Mindful
Continuing Education

Behavioral Health Services for Homeless Populations

Introduction

More than half a million people experience homelessness on any given night in the United States, and the COVID-19 pandemic has made the issue even more visible. Behavioral health professionals often encounter people who are homeless and those facing the immediate threat of homelessness, and their problems are often complex. It is important for such professionals to understand their roles and responsibilities when working with homeless populations and to be familiar with best treatment practices and continuing care strategies.

Section 1: Types of Homelessness and Risk Factors

The 2020 Annual Homeless Assessment Report conducted by HUD estimated there were 580,466 homeless persons in the United States. 70% were homeless individuals (6% of this number are individual homeless youth under the age of 25), and 30% were families with at least one adult and one child. HUD also reports that over half of those who are homeless have a mental health disorder or a co-occurring mental health and substance abuse disorder.

What is Homelessness?

The McKinney-Vento Homeless Assistance Act defines a homeless person as "(1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is-(A) 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); (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."

There are three categories of homelessness:

1. Transitional: People experience this type of homelessness as a temporary situation. This could be a few weeks to a few months, but it is less than a year. It includes those who are leaving jail, prison, or rehab.

2. Episodic: People experiencing this type of homelessness are frequently moving between homelessness and having housing. When they can find housing, it is often unstable, leading to repeated homelessness status.

3. Chronic: People experiencing chronic homelessness have been homeless for over a year or have experienced homelessness four times in the past three years for a combined total of at least one year of homelessness during that time. Those experiencing homelessness in this category are more likely to struggle with a mental health diagnosis and/or substance abuse disorder.

Sheltered vs. Unsheltered Homelessness

Homeless programs offer shelter to 61% of the homeless population, but who is eligible to access these services may vary depending on who the community has deemed most in need. Many communities focus on shelter for children and families who are more vulnerable. Approximately 51% of homeless individual adults are living unsheltered (abandoned homes, parks, subway stations or trains, etc.). If we look at the chronically homeless, this number jumps to 66%! This sub-population also has the highest needs (mental health, substance abuse, cognitive impairment, and physical health conditions). Since 2015 unsheltered homelessness has been on the rise while other homelessness has all continued to decline (National Alliance to End Homelessness, 2021).

Couch surfing or doubling up is considered sheltered living; these numbers are harder to count and are often not included in official homeless counts. Couch surfing is an unstable housing option, as often the relationships with the host are precarious, leaving the person at risk for more unsafe homeless situations to occur.

What are the risk factors for homelessness?

- **Poverty:** In the United States in 2019, 10.5% of the population was living in poverty. Many more individuals and families live paycheck to paycheck and even a minor financial crisis could lead to an economic emergency and the inability to make their monthly housing payment (U.S. Census, 2020).

- **High Housing Costs:** 6.3 Million people experience a severe housing cost burden meaning that 50% or more of their income goes toward housing (National Alliance to End Homelessness, 2021).

- **Mental Health Diagnosis:** There is a clear but complicated link between behavioral health disorders and homelessness. Those who are homeless frequently have a history of poverty, social disadvantage, lower levels of education, and adverse childhood experiences. Homelessness can trigger mental and physical health issues, leading to increased psychiatric distress and lower recovery rates.

  A person's mental illness may cause cognitive and behavioral difficulties, making it difficult to have a stable income or participate in activities of daily living, which all support the ability to have stable housing.

  Studies vary on what percentage of homeless people also have a mental health disorder, with an average number being 75%. The most frequently seen diagnoses reported are Schizophrenia, Bipolar Disorder, Major Depression, Generalized Anxiety, and Personality Disorder (Gutwinski et al., 2021).

- **Substance Use Disorder:** Approximately ⅓ of those experiencing homelessness also have a substance use disorder. The psychiatric distress that some experience with homelessness can increase the use of alcohol and other substances (Gutwinski et al., 2021).

- **Low Income:** Many people become homeless because they do not have enough money to pay for housing. This could be due to a lack of education, gaps in work history, criminal record, transportation challenges, health issues, disability, and lack of child care. Depending on where the person lives and the cost of housing, even having a minimum wage job will not cover living expenses (National Alliance to End Homelessness, 2021).

