Fall 12-18-2022

Mental Health Services: Improving Utilization in Homeless Populations

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NURS 749A: Manuscript Development

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Abstract

Emergency shelters provide a unique location to offer easily accessible services for unhoused individuals experiencing mental distress and serious mental illness. Housing First interventions do not improve mental health or social integration. It is important to consider alternative approaches to providing care for homeless individuals. This integrated review was undertaken to evaluate existing evidence of interventions that improve mental health awareness and utilization of mental health services among unhoused populations living in shelters. Assertive outreach is an important strategy that was shown to improve effectiveness of mental health programs in shelters; reconnect individuals with family; and help with psychological integration. Screening, as a component of the assertive outreach strategy, has an enabling effect on the promotion of mental health awareness and utilization of mental health services. The process of screening individuals was informal and semi-structured; conducted by both clinical and shelter staff; but used validated screening instruments. Initiative taken by clinicians and outreach workers to seek out individuals about mental health changed the context of care. Incorporation of shelter staff helped to expand social networks, rather than establish traditional patient-provider relationships, which improved self-efficacy through social support. The synthesis of evidence recommends that a non-traditional approach to mental health care, which emphasizes outreach and social network building, be implemented within shelters to improve on-site utilization of mental health services.

Keywords: mental health, services, utilization, screening, homeless, shelter, assertive outreach, social support

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On any given night in America there are over half a million people who are homeless (Newman & Donley, 2017). Homelessness is defined as living in a temporary shelter, hotel, public space or places not meant for permanent inhabitants. The majority of homeless individuals live alone and nearly two-thirds are single men (Newman & Donley, 2017). At night in America, 407,966 individuals are homeless with 26.2% having severe mental illness and 34.7% having substance use disorder (SAMHSA, 2011).

One solution to the homeless crisis was the development of Housing First programs in the early 1990s (HUD, 2007). Housing First programs place individuals who are homeless into permanent housing. Housed individuals who have serious mental illness or substance use disorder are not obligated to participate in psychiatric treatment or attempt to attain sobriety. Participants are required to pay 30% of their income with the remaining rent being paid through government funding. Nearly all Housing First initiatives offer support services such as interdisciplinary Assertive Community Treatment (ACT) teams that can refer clients to community health services (HUD, 2007). Housing First programs are successful in creating housing stability, reducing utilization of emergency services and psychiatric facilities, but have mixed results in terms of social and psychological reintegration (Marshall et al., 2020). Major issues that are not discussed are social instability, behavioral problems, threatened evictions, failing to pay rent, and criminal activity in many of the Housing First studies (Newman and Donley, 2014).

Since the inception of Housing First programs, the number of families and veterans experiencing homelessness has been reduced by 12.7%, however, the number of single individuals experiencing homelessness has risen in the same time frame (Gordon et al., 2021).

Many single men that do not qualify for housing programs utilize emergency shelters. Across the country, shelters can be found in nearly every city. Emergency shelters account approximately 45,000 beds available to homeless individuals in California (PPIC, 2022). The number of emergency shelter beds has increased by 18% in the past 2 years compared to the 7% increase in permanent housing units in California (PPIC, 2022). The limited number of available housing units in California is another reason why emergency shelters have become a source of stable housing for many homeless individuals. All this to say, emergency shelters house a vulnerable population that is underserved especially when it comes to mental health. It is important to explore how shelters can broaden their function to include services that can improve quality of life which are not improved through Housing Initiatives (Stergiopoulos et al., 2015).

The perspective of this manuscript shifts the focus from discussing Housing First or Treatment First approaches for which there is a litany of existing literature and a historical legacy of government policy. In this case, given the circumstances created by policy, economy, and the housing climate, shelters have become a source of temporary housing and a resource for finding basic necessities for survival by a large portion of the homeless population in America. Therefore, the opportunity exists for shelters to expand the scope of care given the reality faced by those currently relying on shelter agencies for housing. Shelters should adopt interventions found in literature with the specific focus placed on psychological and social reintegration starting within a shelter setting. The focus of this integrative review is to determine what interventions would help improve mental health service utilization within a shelter that provides on-site mental health services. What can shelter agencies do to improve utilization of on-site mental health services by individuals living temporarily within the shelter?

Search Methodology

Three databases were used to search for literature pertaining to the PICOT question: Cumulative Index to Nursing and Allied Health Literature (CINAHL) Complete, PubMed, and Cochrane Database of Systematic Reviews. Specific journals searched: Community Mental Health Journal, Journal of Health Care for the Poor and Underserved, and Psychiatric Services. Initial Medical Subject Headings (MeSH) terms used together with mental health services were: homeless, persons, population, prevalence, utilization*, counseling, screening, depression, anxiety, PTSD, bipolar, schizophrenia, guidelines, shelter-based care, intervention*, "social support", and outreach. These MeSH terms were combined using Boolean Operators: AND, OR, & NOT. The first phase of searches was broad with limited restraints including: 2012 – 2022, peer reviewed, full text, and research article with an accumulated search yield of 3,415.

