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Mental Health Care for the Homeless

John Rogers

A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

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## Abstract

This paper includes a thorough survey of peer-reviewed journal articles regarding the delivery of mental health care services to homeless people, a gap analysis based on the literature, experiential observations from a mid-Atlantic agency for the homeless, and interviews with people experiencing homelessness. From this research, I propose a model of service delivery. I conclude that while deinstitutionalization in the 1980s led to community-based models of service delivery, the patchwork of approaches available now does not serve the needs of homeless persons with mental health problems. A best practice approach combines the concept of housing first with peer navigated, integrated community services in primary care, mental health counseling, and social support.

*Keywords:* homelessness, mental illness, counseling, shelters, housing first, treatment first

### **Mental Health Care for the Homeless**

Homelessness is a significant and persistent problem in the United States. As of January 2016, on any given night there are an estimated 549,928 people without housing nationwide. (U.S. Department of Housing and Urban Development, 2016). People who are homeless are at elevated risk for substance abuse, mental illnesses, and other physical and social problems. More than 1 in 10 persons seeking substance abuse or mental health treatment in the public health system in the United States is homeless (Substance Abuse & Mental Health Service Administration [SAMHSA], 2013). I have conducted interviews with several people who are homeless and self-reported as having experienced mental illness (I have identified them by first name only). Their words below give voice to the frustration and complexity of their days:

“I have no doctor, I work part time and can’t figure out the paperwork for Medicare. I stay with relatives but am guessing I will wear out my welcome. Just not sure what I’m going to do long-term—not sure who to talk to about it” (Raymond, personal communication, September 17, 2017).

“It’s like that whack-a-mole game. I have to run from the emergency room to the clinic, to my campsite, to the shelter for a shower. My psych meds run \$1,000 a month, and I have to keep my Mom safe all day and on her prescriptions, too” (Brian, personal communication, September 17, 2017).

“I’ve been going back and forth to the CSB for 11 years now, and nothing much seems to change. How do I get out of this runaround? I get good care there but am still homeless and poor” (Robert, personal communication, September 19, 2017).

In this paper, I review the current research on homelessness and mental health, explore the public policy response, and review the spectrum of treatment models. I augment this with interviews and direct experience at homeless shelters. With this background, I utilize a needs assessment model to identify best practices in delivering mental health services to chronically homeless persons. The project also has an advocacy element, in that I propose enhancements in the current delivery system to address inequalities in access to care.

A person without a home and experiencing mental illness faces many challenges. Addiction tops the list, as around 50% of homeless individuals with a serious mental illness (SMI) have a co-occurring substance use disorder (U.S. Dept. of Housing and Urban Development, 2011). Co-occurring medical illness is also common (Breakey et al., 1989; Lundy, 1999), as is legal system involvement (Malone & Malone, 2009). Not surprisingly, the homeless population suffers from mortality rates above those of the general population (Babidge, Buhrich, & Butler, 2001; Hibbs et al., 1994; Kasproff & Rosenheck, 2000). Because homelessness often results from a combination of environmental or systemic factors and individual circumstances, people in this dilemma face a Gordian knot of interrelated issues.

Public policy is complex and transmits mixed signals when it comes to homelessness and mental health. On one hand, there is political pressure at the federal level to defund mental health services aimed at the homeless, and some localities stigmatize the homeless by driving them off the streets. On the other, legacy programs at the federal level and across local agencies fund and support integrated care models and experiment with new conceptualizations of treatment. After close to 40 years of focus on



fighting homelessness, there is still a debate over best practices, and there are still significant gaps in the delivery of mental health services to this population.

Counselors and counselors in training are in a strong position to help develop and promote best practices when it comes to working with homeless clients with mental illness. The professional counselor approaches this problem with an integrated, wellness-oriented view of helping clients resolve their issues. The complex etiology of homelessness and mental illness demands a thoughtful and multi-dimensional response. The set of issues this population confronts represents both a problem and an opportunity, in that with proper supervision, counselors in training can fill gaps in the institutional safety nets.

### **A Day in the Life of a Shelter**

The Shelter (a generic name) operates in a small city in the mid-Atlantic region of the U.S. It functions under the auspices of a local coalition for the homeless and has been open for close to a decade. The Shelter operates as a day facility, open from breakfast until noon. The Shelter has a diverse clientele. Its guests are approximately 40% Black, 40% White, and 20% of other ethnicity (Hispanic, Asian, Arab, and others). Approximately 60% of the Shelter's guests are male, 40% female.

On any given day, from 60 to 90 people register at the Shelter. Most guests will eat breakfast, nap, shower, check for mail, retrieve belongings from their personal bins, use the internet, socialize, or meet with staff. The Shelter is a "low threshold" facility (sobriety is not required), and welcomes all to use its services, so long as house rules (no violence, foul language, drugs, or alcohol on the premises) are followed. From its initial vision of providing a daytime haven for people experiencing homelessness, the Shelter

has diversified its offerings along a continuum of complexity and needs. The first step for a new guest is a coordinated intake and assessment interview, which is designed to identify needs such as health concerns, emergency shelter, or other social services that are provided in the community. Guests are then introduced to relevant resources, which are generally provided by allied agencies unless they are housing-related. The Shelter's deepest expertise is in rapid rehousing, whereby the individual's time without a home is kept as short as possible. It has won multiple grants for this initiative and is successfully placing homeless guests in apartments and homes in and around town.