- **Domestic Violence:** Victims of domestic violence often have the difficult choice of staying with the abuser or becoming homeless. Women are frequently led to believe they have few options but to continue with the relationship in order to have some safety and protection, even if the relationship is abusive. Women experiencing homelessness are more likely to be victims of violence and abuse. They are also more likely to have experienced childhood trauma, which leads to decreased resilience and increased vulnerability to violence and homelessness. Victims of domestic violence often have limited financial resources, education, and support systems. In addition, the shame they may carry about their situation, distrust of law enforcement and social service agencies may prevent them from accessing resources (Reid et al., 2021).

- **Traumatic Experience Early in Life:** Traumatic events contribute to poor mental health, substance use, and other health conditions, and when these factors are combined, it makes it difficult to maintain stable housing. Lack of stability then triggers decreased mental wellness and a potential increase in substance use, creating a downward spiral. Those who experience chronic homelessness are more likely to have experienced childhood trauma and neglect. This is also a contributing factor to distrust of service providers (Woodhall-Melnik, 2018).

- **Racial Equality**: Service providers need to have an understanding of the role of race and racism, and an awareness of racially-based policies that have denied housing to people of color. Interventions need to be culturally sensitive and help bring affordable housing to all (National Alliance to End Homelessness, 2021).

Sub-Population Considerations

- **Veterans:** Veteran homelessness has decreased by 39% since 2007 due to specific programs to help this subpopulation. The Department of Veteran Affairs has a homeless program to support Veterans in keeping or finding housing and addressing the issues impacting their ability to maintain housing. Research shows veterans have a higher rate of substance use and co-occurring disorders than other homeless populations. One subgroup within the veteran homeless population with increasing numbers are female homeless veterans. They have different needs and risk factors to consider that were not seen with their male counterparts. While Post-Traumatic Stress Disorder is experienced by both male and female veterans, Military Sexual Trauma is seen at a higher rate in female veterans. It needs to be acknowledged as a contributing factor to their mental health, substance use, and homelessness (National Alliance to End Homelessness, 2021).

- **Homeless Families:** Families make up 30% of the homeless population. Most homeless families are sheltered and quickly transitioning them into stable housing should be a priority to decrease the risks of traumatic experiences (National Alliance to End Homelessness, 2021).

- **Rural Homelessness:** It is difficult to have an accurate number of those who are homeless in rural areas as they are typically less visible. There are fewer shelters in rural areas, and often people experiencing homelessness live in cars or campers, making outreach and engagement challenging. Rural areas typically

have fewer resources, so even when individuals are identified as homeless there may not be many services to assist them, including fewer job opportunities (SAMHSA, 2021).

- **Youth:** 50% of youth who are homeless are unsheltered. Family conflict is the main reason for youth homelessness. Other contributing factors include poverty, housing insecurity, racial disparities, poor mental health, and substance use disorders. Youth who have had involvement with the child welfare and juvenile justice systems are more likely to become homeless. Youth experiencing homelessness are often involved in risky sexual behaviors and are susceptible to commercial sexual exploitation (National Alliance to End Homelessness, 2021).

What are the needs of behavioral health clients who are homeless?

Needs and best practices should focus on the population and risk factors. For example, those who are chronically homeless may need more physical and mental health needs addressed. Additionally, homeless youth may need socio-emotional development and family relationships addressed. It is very important to complete a comprehensive intake to identify and address risk factors for homelessness and to help reduce recidivism and relapse.

Section 1 Summary

Homelessness is defined as a situation where someone lacks a permanent and adequate place to live. The primary causes of homelessness are poverty and lack of affordable housing. Many additional risk factors impact a person's likelihood of becoming homeless, including domestic violence situations, substance abuse disorder, mental illness, cognitive impairments, low income, and high cost of housing. The different population sub-groups that experience homelessness all have varied risk factors and needs that impact the services they may require to get back on their feet (ex. veterans, homeless families, youth, rural vs. urban homeless persons). Interventions should include a comprehensive intake to assess needs and risk factors and the completion of an individualized plan to reduce relapse.

Section 1 Key Concepts

- It is estimated that in 2020 just over half a million people were homeless in the United States on any given night.
- The base reasons behind homelessness are poverty and lack of affordable housing. This is a simplified view, as there are many contributing factors to homelessness.
- Homelessness can be transitional, episodic, or chronic.
- Risk factors for homelessness include poverty/low income, high housing cost/lack of affordable housing, mental health disorders, substance abuse disorders, cognitive impairment, and domestic violence.
- Different homeless sub-groups have varied risk factors and needs. Ex. Veterans, Families, Youth, Rural homeless all may lack regular nightly shelter, but for different reasons, and therefore, the interventions are going to be different in finding them shelter and offering services to reduce future homelessness.
- Sheltered homeless individuals have somewhere designated to sleep at night (shelter, friends couch, camper). Unsheltered homeless are those spending the night somewhere that would not be considered safe accommodations (barns, parks, subway stations).

