



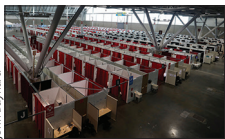
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Disaster psychiatry and homelessness: creating a mental health COVID-19 response



John Baynard

Homeless individuals across the globe live in a constant state of crisis. Yet, during times of societal crisis that affect all populations, disaster planning has rarely included this high-risk group.¹ The high burden of co-occurring physical, mental, and substance use disorders, absence of reliable shelter, scant access to health information, and scarcity of financial, transportation, and nutritional resources all create unique vulnerabilities for this population.^{2,3} These factors restrict the ability of people experiencing homelessness to respond and adapt to public health recommendations before and during a disaster.⁴ In particular, the mental health needs of people who are homeless during disasters have received minimal attention.⁵

Evidence from universal shelter screening programmes indicates that COVID-19 has been widespread in the homeless population.⁶ Recommendations for how to remain safe during COVID-19, such as staying at home or physical distancing, can be impossible to follow when homeless and living in a crowded shelter. As a result, nearly all homeless individuals who test positive need an alternative place to reside and receive care. In response, many cities have constructed field hospitals to temporarily house and treat those who cannot otherwise self-isolate.

In April, 2020, we created and implemented a mental health disaster response at the Boston Hope Field Hospital (Boston, MA, USA)—a 1000-bed facility for patients testing positive for COVID-19. Of the available beds, 500 were set aside for homeless

patients. The paucity of published work on how to address mental health challenges and support the homeless population during disasters created the need to design a new system of care in an evidence-free area of health-care delivery. Our goal was to develop a mental health disaster response that treated psychiatric exacerbations, created a therapeutic social environment with regular groups and daily activities, and prevented undesirable outcomes such as overdoses and suicide attempts. In designing this response, we sought to apply the principles of psychological first aid (PFA), the standard-of-care framework for disaster psychiatry, to our homeless population (panel; appendix pp 1–3). PFA emphasises both emotional and practical support for survivors while taking a non-pathologising stance and allowing people to recover at their own pace.^{7,8}

We provided two social workers and one psychiatrist on site every day for crisis management, consultations with medical teams, individual assessments, group facilitation, and telehealth coordination. The triaging method for determining who received individual visits took into consideration requests from the primary medical team, universal screening of all patients for existing mental health treatment or substance use, standardised withdrawal assessments, and use of the Brøset violence checklist to identify patients at risk for agitation.⁹ Over a 6-week period, our clinicians collectively provided 153 consultations on 60 patients (comprising 19% of the total homeless population treated at the facility). The average number of

Published Online
August 4, 2020
[https://doi.org/10.1016/S2215-0366\(20\)30343-6](https://doi.org/10.1016/S2215-0366(20)30343-6)

See Online for appendix

Panel: Implementation of a mental health COVID-19 disaster response using a Psychological First Aid framework

Contact and engagement

- Standardised welcome packets
- Screening for existing mental health providers
- Immediate introduction of treatment team
- Application of Brøset violence checklist

Safety and comfort

- Private rooms and female-only areas
- Locked cabinets for belongings
- National Guard and police presence for security
- Addiction-informed and trauma-informed culturally diverse workforce

Stabilisation

- Individual consultations for acute needs
- Systemic sleep hygiene efforts
- Outside space for fresh-air breaks
- Display of patients' encouraging messages

Information gathering

- Expert consultants on safety of the milieu
- Patients' input on quality improvement
- Peer specialists during education groups
- Interviews with medical teams

Practical assistance

- Landline access and donated mobile telephones
- Internet café and tablet access
- Newspapers and books
- Housing and clothing resources

Connection with social supports

- Recovery, walking, and dance groups
- Bingo, karaoke, and movie nights
- Positive reinforcement for group attendance
- Connection to providers through telehealth

Coping information

- Coping skills and meditation groups
- Yoga, aromatherapy, and expressive groups
- Stress balls
- Interfaith and spirituality resources

Linkage with collaborative services

- New community providers and therapists through telehealth
- Harm reduction services and sober houses
- Office-based addictions treatment
- Government agencies and shelter services

encounters per patient was two, provided by either psychiatrists or social workers. The clinical indication for these encounters was most commonly anxiety, followed by depression, post-traumatic stress disorder,

and psychosis. No overdoses or suicide attempts were reported throughout the 6-week period.

