Improving Access to Behavioral Health Services for Populations Facing Homelessness

Introduction:

In 2022, the overall number of people experiencing homelessness was 582,462 on any given day,[1] among these, 127,768 were considered chronically homeless (see figure 1).

Mental health can be viewed as both a cause and effect of homelessness. It is important to note that SMI's such as post-traumatic stress disorder, major depression, and anti-social personality disorders are not the primary indicator that a person will experience homelessness throughout the course of their lifetime. When coupled with factors such as substance use, economic instability, limited access to affordable housing, health insurance, and health care providers, adverse childhood experiences, traumatic brain injuries, and societal and internalized stigma can disproportionately lead to episodic and chronic homelessness.

Housing First (HF) programs provide housing without behavioral prerequisites such as sobriety and are the most successful intervention for ending chronic homelessness[2]. Rather than framing substance use as an issue of morality, instead, it is characterized as a chronic condition and decreases the stigma associated with substance use disorder (SUD). Traditional approaches, such as the involvement of the criminal legal system and abstinence-based programming standards, do not reduce the wide availability of substances or improve outcomes among patients with SUD[3].

This evidenced based practice requires that connecting to housing stability be the priority of services providers working with someone experiencing homelessness and behavioral health challenges. Many people such as these will need supportive housing to successfully stabilize in the community. When serving those experiencing homelessness, behavioral health providers need to keep in mind the need for:

- Flexibility, particularly in outreach and engagement strategies
- Partnerships with homeless and housing organizations
- The value of peers, especially as it relates to outreach strategies.
- Financing that sustains their efforts

Health centers, primary and behavioral health service providers, and housing providers will learn about the research and evidenced based practices for serving this population. The guide will cover the central role of peer support and outreach and engagement strategies. Finally, the guide will cover the financing possibilities and challenges of supporting outreach and engagement efforts within the Housing First Framework.

Chronically homeless is defined as a person living with a disabling condition(s) such as physical or serious mental illness (SMI) or substance use disorder who have experiencing homelessness for at least one year or multiple bouts of homelessness.

Figure 1

Prevalence

It is a common misconception that chronic homelessness is caused by SMI such as schizophrenia, bipolar disorder, major depression, and border-line personality disorder. Studies have shown that about one-third of people experiencing homelessness have a SMI. However, additional studies highlight that depression, trauma symptoms, suicide ideations, and substance use are the primary contributors to behavioral health challenges for people experiencing homelessness and not SMI.

An important distinction to keep in mind are the differences between the two categories of homelessness: sheltered vs. unsheltered homelessness, the characteristics of the individuals experiencing sheltered and unsheltered homelessness, and the traumas that a person could face during both types of homelessness. Unsheltered homelessness refers to people living in places not meant for habitation including cars, abandoned buildings, and the streets. 78,615 (61.5%) of the chronically homeless population are experiencing unsheltered homelessness. A 2016 study showed that a majority of the unsheltered chronically homeless population were single males[4]. Sheltered homelessness refers to any unstable or non-permanent, temporary housing which includes couch surfing, emergency shelters, and transitional housing programs. 143,733 (89.2%) of individuals in families make up most of the sheltered homelessness population[5]

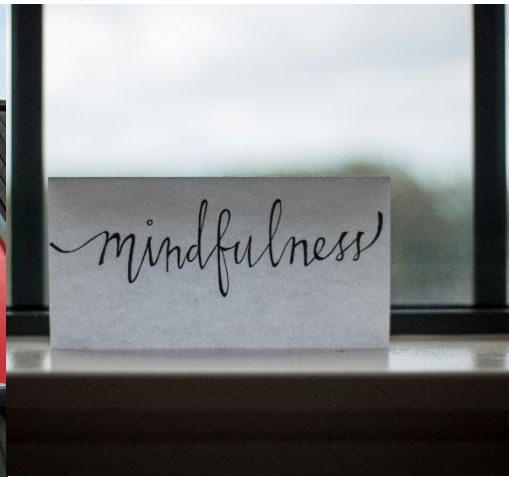
Structural Racism

Structural racism has played a pivotal role in homelessness. Although African Americans make up 13% of the US population, they currently make up 37% of individuals experiencing homelessness and over 50% of homeless families with children. Black Americans are four times more likely to be homeless over the course of their lifetime compared to their White counterparts. Hispanics make up 24% of individuals experiencing homelessness yet only representing 18.9% of the total US population. LGBTQIA+ youth make up 40% of the homeless youth population.