Section 1 Key Terms

Homelessness: not having fixed, regular, and adequate shelter.

Transitional Homelessness: temporary situation lasting a few weeks or months, but less than a year.

Episodic Homelessness: frequent moving between homelessness and housing; housing is often unstable, leading to the repeated homelessness situation.

Chronic Homelessness: a person has been homeless for over one year or homeless four times in the past three years, for a total of at least twelve months.

Mental Illness/Mental Health Disorder: A mental health condition that affects mood, thinking, and behavior and affects one's ability to function.

Substance Use Disorder: Excessive use of psychoactive drugs, such as alcohol, pain medications, or illegal drugs which can lead to physical, social, or emotional harm.

Domestic Violence: a pattern of behavior used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic, or psychological actions or threats that influence another person.

Veteran: a former member of the Armed Forces of the United States who served on active duty and was discharged under conditions other than dishonorable.

Doubled-Up: Individuals are considered living doubled up based on their relationship to the head of household and this includes: an adult child (18 years old or older) who is not in school, is married, and/or has children; a sibling; a parent or parent-in-law; an adult grandchild who is not in school; a grandchild who is a member of a subfamily; a son- or daughter-in-law; another relative; or any non-relative (National Alliance to End Homelessness, 2021).

Couch Surfing: moving from home to home, usually with friends or acquaintances, but having no stable long-term address.

Section 1 Personal Reflection Question

What homeless population group is most prevalent in your community and what additional risk factors does this group experience?

Section 2: Clinical Interventions

Simply helping meet the basic needs of shelter has proven ineffective for homeless individuals. To fully address homelessness, all aspects that impact it, directly or indirectly, need to be addressed.

Best Practices: Full Holistic Evaluation

According to the National Alliance to End Homelessness, a full holistic evaluation includes the following:

- **Community Coordinated System:** The community has assessed their homeless population needs and available resources and services. Communities should have

goals and data collection means across community service providers so that accurate and consistent data can be collected, reviewed, and modified as needed (National Alliance to End Homelessness, 2021).

- **Coordinated Intake:** This includes assessing needs and referring to appropriate services to meet those needs. Once an assessment has been completed, goals can be created with the client to address specific needs, reducing the likelihood of relapse.
    - **The first step is to make sure there is no imminent danger to self or others. Any suicidal or homicidal ideations should be addressed immediately to keep all involved safe.**
    - **Physical Health:** Do they have a primary care physician or need a referral to one? Are they up to date with care for dental, vision, women's health? Do they have any diagnosed diseases or health conditions? Are there health and wellness skills they would benefit from learning?
    - **Mental Health History:** Do they have any history of mental health conditions? What supports were helpful in the past? Are they struggling with mental health concerns currently? Do they have a mental health provider or do they need a referral?
        - Immediate access to housing AND support from a mental health team has been shown to decrease inpatient days, increase stable housing, and improve recovery for homeless individuals with schizophrenia or bipolar disorder (Tinland et al., 2020).
    - **Substance Use History:** Do they have a history of substance use or are they currently using any substances? What are the persons' beliefs around this use? What is their openness to seeking treatment? Providers should also be aware people experiencing homelessness are at a higher risk for overdose.
    - **Victimization:** Have they been a victim of domestic violence or a crime? If so, are they still in danger? Did they experience any victimization while they have been homeless or leading up to becoming homeless? Create a safety plan if necessary.

    - **Legal Involvement:** Are there any legal issues? Does the person need legal advice? Are individuals exiting jail or prison and are there any restrictions on where they can live?

- **Financial Needs:** What are the imminent financial needs? Are individuals eligible for social assistance and benefits? Do they need assistance finding employment or filing for unemployment benefits?
- **Housing Needs:** What are their housing needs? Do they need supportive services to maintain stable housing? Are they capable of living independently?