Our experience setting up a mental health disaster response has yielded several valuable lessons. First, although PFA is often applied on the individual level for interactions with survivors, these same principles can be applied at the systems level to organise a population-wide response for homeless individuals in a disaster setting. Second, mental health providers who have experience working in acute settings can support community medical teams through their experience in trauma-informed care, supportive psychotherapy, and crisis de-escalation. Third, these interventions can be implemented quickly and without needing large staffing, financial, or administrative burdens, particularly when telehealth is used to capitalise on existing outpatient relations with mental health professionals. Fourth, although systematic assessment of this mental health disaster response was not feasible under these emergency circumstances, we received many anecdotes from patients and medical teams who reported benefiting from the presence of mental health providers. Finally, this approach can address many of the traditional barriers that homeless individuals face during times of disaster by providing shelter, treatment of physical, mental, and substance use disorders, access to health information, and connection with case management and other valuable practical resources.

Disaster psychiatry must expand to include planning that creatively cares for vulnerable individuals in need. To our knowledge, this report is the first to describe a formalised mental health response for homeless individuals during a disaster situation. Though our mental health disaster response was applied in a field hospital setting, these same principles can be used as a framework to design interventions for homeless individuals during times of crises in many contexts including inpatient settings, shelters, jails, and prisons. Taken together, this approach may transform the challenges of disasters into a unique opportunity for engagement by providing high-quality mental health care.

We declare no competing interests. We thank our colleagues who have supported us in establishing the mental health programme at Boston Hope, and the staff and patients with whom we had the privilege of working.

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If not now, when? COVID-19, lived experience, and a moment for real change



Wilson Udjiningshah

In a Position Paper published in *The Lancet Psychiatry*, Carmen Moreno and colleagues¹ recommended bolder language and framing with respect to the meaningful involvement of service users in mental health planning, policy, and research in the wake of COVID-19. It is always gratifying to hear enthusiasm for goals the user and survivor research movement has long fought for. We were similarly gratified to read an Editorial in *The Lancet Psychiatry* arguing for pressure from service users to more actively shift societal discourse.² And yet, as welcome as these statements are, we worry that the primary problem we are all up against is not a paucity of articulated support for service-user involvement but rather the gap between rhetoric and reality.

Our collective experience suggests that both before, and now many months into, the COVID-19 pandemic, meaningful service-user involvement remains unevenly implemented in some places, and non-existent in others. In some regions, involvement could be reduced from pre-COVID-19 levels, whereas in others, attestations to the importance of inclusion might have long been unaccompanied by concrete action. The same sentiment—anger and frustration about decades of inaction—has also been at the forefront of the Extinction Rebellion, March for our Lives, and Black Lives Matter movements. At a specific point, one feels the need to say “enough talk”. And if there was ever a moment when we, as a field, might take deeper stock of where we really want to head, it is arguably now. Involvement efforts are too often accompanied by empty promises, insufficient funding or commitment, and superficial gestures (eg, membership on advisory

boards), with no real power to set agendas, influence decision making, or bring about structural change.^{3–5}

Concretely then, what actions might be taken at this pivotal cultural moment? As activists across multiple under-represented social groups have long argued, leadership roles and power over decision making are fundamental.^{4,5} From a systems perspective, this situation means addressing barriers specific to both academic training and advancement and research funding. Beginning with addressing barriers in academia, explicit proactive support for students and investigators with lived experience must be provided across the training pipeline, from undergraduate studies through to independence as mid-career investigators. Ideally, such support would be pursued with the primary goal of supporting junior scholars to ultimately obtain their own grants as primary investigators, particularly in fields in which extramural funding is *sine qua non* for promotion and advancement.^{6,7} In supporting such trajectories, senior researchers must take care to ensure that service-user trainees and researchers, when included in studies and grants, are not there primarily to check a box or shore-up involvement plans, but to substantively shape research activities and, above all, advance their own careers and research agendas. Attention to diversity within this pipeline is also important, certainly of race, ethnicity, gender, sexual orientation, and class, but also with respect to level of disability and intersectional experiences of homelessness, incarceration, discrimination, addiction, and poverty.⁸

Research funders, in turn, must implement safeguards against discrimination, communicate and enforce robust

Published Online
August 18, 2020
[https://doi.org/10.1016/S2215-0366\(20\)30374-6](https://doi.org/10.1016/S2215-0366(20)30374-6)