variance between l/t in- and outpatients (Perlick, Stastny et al., 1992)

Antecedents of homelessness/institutionalization II

Childhood antecedents of homelessness:

Foster care history (15% vs. 2% in never homeless)

Group home placement (10% vs. 1%)

History of running away (20% vs. 5%)

(Susser et al. 1991)

Adverse childhood experiences:

“Lack of care and EITHER physical or sexual abuse”
predicts adult homelessness (Herman et al. 1997)

Antecedents of homelessness/institutionalization III

Men:

More African-Americans & Hispanics (66/54% vs. 23%)

35% of never homeless & 22% of homeless lived with both parents until age 18!

“schizophrenic men who came from families with high levels of disorganization characterized by lack of nurturing constancy, residential instability, economic inadequacy, dependence on public assistance, family violence, mental illness, substance abuse and criminality in a parent were more likely to be in the homeless group.”

(Caton et al. 1994)

Antecedents of homelessness/institutionalization IV

Women:

Poor family support is a risk factor for the persistence of homelessness.

The effect of substance abuse may be to decrease family support which in turn leads to homelessness (Caton 1995a)

Homelessness precedes first hospitalization

- 15% of pts newly diagnosed with psychosis had history of early course homelessness (5 x higher the US gen. pop. Risk)
- 2/3 (10% of total) of those experienced homelessness BEFORE 1st hospitalization
- high negative symptom scores correlated with antecedent homelessness

SUFFOLK COUNTY MENTAL HEALTH
PROJECT (Herman et al. 1998)

Revisiting parental loss, separation and subsequent psychosis

- Having a parent with diagnosis of Sz predicts psychosis, hospitalization and “psychological dysfunction” among offspring. (Erlenmeyer-Kimling, 1991)
- effect of loss due to permanent separation was more striking than loss due to death, as was loss before the age of 9 years compared to later childhood and adolescence AND
- significantly increased rate of EPL was observed in schizophrenia patients particularly before the age of 9 years (Agid et al. 1999).

Revisiting parental loss, separation and subsequent psychosis II

- “unemployment and early separation from both parents distinguish African-Caribbeans diagnosed with schizophrenia from their counterparts of other ethnic groups as well as their normal peers” (Mallet et al. 2002)
- Hazard ratios increased with an increasing number of adverse social factors present (rented apartments, low socioeconomic status, single-parent households, unemployment, and households receiving social welfare benefits). Those with four measures of adversity had a 2.7-fold higher risk of schizophrenia than those with none. (Wicks et al. 2005)
- Separation from, and death of parent before age 16 were both strongly associated with a two- threefold increased risk of psychosis. Separation was more common in Black Carribeans. (Morgan et al. 2007)

Other familial antecedents

- Unwanted children (in Finland) had more than double the incidence of schizophrenia (Myhrman, 1996)
- Increased incidence of sz in families where husband died during pregnancy (Huttunen & Niskanen, 1978),
- Also if grandparent died within two years of birth (Walsh, 1978; Teixeira, 1997).

Revisiting parental loss, separation and subsequent psychosis III

THE MOST COMMON FORM OF ADVERSE CHILDHOOD EVENTS AMONG ADULTS WITH SZ SPECTRUM DISORDER (Rosenberg et al. 2007)

1. CHILD PHYSICAL ABUSE
2. WITNESSING DOMESTIC VIOLENCE
3. FOSTER OR KINSHIP CARE
4. PARENTAL SEPARATION OR DIVORCE
5. CHILD SEXUAL ABUSE
6. PARENTAL MENTAL ILLNESS
7. PARENTAL DEATH

IMPLICATIONS OF THIS STUDY (Rosenberg et al):

1. most clients with diagnoses of sz in public mental health system are likely to have been exposed to serious adverse events in childhood leading to worse health, mental health and functional outcomes.
2. Adverse childhood events are associated with elevated rates of comorbid conditions, eg. Drug & alcohol abuse and PTSD
3. Comorbid disorders have deleterious consequences on course of illness
4. **TAILORED INTERVENTIONS MAY BE NECESSARY**

Trauma preceding psychosis (Read, 2005)

- Female inpatients 64% suffered either CSA or CPS (15 studies)
- Male patients 59% suffered either CSA or CPA

What has happened with families in 150 years of psychiatry?

- Moral treatment (ca. 1 year break)
- Asylum takes over (1860-1960)
- Studying/blaming/treating families (1960-)
- Psychoeducation (1980-)
- Specialized family interventions (MFG, OD, Needs Adapted Treatment)

Where do we stand vis-à-vis families and psychosis today?

“Family systems data ranging from general measures, such as **disruption**, to more specific measures, such as **communication deviancy**, or aspects of **expressed emotion**, will be tested for interaction with a more informative genetic platform” (Carpenter, WT Family Process, 46(2), 2007)

What happens to families at the FEP?

Closure (ca. 30% of cases; Scott & Ashworth, 1967)

Definition:

1. Total severance of the relationship between patient and family at onset of illness.
2. One parent is involved more than the other.
3. The involved parent has experienced “through insanity, death or violent discord a separation from an emotionally significant relative”.
4. Parent has a firm conviction that the patient will never recover.

Transactional modes (Stierlin, 1974)

- Binding (id-ego-superego levels)
- Delegating (“mission impossible”)
- Expelling (neglect)

Extremes of these modes can lead to serious problems.

Stierlin does not account for the origins of these extremes.

He does emphasize the role of psychiatry and its institutions.

3 Responses to “Network Crisis” (Beels, 1981)

- deny that it happened and substitute paranoid or fantastical explanation
- retreat into a state of withdrawal where nothing social is happening at all
- ACCEPT THE SAME DEFINITIONS OF THE SITUATION AS FAMILY AND OTHERS HAVE, AND BEGIN TO COMPOSE AN APPROACH TO IT= shared insight!