Types of Housing

- **Emergency Shelter:** This is usually the first point of entry for many people experiencing homelessness or an economic crisis. This type of housing may be a shelter or a subsidized hotel stay, depending on the community resources and the individual or family's needs (SAMHSA, 2021).
- **Transitional Housing:** This short-term housing, usually up to 24 months, offers support and services to help individuals stabilize and get back on their feet (SAMHSA, 2021).
- **Permanent Supportive Housing:** Permanent supportive housing is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment, and employment services (SAMHSA, 2021).
- **Recovery Housing**: For those recovering from alcohol or substance use, these housing settings are drug & alcohol free, require participants to stay sober, and mandate participation at minimum in Narcotics Anonymous or Alcoholics Anonymous. There are different levels of supervision, from peer-run to more restrictive supervision (SAMHSA, 2021).
- **Rapid Re-Housing:** Rapid re-housing helps people move from emergency shelter to permanent housing as quickly as possible. It provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self-sufficiency, and stay housed. It is offered without preconditions (employment, income, absence of a criminal record, or sobriety). The resources

and services provided are tailored to the person's needs (National Alliance to End Homelessness, 2021).

- The longer a person is homeless, the more challenging and expensive it is to house that individual. This makes rapid rehousing cost-effective. It also helps eliminate potential chronic homelessness. Only 10 percent of families exiting the Department of Housing and Urban Development's Rapid Re-housing for Homeless Families Demonstration sites returned to homelessness (SAMSHA, 2021).

Continuing Care Strategies

Addressing all the risk factors one person may be facing can seem overwhelming. Client retention requires the development of short-term, realistic treatment and prevention goals. Goals should be set collaboratively with clients to include specific milestones within a defined time period and rewards to increase retention.

Trauma-focused group therapy has been shown to empower victims of domestic violence, improve coping strategies, reduce PTSD symptoms, and decrease future risk taking behavior. Trauma informed care is now being seen as a positive approach for treating people experiencing homelessness (Reid et al., 2021).

Trauma-informed care is defined by its emphasis on understanding trauma and its role in all aspects of service delivery and receipt, and by its prioritization of individuals' sense of safety, choice, and control. The main principles guiding trauma-informed practices, which distinguish trauma-informed interventions from usual services, include the following: building awareness of trauma, establishing safety and trustworthiness, offering choice and open communication, and an emphasis on strengths-based and skill-building approaches (Reid et al., 2021).

Other Strategies to Prevent Homelessness

- Programs that help stabilize households by providing food support, such as food stamps and free school breakfast and lunch.
- Programs seeking to increase the supply of affordable housing in America, such as the Housing Trust Fund.

- Benefits advocacy, which helps people find public and entitlement benefits such as Social Security Disability Insurance (SSDI), veterans' benefits, food stamps, child care assistance, Medicaid, and low-income energy assistance.
- Discharge planning for people released from institutional care (ex., hospitals, psychiatric care, substance abuse treatment centers, foster care, military service, jail, prison).
- Case management focused on determining clients' needs for housing assistance, helping them find and get housing, and securing other resources needed to maintain housing stability. Such resources include health insurance, childcare services, medical treatment, psychological services, food, clothing (SAMHSA, 2021)

Section 2 Summary

Best practices for interventions include a community coordinated approach. There should be an integrated and comprehensive intake that assesses needs and sets client driven goals. Trauma informed care and interventions with strengths-based and skill building approaches have positive results with many homeless populations. Helping a person experiencing homelessness to quickly transition from temporary emergency housing to stable, permanent housing is the most cost-effective strategy for the community and the most successful at reducing future episodes of homelessness for the person.

Section 2 Key Concepts

- A community coordinated system is where the community has assessed their homeless population's needs and identified how the community resources and services can meet those needs.
- A coordinated comprehensive intake looks at the person experiencing homelessness as a whole, assessing all needs, and referring to the appropriate service providers to meet those needs.
- Intakes should assess physical health, mental health, substance use, legal involvement, and financial needs.

- Trauma informed care is seen as a positive approach for supporting people experiencing homelessness.
- There are different types of housing responses to homelessness: emergency shelter, transitional, permanent supportive, recovery, and rapid re-housing.
- Other strategies to prevent homelessness include: increasing affordable housing, benefits advocacy, wraparound discharge planning, and case management.

Section 2 Key Terms

Community Coordinated System: community established system to assess needs of the homeless population, identify community resources and services, enable centralized data collection for service providers, and provide a plan to review and modify as necessary to meet homeless needs (National Alliance to End Homelessness, 2021).

Coordinated Intake: assessing homeless persons needs and referring to appropriate services to meet those needs; individuals will receive the same intake procedure at any community agency they present to (National Alliance to End Homelessness, 2021).

Trauma Informed Care: understanding trauma and its impact on a person's sense of safety, choice, and control, including how services are delivered and received (Reid et al., 2021).

Emergency Shelter: the first point of entry for many people, this is often a shelter or subsidized hotel stay.