The Shelter's diversification into housing referrals reflects a national trend (Padgett, Henwood, & Tsemberis, 2015). A variety of financial incentives and new approaches have come together to induce homeless shelters to broaden the ways they support their clients. This is driving the expanded focus, from on-site services, toward permanent housing for the chronically homeless and rapid re-housing for those in crisis. While the Shelter's core services remain in place, the professional staff is being challenged to deal with homelessness by finding clients a place to live. This new focus has employees excited, and it brings fresh challenges, both in their day-to-day assignments and in the complexity of managing caseloads. As the Shelter has grown and extended its mission into re-housing, its operations have become more compartmentalized. That leads to some narrowing of roles, which employees note has both positive and negative impact on their work experience. The ability to move off the front lines to focus on administration can be a welcome break from the emotionally taxing work with clients, but it can also feel detached from the population being helped.

When placed into the spectrum of care models under review, the Shelter's expanding role is consistent with the housing first movement. Beyond housing, it offers supportive resources to connect people with other agencies for primary and mental health care. The Shelter has been successful in moving dozens of chronically homeless people into permanent housing. This gives them a stable base from which to access primary care and mental health services, the latter primarily from the local community services board.

While the Shelter has been successful in combating homelessness, it has not directly tackled substance use and mental illness through an integrated approach. Dealing with this intertwined set of problems is the topic of this paper. The debate over best practice, along with the opportunities for counselors to contribute to the solution, become clear through a review the literature on this topic.

### **Homelessness: The Literature**

#### **Homelessness and Mental Illness: A Vicious Cycle**

A comprehensive assessment of peer-reviewed literature points to a key relationship: homelessness and mental illness are connected and persistent. A study conducted by Greenberg and Rosenheck (2010) found that exposure to personal violence, substance use disorders, and other psychiatric illnesses raise the probability of homelessness. The rates of combined homelessness and mental illness are high: one study estimates that up to 60% of chronically homeless persons have mental health problems (Burt, Aron, Lee, & Valente, 2001). Within that group, SMI is found in approximately 25–33 % of the homeless population (U.S. Department of Housing and Urban Development, 2011; Fischer & Breakey, 1991), and these rates likely have increased over time (North, Pollio, Perron, Eyrich, & Spitznagel, 2005). Many of these

studies were conducted in the 1990s and 2000s, a time of deinstitutionalization and transition to community care in the United States. This is a topic of some focus later in this paper.

Among people with SMI, the risk of homelessness is 10–20 times that seen in the general population (Susser et al., 1997). In one study of patients with SMI treated in a public mental health system, 15% of patients were homeless at some point during a 12-month follow-up period (Folsom et al., 2005). To estimate the national incidence of this multi-faceted problem, Greenberg and Rosenheck (2010) used the National Comorbidity Survey Replication to quantify the relationship between homelessness and mental illness. Their analysis demonstrated high correlations between homelessness and poverty, being Black, incarceration, exposure to violence, and substance abuse. They also confirmed that, in this broad survey replication, homelessness had a significant association with mental illness. Homelessness was meaningfully connected with a lifetime substance use diagnosis, with mood disorder, and with impulse control disorder.

There is also reason to believe that the risk and severity of mental illness are correlated with the duration and number of episodes of homelessness (Lippert & Lee, 2015). Theories behind this relationship utilize the accumulation of risk perspective, which holds that chronic exposure to stress increases the probability of resulting mental health issues. A recent study points to greater severity of symptoms, increased vulnerability, and other elevated risk factors stemming from the traumatic experience of homelessness (Castellow, Kloos, & Townley, 2015). The authors equate the impact of homelessness to adverse outcomes common to those experiencing post-traumatic stress disorder. In Canada, Zabkiewich, Patterson, and Wright (2014) studied a group of

women who had been homeless for two or more years. They found that, compared to women who were homeless but not parenting, these mothers were twice as likely to suffer depression. They cite the trauma experienced by mothers and children when official interventions such as child protective services separate the family. The stress and anxiety associated with this experience and subsequent attempts to reunite with their children take a toll on mothers' mental health. Given the multiple demands mothers face, a failure to recognize their unique needs is likely to contribute to intergenerational legacies of homelessness and mental health problems

Increased susceptibility to substance use disorder is an important feature, given its high prevalence among the homeless. A study noted earlier found that homeless episodes increase the incidence of psychiatric disorders, substance use disorders, and lead to lower rates of recovery. Using interviews, assessment surveys, and regression analysis, the authors found that the experience of having been homeless was associated with higher rates of serious mental illness and substance use disorders (Castellow, Kloos, & Townley, 2015). While causality was not established, this study reinforces many of the patterns noted in earlier research.

Part of the vicious cycle of homelessness is its strain on emergency care services and the resulting alienation of providers, policymakers, and patients. It is commonly believed that people who are homeless often turn to emergency rooms as their primary care facility. This was confirmed in a study that found that homeless individuals with mental health conditions were more likely than housed individuals with mental illnesses to pay return visits to hospital emergency departments and be readmitted (Chun, Arora, & Menchine, 2016). Hospital psychiatric wards have limited inpatient capacity, and

homelessness creates a cascading effect on the behavioral health care system's ability to handle emergencies. So long as emergency rooms are the homeless community's primary care access point, there will be friction among users and providers of care.

Another chronic gap in addressing the complexity of homelessness is the paucity of research that integrates bio-, socio-, and environmental factors. A recent meta-analysis could identify only one study that examined relationships between homelessness, mental illness, and ethnicity (Corrigan, Pickett, Krause, Burks, & Schmidt, 2015). This finding led them to infer that cultural competencies may not be adequately considered in dealing with homelessness and mental health problems. They advocated for research that is informed by community-based participatory research. This technique incorporates a partnership with members of the population being studied. This approach, they argued, should raise the quality and relevance of the questions being asked. As Corrigan and his team explored the services offered to the target population, they found gaps in services for women's health and for individuals with HIV-AIDS. They found that homeless shelters and agencies either had no mental health programs, or if they did, these were not based on best practices. They saw little evidence of integrated primary care and mental health services, and scant consideration of concurrent substance use disorder treatment. They asserted that this lack of integration raises the risk of errors and gaps in care regimens, waste, and inefficiency. They recommended integrating services, and the use of peer navigators to serve as guides and advocates for those dealing with these complex problems.