Overrepresentation in systems such as the criminal legal system, child welfare, and homeless services can play a major role in a person's assimilation into mainstream society. Black men experiencing homelessness are more likely to be harassed and arrested by police. Black women are more likely to be hyper-surveilled than their white counterparts.

Intensive Case Management in Behavioral Health and Supportive Housing Programming:

Intensive case management (ICM) is a critical, team-based, time-sensitive approach that provides intensive, wraparound services and connections to community services to people experiencing homelessness. Although one case manager is typically assigned to the client, caseloads can be shared amongst the entire ICM team to ensure coverage at least twelve hours a day, seven days a week. ICM aims to develop case plans, primarily focusing on housing, stability and other service needs. Other focus areas may include behavioral health, primary and specialty care, enhancing life skills, workforce development, and linkage to community social support. Intensive case managers typically have lower caseloads, capping at 20 clients per ICM, to provide the necessary support in a shorter period. Although ICM was designed for clients with a lower acuity who need intensive support to stabilize, the program can benefit those with a higher acuity, acting as a bridge until a permanent housing and case management option becomes available.



Harm Reduction:

Harm reduction is an evidenced based approach to working with individuals with substance use disorder. Harm reduction services continue to support people no matter their current relationship with or perspectives regarding substance use. Harm reduction incorporates a variety of strategies that promote safer use. If a person is interested in abstinence-based recovery, support to access those services is provided, but receiving assistance is not dependent upon a participant's abstinence. Harm reduction in practice uses people first language, which can reduce the stigma of taking drugs and recognizes that for many, substance use is a coping mechanism and response to long term complex trauma. The harm reduction model takes into consideration structural racism which leads to poverty, homophobia, classism, and ableism. Harm reduction programming promotes the stages of change by establishing health and dignity, participant centered services, participant involvement and autonomy, recognizing sociocultural factors, while recognizing pragmatism and realism[6].

Trauma-Informed Care:

Trauma-informed care (TIC) is a service approach that understands the impact that long-term trauma can drastically affect our development. TIC teaches us to understand the signs and symptoms of trauma, the potential lasting impact of trauma, build awareness on how to address and prevent re-traumatization, challenge agencies to shift cultural values and develop strategies on responding to and addressing the needs of trauma survivors. The tenets of TIC are trauma awareness, safety, respect, control and choice, and strengths-based approaches to case planning and service delivery. TIC can be embedded across all health center services.

The Sanctuary Model, a comprehensive approach developed by Dr. Sandra Bloom in the late 1990s in Philadelphia, is a training program and a transformative shift in organizational culture. It promotes universal training for all staff members, ensuring everyone is equipped to provide trauma-informed care. The model is built on four pillars, each one contributing to its effectiveness and comprehensive nature:

Trauma theory: a scientific foundation for the model

Sanctuary commitments: values and trauma-informed goals

Self-conceptual framework: a shared language around trauma

Sanctuary toolkit: the psychoeducational curriculum includes tasks and exercises that build community engagement and awareness through various activities, including community meetings, safety, and self-care planning.

By implementing models such as the Sanctuary Model, organizations can directly improve the quality of care they provide to their clients, making a significant difference in the lives of those they serve.

Role of Outreach and Engagement:

Collaboration between systems to serve individuals and families and the needed community partnerships are critical components for the Housing First model, which emphasizes access to housing first, but not housing only. Collaboration between systems to serve individuals and families and the needed community partnerships are critical components for the Housing First model, which emphasizes access to housing first, but not housing only. Maslow's hierarchy of needs stresses the importance of meeting an individual's physiological needs, such as food, water, warmth, and rest, in addition to their safety needs, which include security and safety. Housing First programming meets the baseline needs of our most vulnerable population by understanding that the remaining needs of love and belonging, esteem, and self-actualization cannot be achieved until the first two are accomplished.