Transitional Housing: short term housing to stabilize a person to then transition to living independently.

Permanent Supportive Housing: housing assistance with voluntary support services.

Recovery Housing: for those recovering from substance use disorder; typically requires sobriety and participation in mental health and/or substance use treatment.

Rapid Re-Housing: helping people obtain permanent housing quickly,and partnering with services to increase self-sufficiently and stay housed long term.

Section 2 Personal Reflection Question

How does the assessment of needs impact what type of housing the person experiencing homelessness might need?

Section 3: Challenges Professionals May Face

There are many possible challenges professionals may face while providing services to people experiencing homelessness. While it is often demanding to work with individuals facing homelessness, just as often the challenges may arise from other service providers or agency red tape.

Barriers to treating behavioral health clients who are homeless

- **Transportation:** Many homeless persons may lack transportation and live in an area with limited or unreliable public transportation options. Should public transit be available, they may not have the funds to pay the fare. This leads to difficulties attending mental health appointments, doctor's appointments, and picking up prescriptions (Balasuriya et al., 2020).
- **Cost of Appointments:** Even small co-pays or fees for services may be prohibitive to accessing care and homeless individuals may not be aware of eligibility through Medicaid or the Affordable Care Act (Balasuriya et al., 2020).
- **Communication:** Although some homeless persons may have access to a cell phone, there is often a high turnover in phones and phone numbers, making it difficult for service providers and healthcare professionals to stay in touch. For those with limited access to electricity, keeping the phone charged can also be a challenge (Balasuriya et al., 2020).
- **Language Barriers:** Such barriers may cause a challenge to accessing services, especially in communities with limited resources or lacking interpretive services (Balasuriya et al., 2020).
- **Stigma & Vulnerability:** Homeless people with mental illness are highly vulnerable to violence, with a reported lifetime incidence of 74% to 87% of violence being perpetrated against them. Psychiatric care may include prescribed

medications that affect alertness and place them in danger for increased risk of victimization and violence (Balasuriya et al., 2020).

- **Legal Issues:** Having a history with the legal system may create barriers with parole and limit where a person may receive treatment or housing placement (SAMHSA, 2021).
- **Companion Animals:** Many shelters, emergency housing, permanent supportive housing, and even rehousing programs do not allow pets. When individuals are forced to make the difficult choice between having shelter or keeping their pets, they often choose unsheltered options so they can stay with their companions (National Alliance to End Homelessness, 2021).
- **COVID-19:** Since there was not a homeless census completed in 2021, the most recent homeless data is from January 2020, right before the start of the pandemic. Additionally, a national homeless count may not be available until 2022 or 2023. It is unclear at this time the impact COVID-19 and the resulting consequences from the high rates of unemployment and the subsequent recession have had on the homeless. There is growing concern that impending widespread evictions will eliminate the progress that has been made in reducing homelessness (National Alliance to End Homelessness, 2021).

Safety considerations to treating behavioral health clients who are homeless

It is imperative that interactions with homeless clients are safe and respectful. There are universal safety precautions and risk assessments that workers should be taking with all clients. This will help maintain service providers' safety, but it also reduces the chance of stereotyping any group of people over another. Anyone could become agitated and angry under psychological duress, no matter gender, race, or economic status. The following safety considerations are from the National Association of Social Work Guidelines for Social Worker Safety in the Workplace (NASW, 2013).

Office Space Safety

- Accessible exits from rooms should a violent incident arise
- Alarm system to alert others to unsafe situations

- Open meeting space when meeting with a potentially aggressive client
- Restrict access to objects that could be used as weapons
- Secure entry and access to office areas

Field Visit Risk Assessment

- Assessment of environmental factors
    - Does the worker have a complete and exact address to avoid appearing lost or confused?
    - Does the neighborhood pose risks for violence?
    - Is the visit scheduled at a time of day that is riskier than other times?
    - Does the area have reduced reception for mobile devices?
    - Will identification of the social worker's agency increase risk?
- Assessment of client's living space
    - Are exits easily accessible?
    - Who is likely to be in the client's home during the visit? (family members or friends-are any of them known to engage in criminal activity, pets-including guard dogs)
    - Is there an increased risk of disease, infection, or pests in the home environment?
    - Is the family known to have weapons?
- Assessment of proposed work activities
    - Will the social worker engage in high-risk activities during the visit (for example, notifying of reduction in benefits, helping a domestic violence victim transition to a safe house, delivering other potentially unwelcome information)?
- Assessment of increased risk due to client's condition
    - Does the client have an active substance abuse problem?