### **The Trauma of Homelessness**

Reflecting on the experience of homelessness helps us understand how it contributes to mental illness. This can guide us in building a response that is both pragmatic and wellness-oriented. Shelter is a basic physiological need, but a home serves higher, existential needs as well. Homeless people have the same psychosocial needs as the housed population, but the search for shelter often eclipses other important goals. Being released from an institution without a place to live, aging out of foster care, losing the resources to maintain a home—these are traumatic experiences. There is scant research on the phenomenology of homelessness, with virtually no studies conducted on the experience of becoming homeless. One of the few phenomenological studies of homelessness comes from McBride (2012). Using a criterion and snowball method, she worked with 8 individuals experiencing homelessness over a year in semi-structured interviews, and a subset of 3 in a focus group. McBride found that unmet needs in employment, social support, health care, and housing were the primary concerns of the population surveyed. The author noted that substance abuse was cited as a frequent coping mechanism, and encouraged counselors to be aware of this, as well as of the importance of knowing local services to help meet other needs of the homeless population.

Homeless people enter a cycle of drudgery which has the effect of draining self-esteem, energy, and which imposes new obstacles to recovery. The task of satisfying basic physiological needs is often an all-encompassing effort. People who are homeless often have comorbid physical conditions, scant resources, and are itinerant within their communities. Many of these people do not have the time to seek behavioral health care. To shorten the pathway to care, provincial governments in Canada are experimenting

with simplified assessment instruments to measure the mental health needs of homeless people. One study used these tools to assess a population of homeless men. They found that 75% of subjects were experiencing moderate to severe impairment in mental health. Within this group, 68% required either moderate (outpatient) or intensive (inpatient) mental health support (Stergiopoulos, Dewa, Durbin, Chau, & Svoboda, 2010).

### **“Escape Velocity”: Key Findings on Breaking the Cycle**

In considering “escape velocity,” Rayburn (2013) wrote that “most multiply troubled individuals in their early 30s are still multiply troubled individuals 20 years later, still people who struggle with addictions, unstable employment, troubles with the law, and presumably homelessness” (p. 9). His study combined quantitative and qualitative methods to focus on individuals who successfully escaped the cycle of homelessness and mental illness. He found support for social bonding theory, with marriage and employment indicated as strong supporters of creating and maintaining escape velocity.

Inpatient mental health care is a drag on escape velocity, as one group of researchers discovered (Kuno, Rothbard, Avery, & Culhane, 2000). They tracked a population of individuals who had spent time in psychiatric hospitals for SMI, and found that even in an area with well-established community mental health systems, homelessness among this population was substantially higher than in the general population, particularly among African-Americans. They found that poverty and co-occurring substance abuse were highly correlated with homelessness upon discharge. Their recommendation: incorporate strategies to prevent homelessness as part of the inpatient treatment plan, so that on discharge, the client has a housing strategy in place.



It is important to describe what successful escape velocity from homelessness looks like, so that we can build delivery systems with the highest odds of success. A meta-analysis of homelessness and mental health care in Great Britain found that multiple studies confirm that permanent housing is associated with reduced rates of mental illness in populations that were previously homeless (Smith, 2005). While housing alone may not suffice, the lack of a home is a major barrier to recovery. One study combined a literature review with focused interviews in seeking to answer the questions of what elements of care are effective, and why this is the case (O'Campo et al., 2009). The authors listed six strategies that have the most promise in improving mental health outcomes for the homeless. These include a consumer-orientation, the client/helper relationship, an outreach orientation (often referred to as assertive community treatment), housing support, support of basic needs, and a permissive environment (O'Campo et al., 2009). The theme of autonomy runs through these findings, and will be addressed further in this paper.

One way to conceptualize escape velocity is as a social process that incorporates agency, life quality, and other individual factors (Watson, 2012). This is distinct from the medical or clinical perspective; which, by defining recovery as the end of an illness, implies a normative state of being. Watson supported this social definition of recovery by pointing to the decades-old deinstitutionalization movement in mental health care. The prospect of a lifetime spent in what were called lunatic asylums has been replaced by a community-level recovery model based on consumer choice. Watson pointed to the need for sociological research on the conditions of care and interactions between the environment and the individual to better understand how to deliver a higher probability of

recovery. He acknowledged that deinstitutionalization during the 1980's may have contributed to the significant rise in homelessness during that period, and acknowledged weaknesses in the systems of care initially established to transition to community-based services. To delve into those systems, and their pros and cons, the next section outlines and comments on the spectrum of care delivery models currently in use in the United States.

### **Public Policy: The Road from Deinstitutionalization**

The 1980s began an era of deinstitutionalization in the mental health care field. Large, state run hospitals, in some cases with thousands of long-term patients, were systematically downsized and patients were disbursed into community mental health networks. This decentralized approach persists to this day, and is taken for granted as the basic delivery model for all but the most trenchant and/or forensic expressions of mental illness. Perhaps it was predictable that in the wake of deinstitutionalization, many people with SMI dropped out of the behavioral health care system and ended up chronically homeless.

As a public policy response to this unintended consequence, two initiatives, Programs for Assistance in Transition from Homelessness (PATH) and Access to Community Care and Effective Services and Supports (ACCESS) were launched in the 1990's with the support of SAMHSA. Lam and Rosenheck (1999) found that the ACCESS program was effective in reaching and providing services to homeless people with mental illnesses. The PATH program continues to be a source of direct federal funding, through SAMHSA, to the state level. SAMHSA also serves as an information hub and training resource through the Homelessness and Housing Resource Network.