The trauma incurred from these systems can have devastating impacts on a person's mental health and well-being[7]. Adults and children experiencing homelessness can experience chronic stress from housing and food insecurity, which can impact their ability to thrive. Homelessness, sheltered and unsheltered, is accompanied by various forms of trauma, first and secondhand[8].

Homelessness, sheltered and unsheltered, is accompanied by various forms of trauma. Commonly referred to as Big T trauma, also known as type 1 trauma or acute trauma, is an unexpected singular incident, including violent or sexual abuse, traumatic loss, witnessing violence, childbirth, natural disasters, and attempted suicide[9]. Complex trauma, also known as repetitive trauma, is a repeat of traumatic events that may involve childhood experiences or traumatic events that took place during childhood. Events include repeated physical or sexual abuse, domestic violence, child abuse, bullying, religious abuse, parental neglect, and attachment trauma[10].

Street homelessness can lead to a variety of challenging decisions for day-to-day survival including unprotected sex, sex work, substance use, exposure to the elements, emotional and physical trauma. Sheltered homelessness can be as traumatizing as unsheltered and presents a variety of traumatic experiences due to unsanitary and de-humanizing living conditions, living among strangers and strict shelter rules. Having to assimilate to another system and being under the monitoring of social service programming can exacerbate mental health.

Peer Supports and Community Health Workers:

Utilizing Peer Support Specialists (PSS) in the behavioral health and homeless services space and Community Health Workers (CHWs) in the health center space is critical to clinical treatment teams. Although the positions have similarities, they have distinct identities that separate them. PSS are people with lived experience who walk with the client, which is essential for social integration and feelings of inclusion and belonging. CHWs are respected community members who build rapport with community members, leaders, and programs to promote equal access and health equity. Utilizing both positions can lead to various outreach and education opportunities for people experiencing homelessness, the community, and policymakers. Participant trust and comfort with each of these types of support is a critical foundation to the role. Participants may benefit from the use of both PSS's and CHW's, but it is important to let the participant decide.

Peer support services are recovery-oriented, person-centered, and voluntary, and they are relationship-focused and trauma-informed11. PSS utilizes a strengths-based framework that promotes the physical, psychological, and emotional safety of the client. Peer Support Specialists play a crucial role in helping people experiencing homelessness address mental health barriers. PSS are in the recovery stage of behavioral health and substance use conditions who provide guidance and support services to people experiencing a variety of challenges, including substance use, behavioral health, and homelessness[12]. The role of a PSS is to guide and mentor clients and teach them how to navigate the behavioral health and homeless systems. Although this position is not considered clinical, PSS works with the clinical and case management teams in the behavioral health setting to provide supportive services that promote clinical support plans.

Community Health Workers (CHWs) are frontline public health staff who help clients navigate the behavioral health and healthcare landscapes[13]. CHWs are entrusted community members with a profound understanding of their designated communities, being the link between healthcare/social service providers and the community. CHWs in the behavioral health space help the community increase knowledge through outreach activities such as community education forums, healthcare testing, and education events. CHWs can support clients experiencing homelessness through advocacy, informal counseling, and providing social support [14].

On the client level, PSS can collaborate with in-house and interagency CHWs, behavioral health clinicians, physicians, and case managers to support intensive case management goals, assist with the development of behavioral health and housing planning goals, serve as an advocate, teach clients how to advocate for themselves and facilitate groups on life skills, coping with trauma, and triggers. CHWs can provide similar skills, but their work can focus more on the education portion of service delivery, including primary and specialty care concerns, connecting the client with community resources to meet service plan goals, and providing referrals within the agency.

On the systems level, PSS can help develop community partnerships and outreach strategies tailored to the voices of those with lived experience, train clinical and case management staff on best practices around client outreach, engagement, and retention, educate the public and policymakers, and lead programs and support groups within the agency. CHWs can provide the same services from the community perspective and add to the training and dissemination of tools and programming within the agency and community.