    - Does the client have a mental illness, particularly if untreated?
    - Does the client have a history of or frequent violence or threatening behavior?
    - Does the client have an infectious disease?
- Assessment of worker vulnerability
    - Visible physical conditions that may increase vulnerability (pregnancy, disabilities, use of cane or walking aid)
    - Appearing timid, vulnerable, lost, or confused
    - Lack of experience, lax attitude, or overconfidence
    - Worker bias or stereotyping that causes overreaction or underreaction to safety threats
    - Attire (wearing jewelry and other valuables, high-heeled shoes) that adds to vulnerability
    - Accessories (political buttons, religious jewelry) that may trigger reactions
- Assessment of the condition of emergency equipment
    - Vehicle in good repair and working condition
    - Mobile device fully charged
    - Emergency telephone numbers are available

Homelessness is a complex public health issue

Contributors to homelessness occur at an individual, family, community, and public policy level. This is one of the key reasons it is challenging to address and remedy the issue as there is no one solution. Approaches to addressing and ending homelessness should vary based on population and contributing factors (Giano, Zachary et al., 2020).

Section 3 Summary

Challenges service providers may encounter when serving homeless individuals include barriers to treatment and safety considerations. Hindrances to treatment may include lack of transportation, cost of appointments, communication, language barriers, stigma and vulnerability, legal issues, and the existence of companion animals. COVID-19 has added additional complications and stretched resources. Safety considerations should be taken both in the office and in the field. While office space safety may be more on the employer to provide, in field safety assessments lay heavily on the individual service providers. Field visit safety considerations should include environmental factors, client living space, client's condition, worker vulnerability, and the working condition of emergency equipment.

Section 3 Key Concepts

- Challenges professionals may face when providing services to behavioral health clients who are homeless may include personality challenges from the individual client but also may come from other service providers, the individual agency requirements, and overall program participation.
- Transportation can be a challenge for many homeless persons. Public transportation is limited in smaller communities and can be cost-prohibitive.
- Communication challenges can come from difficulties to maintain cell phone plans to language barriers.
- Pet ownership may determine if someone can leave a domestic violence situation or even be eligible for emergency or supportive housing.
- Applying universal safety precautions to all work situations reduces the potential to stereotype any specific group of people and maintains a standard safety protocol across all work environments.
- Safety risk assessment involves not only assessing for the environment and client, but also the workers appearance and attitude.

Section 3 Key Terms

Transportation: public transportation includes buses, subways, trains, taxis, and ferries while private transportation includes privately owned vehicles such as cars, trucks, vans, or RV's.

Language Barriers: inability to communicate due to failure to speak a common language. This may include clients unable to speak English and workers unable to speak clients native tongue. This can also include people who are hearing impaired, mute or have other physical communication difficulties.

Companion Animals: pets may include cats, dogs, hamsters, and other small mammals, birds, reptiles, or fish.

Field Visit: an out of office appointment that may include a home visit, shelter visit, or community visit.

Living Space: house, apartment, camper, or possibly an uninhabitable space the person is living at the time of intake, such as an abandoned home, barn, under a bridge.

Stereotype: an unfair belief that all people with a particular characteristic are the same.

Section 3 Personal Reflection Question

How can service providers assess barriers and safety when working with behavioral health clients who are homeless?

Case Study: Behavioral Health and Homelessness

A case study is presented below to review the concepts found in this course. A case study review will follow the case study. The case study review will follow the steps of a comprehensive intake and questions behavioral health professionals should be aware of when working with a person experiencing homelessness. Within the case study review, reflection questions will encourage further internal debate and consideration regarding the presented case study.

Case Study

Jane is a 20-year-old female who presents to the county case management services for a needs assessment. She is referred by the local shelter after she stayed with them last night, as their requirement for future nightly stays is to complete a needs assessment. She makes it clear this is the only reason she is here today.

Jane reports unstable housing since she was kicked out/ran away from her mother's home after a fight with mom's paramour resulted in screaming and shoving with him. It escalated to him slapping her and her mother screaming at her that she always ruins things with her boyfriends. Jane was 17 and has not talked to her mother since. Jane states her mother has always had abusive boyfriends and Jane frequently stood up to them as a teenager.