Aside from these initiatives, individual states have developed outreach programs, each of which has its own set of policies and practices (Rowe, Styron, & David, 2016) .

In the new millennium, the high rate of co-occurring substance abuse among homeless people resulted in additional targeted federal programs. Broner, Dates, and Young (2009) described the U.S. government's response to the disproportionate number of homeless individuals with persistent mental health problems. A SAMHSA division, the Center for Substance Abuse Treatment Co-occurring and Homeless Activities Branch, began making grants with three primary objectives: connect substance use and mental health treatment with housing programs and other services; bolster and extend treatment services; and place more homeless people in stable housing. Over 8 years, grantees supported more than 30,000 people who were experiencing co-occurring homelessness and behavioral health issues, and the program led to a series of policy recommendations on care modalities.

A related, and lasting response to the impact of deinstitutionalization was the Health Care for the Homeless (HCH) initiative. This initially private, but later federally-sponsored program began in the 1980s, and now supports over 200 sites nationwide (Zlotnick, Zerger, & Wolfe, 2013). Now housed under the umbrella of community health organizations, HCH has been at the forefront of innovating and promoting new treatment models for the homeless population. Many of the care models under review have emerged from HCH pilot programs.

President Barack Obama's eight years in office coincided with two major initiatives addressed at homelessness and mental illness. In June 2010, his administration released "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness" (Interagency Council on Homelessness, 2010). One aspect of this

program is the improved provision of behavioral health care to the homeless. Secondly, the Affordable Care Act of 2014 (ACA) opened new avenues to extend primary and mental health care to the homeless. Of note, states that chose to expand Medicaid as part of the ACA covered 22% more of their homeless population, compared to 4% in non-expansion states (DiPietro & Zur, 2014).

Although federal and state programs to extend care to homeless people have been in place for decades, it is questionable how well they reach their intended populations. To this point, one study found that while people experiencing homelessness were just as likely as housed individuals to have their needs for medical and dental care services met, those who were homeless were less likely to access mental health care services (Zur & Jones, 2014). They studied users of Federally Qualified Health Centers (FQHC), which collectively have 1.1 million visits by people experiencing homelessness each year. Many of these centers are eligible for HCH subsidies, and in many communities, they are the primary methods of health care delivery for homeless people. Despite this, individuals using this delivery method report significant gaps in their access to care. Zur and Jones focus on the unfilled health care needs of homeless and housed users of FQHCs who also receive HCH subsidies. Their findings showed a single, striking difference in the category of access to mental health services. In Zur and Jones' unadjusted model, homeless clients were 2.35 times more likely to have delays in obtaining mental health services. After adjusting for a variety of demographic and socioeconomic features, their model identified a 733% higher probability that homeless clients would report being unable to receive any mental health services from the FQHC. Zur and Jones attribute this difference to two major factors: cost and lack of information on how to access behavioral care. They further note that FQHC clinics with HCH grants

are not required to have mental health professionals on staff. This presents an obstacle to providing such services to the population of homeless individuals who use these facilities as their primary health care centers. The unstated implication in these findings is that more proximate and better-connected mental health care services at the point of contact, i.e. on the streets or in shelters, could address this gap.

### **The Counseling Profession and Homelessness**

The counseling profession is in a strong position from which to address the complexity of homelessness. Counselors are trained to meet clients where they are, and to walk with the client on his or her journey. Complicated problems require an integrated response, a hallmark of counselor training. Unfortunately, it appears that many of today's one-dimensional treatment models conform to the old saying that "to a person with a hammer, everything looks like a nail." The pernicious combination of homelessness, poverty, medical, and behavioral issues drives a wedge between caregivers and clients. There is a persistent pattern of mutual avoidance between the community of caregivers and homeless individuals released from psychiatric hospitals (Drury, 2003). This mutual avoidance is understandable but unhelpful in breaking the cycle of institutionalization, homelessness, and mental health problems. Poor communications between caregivers, logistical barriers to access and delays in treatment, and perceived lack of motivation by clients serve to create a self-fulfilling cycle of failure and mutual disappointment.

In considering how counselors can help break this cycle, Dykeman (2011) identified over 40 different models of homelessness, and proposed a biopsychosocial model to assess homelessness through an integrative framework. His four-stage model includes consultation, collaboration, counseling, and advocacy. The counseling stage

incorporates a clinically-based, holistic approach to self-awareness and success in interpersonal relationships. He also notes the importance of family therapy in dealing with homelessness that extends beyond the individual and incorporates social units.

Along these same lines but with a different lens, the American Counseling Association notes several research papers on effective counseling services for the homeless. In one such study, Baggerly and Zalaquett (2006) used a social justice framework to call counselors to action to reduce the gaps in mental health services to the homeless. They note a dearth of literature and research in the field of mental health counseling to the homeless, despite its prevalence and impact on American society. Their assessment, which involved a combined literature review, period-prevalence research, and counseling strategy, points to the complexity and interconnected nature of causes of individual and family homelessness. They note the significantly elevated incidence of substance use disorders among those in a condition of homelessness. By using a period-prevalence study, the authors seek to overcome a bias toward attributing homelessness to deviance that they believe exists in point-prevalence studies. They follow a homeless population in a single setting for two years, and while many of the demographic findings were similar to point-prevalence studies, the authors found that mental health issues and substance use disorders were substantially higher than had been previously reported in large-scale point-prevalence studies. The authors highlight the need for on-site mental health care providers to offer care over extended periods. Baggerly and Zalaquett urged counselors to increase their awareness of homelessness, to support people experiencing homelessness with wellness and goal-oriented counseling, and to advocate on behalf of mental health care access for the homeless.