The elimination process excluded pediatric population and acute inpatient services. Narrowing the search yield with manageable returns included using terms: *utilization, homeless, people, depression, services,* and *mental disorders*. Restricting article types to meta-analysis, systematic review, and RCTs reduced the return to less than 50 articles for results with greater than 800 articles. The articles included in this integrated review were found within the first 30 articles listed after restricting the search. Ten articles were used for this integrated review that focused on assertive outreach, screening, and social network building to improve mental health services with emergency shelters and programs for homeless individuals.

Integrated Review

Peer-reviewed journal article quality level and strength of evidence was appraised using the Johns Hopkins Nursing Evidence-based Practice Appraisal Tools (Dang & Dearholt, 2018). Appendix A is an evidence table which entails findings from each article used in the integrated review. The majority of studies were Level III; one study was a Level I randomized control trial;

and all studies had good quality evidence. Two of the articles were published prior to 2012, however, the findings and insights are applicable to today's shelter-based programs conducting outreach, screening, and referral interventions.

Assertive Outreach

Assertive Outreach or assertive community treatment (ACT) was mentioned in the literature as a delivery of care model (Rowe et al., 2016 & Starks et al., 2017). The principles and components of assertive outreach attempt to address psychosocial needs of vulnerable populations that traditional service models fail to recognize (Firn, 2007). Specific characteristics include services provided directly by the care team; regular team meetings; frequent and persistent outreach; and focus on everyday problems (Firn, 2007). Assertive outreach is not therapy; however, it emphasizes building relationships and helping with non-professional needs along with mental health needs (Firn, 2007). Relationships are built by both clinical and non-clinical staff with the term outreach worker being used interchangeably (Rowe et al., 2016). Outreach workers can be case managers, social workers, community members, shelter staff, advocates, and clinicians (Rowe et al., 2016, Starks et al., 2017 & Zur et al., 2014). Interventions include frequent contact with clients; developing long-term relationships with individuals who are hard to engage; and helping clients practice daily living skills (Firn, 2007). Assertive outreach does not neglect clinical components of care, but helps to bring care to the individual and seeks to increase participation in care by proactive outreach.

As a strategy, assertive outreach, was shown to be effective in increasing social and psychological integration interventions (Marshall et al., 2020). Personnel conducting assertive outreach were shelter workers who referred clients to trained professionals that worked in social services, psychiatry, and substance use counseling. Assertive outreach proved to be beneficial for

increasing contact between clients and family members or close friends. Clients reported greater satisfaction with relationships because of the intent to help clients connect with family while living in respective shelters. Assertive outreach-based interventions were shown to be statistically significant in improving social and psychological integration compared to housing first initiatives (Marshall et al., 2020). Assertive outreach should be used as a model of care to help clients reconnect with existing social support systems.

The initiative of shelter workers can play an important role in improving utilization of mental health services in a shelter-based intervention through the use of the assertive outreach model. Another benefit of assertive outreach teams is that they can be made up of case managers, nurses, non-clinical staff, advocates, and other individuals as long as building lasting purposeful relationships is the goal of the outreach worker (Firn, 2007). A screening and referral protocol should include non-clinical staff that can notify social workers or clinical staff of client behavior that might warrant further evaluation (Bradford et al., 2005). There was a measurable effect on the reduction of depressive symptoms even if client issues are not related to mental health when non-clinical staff were included in the model of care (Gordon et al., 2021). Shelter staff should be educated and trained as a component of shelter-based interventions because it helps create a sense of awareness about mental health and an important component of assertive outreach (Hayward, 2007). The most important training curriculum components for outreach team members should include treating clients with positive regard; commitment to outreach, and working as a team (Rowe et al., 2016).

Two system-based study used the assertive outreach model to improve care of homeless individuals (Starks et al., 2017 & Zur et al., 2014). Full-service partnerships (FSPs) were helpful in building trusting relationships in which homeless individuals volunteered more information

during mental health sessions (Starks et al., 2017). Field and team-based care that was not structured like traditional office care improved the utilization of mental health services and client experience within the FSPs (Stark et al., 2017). In Federally Qualified Health Centers (FQHCs), when the scope of services was broadened and unbound, treatment utilization for substance use disorder improved compared to non-homeless patients (Zur et al., 2014). Health Care for Homeless (HCH) FQHCs employed case managers, outreach workers, and mental health treatment providers on-site to specifically address substance use disorder which is likely the reason for better utilization of services for homeless patients (Zur et al., 2014).