Incidence of hospitalization in first episode psychosis

- Australia: 77% hospitalized in first 3 months (57% once; 20% more than once) Wade et al. Austr NZ J of Psychiatry 40:429-36, 2006
- UK: 80% hospitalized immediately (Castle et al. Br J Psychiatry 165: 101-106, 1994)
- US data lacking!

Outcome of first episode psychosis: Treatment as usual

- Sweden: At 5-year follow-up, 73 % of the patients in the schizophrenia syndromes group versus 47% of the non-schizophrenia group had a sick pension or were on long-term sick leave. (Svedberg, Mesterton & Cullberg, 2001)
- Holland: Half the patients (52.0%) showed symptomatic remission and a quarter (26.4%) functional remission, while one-fifth (19.2%) met both criteria sets and were considered recovered.(Wunderink et al. 2009)
- USA: After 5 years, 47.2% of the subjects achieved symptom remission, and 25.5% had adequate social functioning for 2 years or more. Only 13.7% of subjects met full recovery criteria for 2 years or longer. (Robinson et al. 2004)

Risks of TAU

- 1. RISKS OF HOSPITALIZATION
 - Separation from family/closure
 - (Re)traumatization
 - Stigma
 - Discontinuity of care
 - Homelessness
- 2. RISKS OF MEDICALIZATION
 - Premature diagnosis
 - Instant neuroleptics for everyone (includes 30-40% who would have recovered without)
 - Short-and long-term side effects
 - Chronification
- 3. RISKS OF CONVENTIONAL FAMILY WORK
 - Perpetuates separation “Sick role”
 - Interferes with dialogue
 - Does not add resources to already overstressed family



**CHANGING COURSE AND
OUTCOME THROUGH
DIFFERENT TYPES OF
ENGAGEMENT/FAMILY
INVOLVEMENT AT ONSET**

PREVENTING THE SECOND EPISODE (Alvarez-Jimenez, et al. 2009)

- Specialized FEP Programs reduce relapse rates & hospital days (2/5yrs?)
- Multimodal relapse prevention therapy (indiv. & fam.) 7 mo. Additional benefits
- Family interventions (2 studies) no effect on relapse prevention

Ingredients for FEP Interventions (based on data about antecedents)

- **Rapid response (within 24 hours)**
- **Designated team with continuous availability**
- **Home-based interventions**
- **Opening a dialogue**
- **Shared decision making**
- **Coercion/hospitalization to be avoided**
- **Trauma-informed**
- **Flexible approach to medication (no immediate use of neuroleptics)**
- **Informed by Needs-adapted approach (Alanen, 1991)**
- **Response to individual needs (educational, social, psychological)**
- **Peer expertise**
- **Safe, communal residence should be available (respite homes or Soteria)**

Need-adapted Treatment (Alanen, 1991)

- Therapeutic activities are planned and carried out flexibly and individually so that they meet the real, changing needs of the patient and of the people making up their personal networks.
- Examination & treatment are dominated by a psychotherapeutic attitude
- Different therapeutic activities should support and not impair each other
- Process quality of therapy is clearly perceived.

Parachute Project - Key Features

- Intervention without delay, preferably in the patient's home
- Initial structuring crisis intervention
- Immediate and recurrent family meetings together with the patient.
- Accessibility to a stable specialized treatment team for up to 5 years.
- Lowest optimal doses of neuroleptic medication with an attempt to avoid neuroleptic medication during the first 1-2 weeks. (Benzodiazepines used instead for anxiety and insomnia.) When psychotic symptoms did not abate or were perceived as painful by the patient, an initial daily dose of 0.5-1mg of haloperidol-equivalents was recommended.
- Access to small-scale, homelike, low-stimulus overnight care in the community when the care that can be offered in the patient's home proves insufficient or negative.

Parachute Project - Outcomes

- Symptomatic and functional outcome was significantly better compared with the Historical group and equal with the Prospective group. During the first year, the direct costs for in- and out-patient care per patient in the Parachute project were less than half of those in the Prospective group.
- A total of 175 patients (69%) were followed up through the first year of treatment. Global Assessment of Functioning (GAF) values were significantly higher than in the historical comparison group but similar to the prospective group. Psychiatric in-patient care was lower as was prescription of neuroleptic medication. Satisfaction with care was generally high in the Parachute group. Access to a small overnight crisis home was associated with higher GAF.

Principles of Open Dialogues (Seikkula 1991)

- Immediate help
- Social network perspective
- Flexibility & mobility
- Responsibility
- Psychological continuity
- Tolerance of uncertainty
- Dialogism

Open Dialogue-Outcomes

- In a nonrandomized, 2-year follow up of first-episode schizophrenia,
- hospitalization decreased to approximately 19 days;
- neuroleptic medication was needed in 35% of cases;
- 82% had no, or only mild, psychotic symptoms remaining;
- and only 23% were on disability allowance. (Seikkula & Olson, 2003)

Soteria-Outcomes

- 3 controlled trials involving a total of 223 participants diagnosed with first- or second-episode schizophrenia spectrum disorders.
- Soteria paradigm yields equal, and in certain specific areas, better results in the treatment of people diagnosed with first- or second-episode schizophrenia spectrum disorders (achieving this with considerably lower use of medication) when compared with conventional, medication-based approaches. (Calton et al. 2008)

Remaining issues

- Applicability of these models to more disadvantaged populations
- Short & long-term housing instability
- Unemployment/poverty
- Cultural incompatibility
- Selective assignment or logical flow
- Peer input
- Funding