The emotional implications for helping professionals working with the homeless are an important ingredient in getting the delivery model right. In this vein, Ferris, Jetten, Johnstone, Parsell, and Cameron (2016) identified a “Florence Nightingale effect” that serves as a protective factor to counselors and others working on the front lines of homelessness and mental health. Through interviews with workers at homeless shelters, the researchers found that there was a correlation between perceived client suffering, dedication to the job, and the employee’s identification with the organization. This finding evokes bonds of hardship such as “band of brothers” associated with particularly arduous, thankless, dirty, or dangerous work. They found that helpers’ mutual recognition of their clients’ suffering was sufficient to raise job satisfaction and control burnout, and that organizational identification served an additional source of strength and longevity.

In addition to paradoxical supports such as the Florence Nightingale effect, there are concrete ways to raise the odds that counselors will persevere in their roles as helpers to the homeless. In a study of outreach programs in Connecticut, Rowe, Styron, and David (2016), identified factors including constructive team characteristics, opportunities for training, and clear and appropriate work guidelines as critical success factors in raising therapist job satisfaction.

### **The Spectrum of Service Delivery Models**

In this portion of the literature review I outline the range of treatment models for homeless people with mental illnesses and report on studies of their effectiveness. There is a debate in the helping community over where to start in addressing the problem. At one end of the spectrum lies Treatment first (TF) models of care, and housing first (HF)

models are on the opposing pole. In reviewing the literature, I did not uncover robust comparisons of the effectiveness of these two models. Instead, each end of the spectrum had its proponents, with research seeking to measure the respective modality's effectiveness against a null hypothesis. The treatment first approach is medically-oriented, with a focus on seeking to diagnose, treat, and monitor progress of the mental illness. Treatment first often predicates the provision of continued housing on the client's compliance with treatment programs. On the other hand, the housing first model is a consumer-oriented approach. Clients get a permanent roof over their heads, and then they decide which services to utilize. In practice, the spectrum of service delivery models looks more like a circle, encompassing a continuum from bare bones TF models through hybrid models and back around to purist HF programs.

### **The CSB Referral Model**

A basic approach to extending mental health services to a homeless person is a referral from an emergency clinic or shelter to the local community services board (CSB). This modality falls on the TF end of the spectrum, as the CSB focus is primarily on behavioral health. Since deinstitutionalization, the CSB has, in many states, become the primary source of low or no barrier mental health services. In practice, there are multiple logistical and administrative barriers to successful referrals from shelters to CSBs. The initial referral to a CSB, according to Page (2007), can be problematic. Page collected data from specialists working with homeless persons with SMI, and found that 45% of respondents reported "major barriers" in transferring clients to CSBs. In searching for ways to improve access to care, those involved in working with the



homeless have developed several improvements on the basic referral model. These are outlined below.

### **The Assertive Outreach Model**

The assertive outreach model can be thought of as a supply-driven TF approach. Trained clinicians and/or helpers reach out to create relationships with clients where they find shelter and spend their time. One study (Rowe et al., 2016) followed six outreach programs in Connecticut, and identified four critical success factors in keeping the teams engaged. They found that cohesive care teams, a broad menu of service options, support in navigating service systems, and a good working and training environment were strong motivating forces for these helpers.

Assertive outreach has been in use for over 20 years, is largely left to individual states to design, implement, and monitor, and often is conducted primarily by paraprofessionals who are supervised by clinical directors. The published research on these programs consistently points to the importance of “connectors.” These individuals, be they agency staff, case managers, or peer navigators, are critically important as links to and advocates for people who are homeless.

Staying with outreach, some mental health professionals offer pro bono therapy at homeless shelters, often on a rotating basis outside of their regular practices. There are several systematic reviews of the ways in which these outreach programs seek to achieve their goals. In a randomized, controlled trial, Bradford, Gaynes, Kim, Kaufman, and Weinberger (2005) showed that a shelter-based outreach program by mental health professionals significantly increased the likelihood that people experiencing homelessness would follow up with one or more scheduled meetings at community

mental health centers. The study also reported significantly higher rates of treatment for substance abuse for those in the intervention group. The study did not conclude that outreach led to consistent use of community mental health services beyond a second visit, and its authors pointed to study design limitations (the control group had access to on-site counseling) as a possible explanation.

### **Co-Located Primary and Behavioral Health Services**

Further along the spectrum, there are models of care that might be conceptualized as more demand-driven. In search of services, many people experiencing homelessness seek primary care at emergency rooms, free clinics, or urgent care centers. When it comes to mental health care, this population often seeks or is referred to community service bureaus, emergency rooms connected to psychiatric services, or free counseling clinics. The comorbidity of homelessness, mental health issues, and physical maladies has led to efforts to combine primary and mental health care at facilities that are convenient for people who are homeless. One review (Gordon et al., 2007) sought to quantify the success of one such integrated model that was piloted in Pennsylvania in 2002. In addition to primary care and mental health services, this facility also made substance abuse counseling available in a one-stop location. This program, known as “AIM HIGH,” conducted extensive training for members of the community involved in providing support services for the target population. While the study reported extensive use of the various services offered, it did not examine outcomes relative to a control group of individuals without access to these integrated services. The authors note the difficulty this pilot project encountered in trying to connect with homeless shelters not directly involved in the integrated service model.

Such efforts at integrated care models have influenced federal guidelines in supporting people who experience both homelessness and mental illness. In assessing treatment modalities, SAMHSA points to what they call the Comprehensive, Continuous, and Integrative System (CCIS) as their recommended model (Harrison, Moore, Young, Flink, & Ochshorn, 2008). This integrative and overlapping approach brings elements from social work, counseling, psychiatric services, dental, and mental health together to serve homeless populations. Research conducted by Harrison et al. (2008) on one such program identified “system-level change, efficient use of existing resources, incorporation of best practices, and integrated treatment philosophy” (p. 257) as the key elements of the CCIS model. Their study indicated improved client outcomes as a direct result of program design and systematic application.