Jane states she was able to finish high school by staying at different friends' homes, but once she graduated, her friends' parents were less open to having her stay indefinitely. She had a part-time job at a fast-food restaurant and met her boyfriend there, and he invited her to move in with him. She reported when they weren't working, they were partying. When her boyfriend broke up with her and kicked her out, she had another co-worker looking for a roommate and she said Jane could move in with her, if she paid half the rent. Jane reports she was devastated by the breakup and had difficulties getting out of bed and getting to work. After being spoken to and written up on numerous occasions, she was fired. Her roommate was livid and accused Jane of using her for a place to stay and kicked Jane out "since you can't pay rent now." Jane also reports that since her boyfriend didn't like any of her old high school friends, she did not stay in touch with them. As a result, she no longer had anywhere to turn. The first shelter she called did not allow single females,and the second one only took women with children or who were pregnant. At the third shelter she stated she was pregnant, not knowing how else to find somewhere to stay. Jane denies any suicidal or homicidal ideations.

Case Study Review: Comprehensive Intake

Personal Safety

Jane denied having any suicidal or homicidal ideations.

While we do not know if she has any history of suicide or self-harm, this should also be part of the personal safety assessment.

Should other safety questions be explored with Jane?

Physical Health

Jane makes no mention of health issues and it is presumed she presents as an average, healthy 20-year-old. Based on her report that she had a conflict-filled relationship with her mother when she lived with her, that she has been working a minimum wage job, and she has been living with friends and a boyfriend over the last couple of years, it could easily be assumed she has not had regular medical care.

More information is needed on who her primary care physician is and when was the last time she had an examination. Has she had regular women's health appointments? As she was living with a boyfriend for almost two years, it is assumed they were sexually active. Does she have any sexual health concerns? When were her last dental and vision appointments?

Are there additional health questions you would address?

Mental Health

Jane states she has had difficulty getting out of bed and was late to work because of it enough times to get fired. Her roommate was frustrated enough by her lack of motivation to kick her out. Her lack of energy and comment of feelings of devastation surrounding the breakup could all point to the possibility of Jane struggling with depression.

More information is needed about symptoms Jane is experiencing and if they are all tied to the breakup or if there is a longer-standing depressed mood. Jane should also be assessed for anxiety and other mental health concerns. Does she have any history of mental health concerns or mental health treatment history?

Are there other concerns you have surrounding Jane's mental health?

Substance Use

Jane stated when she and her boyfriend were not working, they were partying. What does this mean? What was their substance(s) of choice? How often were they using?

How much were they using? Is Jane still using? If she has stopped, are there withdrawal concerns? If she is now sober, are there concerns for relapse?

What other substance use behaviors would you assess?

Victimization

Jane left her mother's home after experiencing conflict with her mother's numerous boyfriends. The last one did escalate to physical violence. She states mother's previous boyfriends were abusive; was this only toward her mother or also towards Jane? Shortly after graduating from high school, Jane moved in with her boyfriend. Presumably, he is older as he has his own place. Was this a consensual and safe relationship or were there any incidents of violence?

What other areas of victimization might Jane have been exposed to?

Legal Involvement

Jane makes no mention of legal involvement or belief that she has been a victim of a crime.

Just because Jane does not mention legal involvement, it should be asked explicitly as this could impact what services she needs and what housing options she may or may not be eligible for based on her legal status.

How would you explore with Jane if she has a history of legal involvement or needs legal advice?

Financial Needs

As Jane has recently been fired she has no income at this time. Depending on her state laws, she may be eligible for unemployment benefits. If her mental health and housing needs are addressed she may be able to return to work successfully. Meeting with a benefits advocate to determine eligibility for food stamps, insurance, and other social supports should be prioritized. Does she wish to return to work? She successfully graduated high school even though she had to leave her volatile home environment and couch surf for the remainder of her senior year. Has she thought about college? Does she have any long-term educational or career dreams and could she use support to pursue those types of goals?

What other financial support might Jane be eligible for?

Housing Needs

Jane is currently utilizing emergency shelters, and since many of these have very strict rules for safety purposes, it makes it challenging to comply for some people. What are the rules of the shelter where Jane is staying at and can she abide by them? Will they allow her to stay now that it is known she is not really pregnant? Will Jane need a different emergency shelter tonight? Is there a night limit to how long Jane can stay at the emergency shelter? What long-term stable housing assistance is available for Jane? What are the expectations with those programs and can she meet those expectations? What additional support services would she need to maintain stable housing?

Are there other questions and considerations about Jane's situation you would require to complete a comprehensive assessment in order to fully understand her needs and match her with appropriate services?