Screening for Risk Factors

Screening for mental illness was mentioned in several studies. In Rhoades et al. (2014), individuals that screened positive for either depression or PTSD were six to seven times more likely to utilize mental health services. Those with substance use disorder were recommended to be screened for other mental illness and vice versa because they often exist dually (Rhoades et al., 2014 & Gutwinski et al., 2021). A similar increase in utilization of treatment among homeless patients that screened positive for substance use disorder was reported in Zur et al. (2014). Emergency shelters should screen and assess clients which starts the process of addressing mental health needs by inviting dialog (Newman & Donley, 2017). Screening could be thought of as an enabling factor that motivates individuals to improve their mental and physical health.

Specific standardized instruments mentioned in the literature were the Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire-9 (PHQ-9), and Primary Care Post-Traumatic Stress Disorder (PC-PTSD-5) Screen (Rhoades et al., 2014). One study used a broader definition when screening for mental distress and serious mental illness

known as the Kessler scale (Zur et al., 2014). All studies that defined mental disorders and substances use disorder used some form of the Diagnostic and Statistical Manual and professionally certified clinician to make formal diagnoses or studies used previous medical records. No studies were found to measure the association between utilization of mental health services and the specific type of screening tool implemented. Identifying those with mental health illness remained largely a unique approach based on setting, personnel, and context of interaction between clients and program workers. The important thing to remember is that the scientific validity and reliability does not change when these tools are implemented under unique circumstances such as active outreach in a homeless shelter.

There was no specific format for screening, assessment, and referral when engaging individuals consistent with the assertive outreach model (Bradford et al., 2005 & Stergiopoulos et al., 2015). Informal semi-structured interviews using standardized instruments or medical records to identify mental health disorders were used in some of the literature (Rhoades et el., 2014, Voisard et al., 2021, & Zur et al., 2014). However, engagement with individuals took place in the community setting, without regard to time, and less with less focus on traditional means of delivering care (Starks et al., 2017). Engagement with clients about mental health, whenever possible, was helpful in reducing psychiatric morbidity through improved utilization of shelter substance use services (Hayward, 2007). Screening for other behavioral, social, or general issues had a positive effect on improving social support (Gordon et al., 2021). Once individuals were identified and agreed to follow-up after referral then a more formal process took place between the client and mental health clinician (Bradford et al., 2005). Screening, within an assertive outreach model, should be a constructive relationship building intervention with the intent of

addressing long-term goals instead of the traditionally rigid use of standardized tools to identify mental illness.

Purposeful Social Network

One of the most challenging barriers individuals living in shelters experience is a lack of social support to help them escape homelessness (Newman & Donley, 2017). Two studies pointed out the importance of building informal social relationships within shelter programs to improve mental wellbeing (Gordon et al., 2021 & Voisard et al., 2021). Providing recovery-oriented services within the program without strict regulations allows clients to expand their social network to increase their sense of connectedness (Voisard et al., 2021). A significant improvement in self-efficacy through added social support was seen when non-clinical staff were able to help clients access resources; accompany clients to appointments; and have someone to talk to when clients were angry or upset (Gordon et al., 2021). Addressing practical and social needs like reconnecting with family will increase the likelihood that individuals will utilize mental health services because of the holistic approach of assertive outreach.

Building a social network within a shelter-based mental health program must involve shelter staff. The effects that non-clinical staff have on utilization was not discussed specifically in the literature. However, there was no difference in client community scores when comparing two shelter-based care models (Stergiopoulos et al., 2015). The Integrated Multidisciplinary Collaborative Care (IMCC) model used shelter staff, psychiatrists, and primary care physicians while the Shifted Outpatient Collaborative Care (SOCC) model only had one psychiatrist working closely with shelter staff to provide outpatient care in the shelter (Stergiopoulos et al., 2015). Close collaboration with shelter staff was a common denominator in both the integrated IMCC and SOCC model. The SOCC was less resource intensive because it only used one on-site

psychiatrist, however there was a shared commitment between the shelter staff and psychiatrist to improve mental health care and outcomes (Stergiopoulos et al., 2015). Regardless how many professional resources used in establishing mental health services within a shelter the continual support from shelter staff is necessary for any shelter-based program to be successful.

Implications for Practice

This integrated review discussed potential best practices and principles to implement alongside on-site mental health services within emergency shelters. Single men living on the streets or within shelters make up a significant portion of the homeless population that have unmet mental health needs. Assertive outreach is an effective model in not only improving utilization of mental health service, but as well as improving social support which was a significant barrier faced by homeless men. Assertive outreach strategies implemented by case management, social work, or as non-clinical staff are beneficial to shelter-based programs. The end goal of assertive outreach is to be consistently present and attuned to the needs of clients, whatever the needs may be, with the intention of promoting mental health services.