Collaborating with Homeless and Housing Systems in your Community

Housing is Healthcare is a philosophy that can be adopted in the behavioral health space. Once housing is secured, a patient can begin the journey of healing from both homelessness and the trauma incurred from it and prior to homelessness [15]. Agencies do not have to be a one-stop shop for clients. However, agencies should have partnerships with the following entities to ensure that those you serve are having all needs met:

- Local Homelessness Continuum of Care
- Emergency Shelters
- Transitional Housing Programs
- In-Patient Detox Programs
- Out-Patient Substance Use Programs
- Local FQHCs
- Ryan White HIV/AIDS Provider
- City Health Department
- State Health Department
- Public Housing Authority

Housing navigators can play a crucial role in the healthcare space. They can be considered entry level case managers or intake workers. Housing navigators are frontline staff who are the bridge between the community and healthcare, working directly with clients and the community. They can also be an essential part of the service planning process. Housing navigators conduct housing assessments with clients, link them to housing and community resources to help support their housing plans, provide education on topics such as credit repair, and help clients reduce barriers to issues such as criminal records and past evictions. Housing navigators should deeply understand Housing First programs, housing vouchers, real estate trends, and community resources in their designated community. Visit www.csh.org/hrsa to see additional resources regarding health and housing partnerships.

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0 percentage financed with non governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov

Endnotes

[1] *State of Homelessness: 2023 edition*. National Alliance to End Homelessness. (2024a, January 6). https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/

[2] Dignity Moves. (2023, February 18). *Policies for homelessness: Understanding homelessness*. Dignity Moves. https://dignitymoves.org/understanding-homelessness/

[3] Paquette, Catherine E., Stacey B. Daughters, and Katie Witkiewitz. "Expanding the continuum of substance use disorder treatment: Nonabstinence approaches." *Clinical Psychology Review* 91 (2022): 102110.

[4] Saldua, M. (n.d.). *Addressing social determinants of health among individuals experiencing homelessness*. SAMHSA.

[5] Logan, D. E., & Marlatt, G. A. (2010). Harm reduction therapy: A practice-friendly review of research. *Journal of clinical psychology*, *66*(2), 201-214.

[7] Schimmenti, A. (2018). The trauma factor: Examining the relationships among different types of trauma, dissociation, and psychopathology. *Journal of Trauma & Dissociation*, *19*(5), 552-571.

[8] Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming children and youth*, *17*(3), 17-21.

[9] Amstadter, A. B., & Vernon, L. L. (2008). Emotional reactions during and after trauma: A comparison of trauma types. *Journal of Aggression, Maltreatment & Trauma*, *16*(4), 391-408.

[10] Wallace, C. (2020a, July). *An overview of trauma-informed approaches (TIA)*. Casacdewales.org. https://cascadewales.org/wp-content/uploads/sites/3/2020/11/Information-sheet-on-TIA_CASCADE-2.pdf

[11] Shalaby, R. A. H., & Agyapong, V. I. (2020). Peer support in mental health: literature review. *JMIR mental health*, *7*(6), e15572.

[12] Fortuna, K. L., Naslund, J. A., LaCroix, J. M., Bianco, C. L., Brooks, J. M., Zisman-Ilani, Y., ... & Deegan, P. (2020). Digital peer support mental health interventions for people with a lived experience of a serious mental illness: systematic review. *JMIR mental health*, *7*(4), e16460.

[13] Logan, R. I., & Castañeda, H. (2020). Addressing health disparities in the rural United States: advocacy as caregiving among community health workers and Promotores de Salud. *International Journal of Environmental Research and Public Health*, *17*(24), 9223.

[14] Peretz, P. J., Islam, N., & Matiz, L. A. (2020). Community health workers and Covid-19—addressing social determinants of health in times of crisis and beyond. *New England Journal of Medicine*, *383*(19), e108.

[15] Padgett, D., Henwood, B. F., & Tsemberis, S. J. (2016). *Housing First: Ending homelessness, transforming systems, and changing lives*. Oxford University Press, USA.