Service Recommendations for Jane based on Needs Assessment

1. Jane needs a safe place to live that is permanent and stable and not a temporary emergency shelter. It appears permanent supportive housing or rapid re-housing with support services would be the best match for her. It is assumed that Jane has limited independent living skills as she left her mother's home while still a teenager and has been living with others since then. She would benefit from supportive services focused on independent living skills.

2. Jane has no financial means at this time. Making an appointment with a benefits specialist to determine eligibility for food stamps, housing assistance, health insurance and possibly unemployment is recommended. Additionally, explore with Jane further what her skills and interests are for future employment or school.

3. Jane is at the very least struggling with depressed mood due to her breakup with her boyfriend. Not addressing her mental health would be setting her up for failure. Help Jane schedule an appointment with a mental health therapist who she feels comfortable with so that she can discuss her history, her present living and work situation, and her current struggle with depression. The therapist can also assess more thoroughly Jane's substance use history.

4. Jane may not have a primary care physician and may not have had a check-up in a while. Although if she is generally healthy, she could wait until she receives health insurance to make an appointment, she may need assistance finding a doctor. If she does have health concerns, coordinate a referral to a community clinic that will see her without insurance.

Would you prioritize Jane's needs and services differently? If so, why? Are there other services you would have included?

Conclusion

Homelessness impacts hundreds of thousands of people a year in the United States. Homelessness is caused by a variety of contributing factors such as poverty/low income, high housing cost/lack of affordable housing, mental health disorders, substance abuse disorders, cognitive impairment, and domestic violence. Understanding this is imperative to offering services that meet the needs of the person experiencing homelessness. Communities that coordinate care, have comprehensive needs assessments, utilize trauma informed care, and rapidly move people from temporary housing to long-term stable housing have the most success with fewer relapses. Community coordinated care programs can also work toward eliminating barriers to treatment, which is often one of the most challenging aspects professionals have while working with people who are homeless.

References

Balasuriya, L., Buelt, E., Tsai, J. (2020). The Never-Ending Loop: Homelessness, Psychiatric Disorder, and Mortality. Psychiatric Times, 37(5). https://www.psychiatrictimes.com/view/never-ending-loop-homelessness-psychiatric-disorder-and-mortality

Giano, Z., Williams, A., Hankey, C., Merrill, R., Lisnic, R., & Herring, A. (2020). Forty years of research on predictors of homelessness. Community mental health journal, 56(4), 692–709. https://doi.org/10.1007/ s10597-019-00530-5

Gutwinski, S., Schreiter, S., Deutscher,K., Fazel, S. (2021). The prevalence of mental disorders among homeless people in high-income countries: An updated systematic review and Meta-regression analysis. PLOS Medicine. https://doi.org/10.1371/journal.pmed.1003750

National Alliance to End Homelessness. (2021). https://www.https://endhomelessness.org/

National Association of Social Workers (2013). Guidelines for Social Work Safety in the Workplace. https://www.socialworkers.org/LinkClick.aspx?fileticket=6OEdoMjcNC0%3D&portalid=0

Reid, N., Kron, A., Rajakulendran, T., Kahan, D., Noble, A., & Stergiopoulos, V. (2021). Promoting Wellness and Recovery of Young Women Experiencing Gender-Based Violence and Homelessness: The Role of Trauma-Informed Health Promotion Interventions. Violence Against Women, 27(9), 1297–1316. https://doi.org/10.1177/1077801220923748

Substance Abuse and Mental Health Services Administration (2021). Behavioral Health Services for People Who are Homeless. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-04-003.pdf

Substance Abuse and Mental Health Services Administration (2021). Homelessness Resources: Housing and Shelter. https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/housing-shelter

Tinland, A., Loubière, S., Boucekine, M., Boyer, L., Fond, G., Girard, V., & Auquier, P. (2020). Effectiveness of a housing support team intervention with a recovery-oriented approach on hospital and emergency department use by homeless people with severe mental illness: A randomised controlled trial. Epidemiology and Psychiatric Sciences, 29, E169. doi:10.1017/S2045796020000785

United States Census Bureau. (2020). Income and Poverty in the United States 2019. https://www.census.gov/library/publications/2020/demo/p60-270.html

Woodhall-Melnik J, Dunn JR, Svenson S, Patterson C, Matheson FI. (2018). Men's experiences of early life trauma and pathways into long-term homelessness. Child Abuse Neglect, 2018 Jun(80),216-225. doi: 10.1016/j.chiabu.2018.03.027.

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