### **Continuity of Care**

Some argue that treating physical and mental conditions without provision for permanent shelter is a form of triage. Others doubt the lasting effectiveness of providing permanent housing without a regimen of care to deal with recurring health problems. On the treatment first side of the debate, continuity of care (CoC) is a long-established approach to rehousing people with mental illness, particularly substance use disorders. Often referred to as the “abstinence model,” CoC is a stage-based approach with emphasis on care at the outset (Watson, 2012). Shelter is a provisional reward for compliance with the care regimen. Detox and “dry” shelters are often the first stages in this model. With compliance comes the opportunity to move to a halfway house. These temporary homes are characterized by a rules-based structure, regular drug testing, and mandatory attendance at counseling sessions. Despite their label, continuity of care

programs are generally limited in duration and often are not connected to permanent housing agencies. This creates a gap when clients reach the end of their permitted stay in temporary housing. The jarring transition between unstructured life on the streets, the discipline of halfway houses, and the burden of finding permanent housing is often too much for people who have been chronically homeless. In his 2012 study, Watson concluded that the model's rigidities result in it becoming simply a community-based replication of the problems created by institutionalization, which was the very model CoC was designed to replace.

### **Residential Recovery Homes**

Another modified TF model is the residential recovery home. In a recent study, Polcin (2016) pointed to promising results coming from such programs as Oxford House. In this model, substance abusers who are homeless and/or dealing with other mental health issues live in a shared home, with support from peers and community health workers. While offering a more permissive and supportive environment than the most restrictive CoC programs, Polcin noted some of the same limitations in residential recovery homes. Such facilities are often not connected to permanent housing, are time-limited, and require abstinence. Polcin calls for integration of residential recovery homes as a bridge between homeless shelters and housing first programs.

### **Housing First Models**

At the other side of the divide over housing vs. treatment, the housing first philosophy embraces a low threshold approach to availability, coupled with belief in the client's personal agency as to whether, when, and how to address substance abuse and/or mental health problems. Housing first programs provide a residence largely without

conditions, either in apartments or group facilities. This permissive approach may be particularly helpful to persons who are chronically homeless (generally defined as longer than one year) and persons with chronic psychiatric conditions such as schizophrenia (Padgett, Gulcur, & Tsemberis, 2006). For people who are averse to formal treatment programs, housing first is an alternative that resolves a major piece of their struggle—finding a stable residence. Polcin (2016) summarized research that indicates positive outcomes from housing first strategies on substance abuse, but went on to note methodological limitations in the studies to date. By contrast, the TF (abstinence-contingent housing) model has more robust research history, but the model itself has weaknesses. The most obvious of these come from the impact of being evicted as a consequence of relapse, and on the scramble to find the next place to stay for those completing residence in a TF facility.

The housing first model is built on the assumption that permanent shelter is a therapeutic intervention that promotes improved mental health outcomes. This is a consumer-based approach, in contrast to the TF models that assume a normative threshold for screening individuals into rehousing programs (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005). The idea that housing, per se, increases an individual's agency, challenges traditional ways of conceptualizing care (Greenwood et al., 2005). Viewed from the Adlerian standpoint, the idea of personal responsibility and freedom as powerful tools lends support to solving the housing problem first. When Greenwood et al. (2005) sought to establish a direct link between choice, mastery, and improved mental health (measured via self-report), they found an association between these factors, but noted that mental health issues have etiologies that are not explained

solely by homelessness. Further corroboration of the link between housing and improved mental health came from a study by Benston (2015), who performed a literature review on 14 methodologically consistent studies of the impact of permanent housing on homelessness and mental illness. She found that homeless persons placed in permanent housing with case management support stayed housed for significantly longer than those in control groups.

This line of inquiry—whether satisfying basic physiological needs builds a lattice to tackling higher order needs, has roots in Maslow’s theoretical framework. Along these lines, Henwood, Derejko, Couture, and Padgett (2015) studied homelessness in part to answer the question of whether Maslow’s hierarchy of needs operates in a linear fashion, where satisfying one level of demands is a precondition to moving to the next. Using the housing first model, their mixed method study found that this was not the case, but that categories of need were intertwined and non-linear. They found that treatment first programs in which basic demands for shelter were not met triggered a focus on self-actualization. They suggested this “supports Maslow’s later hypothesis that being needs may emerge from the frustration, not fulfillment, of basic needs” (Henwood et al., 2015, p. 226). Enrollees in housing first programs appeared oriented toward a step-wise approach to needs and goals, but the authors were loath to characterize this as a formal construct. Within Maslow’s hierarchy, social capital--the degree of connectivity to a supportive community—has meaning. Degrees of connectivity, the presence and prominence in everyday living of what Fitzpatrick, Myrstol, and Miller (2015) called “hassle factors,” is directly tied to degrees of well-being. Their study of the context of

mental health and homelessness identified an inverse statistical correlation between depressive symptoms and social capital.

At the outset of this section, I noted the paucity of long-term comparisons between TF and HF treatment models. One meta-analysis (Watson, 2012) concluded that housing first is the current evidence-based and consensus-based standard of care for chronically homeless persons. He pointed to the increased agency of persons participating in housing first programs as a possible explanation for their success. As discussed earlier, the ontological benefits of a consumer-oriented approach to recovery may be a factor in the program's relative success. While it is useful to have this perspective on the treatment vs. housing first debate, the findings do not tell us about hybrid or integrated models that take the best of both worlds. The following sections focus on these models.

### **The Mental Health Home Model**

One interesting approach when homelessness and mental illness present together is the "mental health home," which is informed by the success of the medical home model (Smith, Sederer, Smith, & Sederer, 2009). The mental health home is not so much a specific place as a locus of coordinated and comprehensive care, a successful delivery system for at-risk patients. In the case of seriously mentally ill and homeless people, their conditions render them not only without housing, but also medically homeless. The mental health home incorporates clinical expertise including diagnosis, medication, and stabilization. From there, it expands to include preventative and primary care, outreach in cases of noncompliance, integration with medical and social needs, advocacy, case management, and housing. The objective is reintegration onto community. Service integration, with the principle of client self-determination, engagement, and partnership

with the treatment team, guides the process. In the mental health home, lead clinicians focus on wellness, recovery, partnership, and self-efficacy. In their suggestions for best practice, Smith et al. (2009) proposed that a non-medical clinician lead the treatment team, working with psychiatrists as expert consultants. Counselors, perhaps working with counselors-in-training, would seem to be well-suited for this role.

The mental health home model shares characteristics with community service boards (Smith et al., 2009). CSBs extend support and coordinated services to individuals in the community, as do mental health homes. CSB program funding and services, however, are broad-gauge, with outpatient centers serving defined population areas and a wide range of individuals of all ages, housing status, and other demographic characteristics. The mental health home targets a more limited population of individuals with serious mental illness and emphasizes a focused care management model that integrates medical and psychiatric services. Smith et al. (2009) believed that by focusing on this underserved population and given sufficient funding, “the mental health home could succeed where the CMHC [CSB] movement failed by providing a stable locus of care for the neediest recipients” (p. 3).

### **Bridging the Gap: An Integrated Approach**

There are treatment models that appear to have sidestepped the TF-HF debate. One pilot program in the Philadelphia area that combines the medical home and housing first models has shown promising results (Weinstein, et al., 2013). This initiative integrates housing, primary medical and psychological care, and community support. The Weinstein team assessed this program through a Likert scale rating against a set of ten essential public health services. While the ratings system has limitations (the authors



themselves provided the scores) indications are that the partnership is providing valuable, integrated services to formerly homeless people dealing with serious mental illness. The authors noted that one of the major obstacles to continuing the program is the reimbursement of services for the primary physician and other health professionals. They also noted workforce training as a limitation. The primary physician has been the lynchpin of the medical home model, but it is not a popular area of specialization in medical school. As with the mental health care home model, it is interesting to consider whether counselors could be trained to fill this coordinating role, with physicians and psychiatrists serving on the treatment teams.

The results of this Philadelphia pilot were corroborated by outcomes of a statewide initiative in California. In 2004, voters approved a proposition known as the Mental Health Services Act (Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010). Described as “one of the largest natural experiments in mental health policy in recent history...this natural experiment relies heavily on Housing First” (Gilmer et al., p. 625). Assessing three years of this broad initiative in San Diego, the authors reported a 67% decrease in the mean number of days homeless, a rise in outpatient mental health visits and a decrease in emergency, inpatient, and justice system usage (i.e. detention or incarceration), and an increase in housing and outpatient costs that was 82% offset by crisis-oriented service costs.

The California initiative to integrate care, social services and housing support borrows elements from many of the care models discussed above. It offers low- or no-cost housing, and a dedicated team of providers oriented toward client rehabilitation and recovery. It features a wide entryway by sourcing clients from referrals, agencies,

hospitals, jails, shelters, and street outreach. Clients are not removed from the community in which they have legal right to reside. There is no requirement to participate in treatment to receive housing, other than a monthly check-in with the treatment team. When possible, housing is in the community of legal residence, where the client has tenancy rights.

### **Integrated Models for Targeted Populations: The (family) critical time intervention model**

The Critical Time Intervention (CTI) model, applied to homeless families, is cited as an effective method of reducing mental health issues among homeless family units (Samuels, Fowler, Ault-Brutus, Tang, & Marcal, 2015). This study described positive long-term results from CTI programs in New York, and analyzed a focused FCTI program on female heads of households who become homeless. In their work, Samuels et al. (2015) described an intensive, 9-month program incorporating rapid rehousing, medical and psychological care, community connections, employment, and benefits assistance, and full re-entry into community life. This longitudinal study concluded that the most important factor in reducing self-reported mental health issues is in rapid, permanent rehousing.

**Services for women.** With feminist theory as their framework, David, Rowe, Staeheli, and Ponce (2015) applied a theoretical approach that conceptualizes homeless women as victims of an oppressive set of intersecting forces. They studied a federally-funded pilot program for homeless women with serious mental illness and highlighted four tools to improve services to this population. These include peer support, flexibility in service delivery, strong and supportive leadership, and the use of women to treat other

women. They posit that these four factors increase trust, safety, and serve to meet clients where they are. This integrated model raises clients' autonomy and agency. The authors note that an essential element of the successful model involves assertive outreach in the face of what might appear to be low demand for services.

**Canada: The collaborative care model.** One approach to dealing with the complexity of homelessness and its mental and primary health care issues is to physically integrate shelters with hospital and clinical resources. This model, known in Canada as collaborative care, has been in place in several major urban areas since the early 2000s. A study of one such program (Stergiopoulos, Dewa, Rouleau, Yoder, & Chau, 2008) found that the integrated and community based nature of the services offer a more effective approach than piecemeal service options.

**The peer navigator model.** An adjunct to all the modalities described above is the peer navigator model. Here, people with lived experiences of homelessness use their knowledge and skills to support currently homeless people obtain services they need. Such individuals appear to break down the wall of suspicion and hostility that many people experiencing homelessness have with the formal care system. One such program in Chicago was studied using community-based participatory research with a focus on African-American homeless with mental illness (Corrigan, Pickett, Kraus, Burks, & Schmidt, 2015). Their research identified a need for peer navigators to help advocate, teach, and connect the homeless population with primary care, behavioral health services, and other critical resources. Subsequent research by Corrigan et al. (2017) corroborated earlier studies, indicating higher levels of treatment and client satisfaction when using peer navigators compared to a control group.

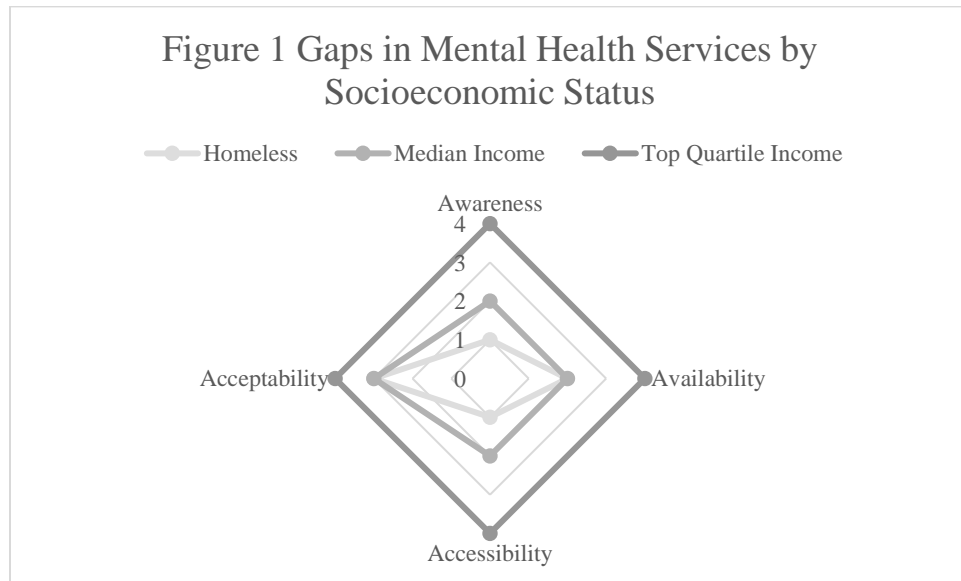
### **Care Models Through a Needs Analysis**

So far, this review has identified and described the range and evolution of care models for people dealing with homelessness and mental illness. In this section, I evaluate these models through a needs analysis framework, and filter and score them against a set of criteria. I use Bradshaw's typology (Royse, 2009) as a framework. This provides the researcher with four approaches to needs analysis: normative, which generally is based on expert opinion, for example through a panel of qualified specialists; expressed need, in which demand from the target population is measured ex post; felt need, in which the target population is interviewed; and comparative need, in which services available to the target population are considered next to those available to similar groups or the general population.

I have elected to use the fourth typology, comparative need, based on norms in the counseling profession, including social justice and equity. My perspective is that our mental health care delivery system should, to the greatest extent possible, extend to all persons. In practical terms, this means making mental health services universally available, regardless of socioeconomic or other factors. Today's reality is that mental health care services differ in availability from state to state, are on a continuum of availability within individual states, and are likely to be influenced by the intense national debate over health care and health insurance. For the sake of organizing disparate information, I have categorized mental health care delivery in three income groups: one for the homeless, one for the median employed person, and one for the top quartile employed person.

Having chosen a form of needs analysis, the next challenge is to decide what to measure. Royse (2009) suggested four axes for quantifying need for services: awareness of services, availability of services, accessibility of services, and acceptability of services.

Figure 1 is a conceptualization of homelessness within this framework.



**Awareness of services**

The state of homelessness creates a constant logistical struggle, with mental health care well down the list of “to-do” items during the day. Nonetheless, most shelters and other service organizations attempt to make clients aware of opportunities for mental health services at low or no cost. By contrast, median and upper-income levels generally involve social and professional opportunities to identify and research pathways to care. Many employers offer direct channels to behavioral health programs that are part of the wellness packages available at work.

**Availability and accessibility of services**

The ACA dramatically (and perhaps temporarily) expanded coverage for mental health care for millions of Americans. For the average household, the challenge is

finding a provider with openings, and obtaining clearance from the insurer to pay for services. At the high end of wage earners, buying power and referrals can usually work to obtain highly qualified care. For the homeless, most communities have mental health care services, but logistical issues create logjams and frustration on both sides. Logistics are a major barrier for the person who is homeless, and is a minimal issue for those further up the socioeconomic scale.

### **Acceptability of services**

The literature and personal observations suggest that, once engaged, the quality and acceptability of services is high for people who are experiencing homelessness, regardless of socioeconomic status. For the homeless, services available through local CSBs and allied organizations are staffed by licensed and dedicated practitioners. The support systems in place in many regions noted in this paper offer specialized programs that address dual diagnosis of SMI and substance use disorders, with case workers and/or peer navigators to support with community reintegration.

### **A Best Practice Model**

Nearly forty years have passed since the dual challenge of homelessness and mental illness became a public policy priority. In the intervening decades, a range of theoretical frameworks and applications has been tested, enhanced, and woven into public health care across the country. Today, there are reasons to be optimistic. The combination of public policy support, integrative delivery models, appropriate conceptualization of care, and motivated counseling resources presents a positive outlook for raising the level and quality of mental health care services for the homeless. More

research is needed to identify organizational models and career pathways for helping professionals who choose to make this important population their life's work.

That having been said, there are several best practices in building community-based services for this population. First, assertive outreach is helpful in meeting clients where they are. Second, peer navigators are a bridge to connect this population with clinical resources and formal programs. Third, the psychosocial needs of this population are best satisfied through a low-barrier, housing first orientation. Fourth, housing alone is insufficient to systematically address the primary, mental health, and substance dependency issues faced by this population. Fifth, an integrated approach that provides the consumer with sustained housing, and options to receive primary care, mental health, and social advocacy services has the highest likelihood of helping these individuals break the vicious cycle of homelessness and mental illness. Putting this together, best practice combines the concept of housing first with peer navigated, integrated community services in primary care, mental health counseling, and social support.

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