Screening, as a single intervention, was not shown to improve utilization, mainly because most of the outcomes measured in the literature were retrospective rather than randomized control trials. However, informal or semi-structured screening is beneficial in detecting potential mental illness and raises awareness of unmet mental health issues. The act of screening fits into the assertive outreach model because it enables clients within shelters to seek out mental health services. There was little evidence that specific standardized tools were necessary to conduct screening, however, substance use disorder needs to be concurrently addressed with other mental illnesses. The opportunity to screen for mental illness often came after addressing other client

needs which speaks to the importance of meeting clients where they are and building rapport with frequent interaction.

Building social support helps clients to reintegrate socially and psychological. Social and psychological needs are often neglected in traditional care models which is why assertive outreach does a better job at treating the whole person rather than isolated issues. Social support interventions were successful when shelter staff, outreach workers, and clinicians all focused on implementing the principles and components of assertive outreach. Interventions geared towards improving the use of mental health services will be successful if client needs are first met, whatever they may be because assertive outreach is meant to be a means to meet with people wherever they are. Essentially, shelter agencies intending to help clients recover will be successful if they assimilate themselves into the lives of their clients rather than asking clients to reintegrate themselves. Community assertive treatment within a shelter-based program is a proactive attempt at becoming a part of the lives of homeless individuals in the hopes that they will accept mental health services when they are ready. Shelter and clinical staff that are committed to helping build meaningful social connections will be able to reduce depression scores; improve quality of life; and improve the chances of clients seeking mental health services.

Limitations

It was difficult to find recent prospective studies on shelter-based interventions that promote utilization of mental health services. There was one randomized control trial that was published in 2005, which measured the effectiveness of shelter outreach, screening, and referral, but it was successful in prompting clients to follow-up with mental health services. While a number of studies mentioned the benefit of social support, only one alluded to the effect of social

support on depression, but there was no direct relationship evaluated in any study. The effect of social support was measured qualitatively with recorded responses from clients, but no there was no prospective study of social support on mental health outcomes. Assertive outreach was recommended and used, but there was no specific description of the actions taken by case managers, social workers, shelter staff or clinicians. Another concern with assertive outreach is that it may be intrusive given the objective of being proactively engaging with clients. Despite the lack of specificity, evidence within this integrated review reveals qualities and characteristics that shelter agencies should adopt to help promote mental health awareness and service use.

Conclusion

Shelters that offer on-site mental health services can play an important role in helping clients to utilize available service. As an organization, shelter agencies should promote a culture of assertive community outreach with the focus on building purposeful long-term relationships. A designated shelter outreach worker should work closely the mental health agency clinician to coordinate screening and referrals. The format of screening can be informal or formal depending on the level of training given to the shelter outreach worker. Other shelter staff should be educated on the role of the shelter outreach worker and the goal of the agency to promote mental health services. Every individual working within the shelter must play an active role in assertive outreach. Continuation of care can be tracked by the shelter worker as a form of assertive outreach and to address barriers if care is disrupted or discontinued. Specific tasks for the shelter outreach worker should include screening, frequent interaction with clients, addressing practical problems, and encouraging clients to engage in mental health services. The collaboration between the shelter outreach worker and clinician will promote efficacy of services and improve social connectedness with clients. Implementing this type of workflow will help to broaden the

scope of services and infuse into the lives of clients as a source of social support and mental health service.

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Appendix A

Evaluation Table

Purpose of Article or Review	Design / Method / Conceptual Framework	Sample / Setting	Major Variables Studied (and their Definitions)	Measurement of Major Variables	Data Analysis	Study Findings	Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
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. *Public Library of Science*, 18(8), e1003750. https://doi.org/10.1371/journal.pmed.1003750							
Prevalence of any mental disorder and major psychiatric diagnoses in clearly defined homeless populations in any high-income country.	Systematic review Random effects meta-analysis Conceptual Framework: PRISMA guidelines	39 studies 8,049 participants US, UK, Canada, Australia, Japan, or Germany	**Dependent:** schizophrenia spectrum disorders, major depressive disorder, bipolar disorder, alcohol use disorders, drug use disorders, personality disorders, and any current mental disorder. **Independent:** Number of participants, sex distribution (female/all), and final year of diagnostic assessment.	**Diagnostic method:** structured/semi-structured interview versus non-structured clinical evaluation **Sampling Method:** randomized versus non-randomized sampling methods	**Study heterogeneity:** test statistic Q_E, p-value, & I^2 statistic Subgroup analysis of low-risk and moderate risk of bias using Q-test. Proportion of variance of prevalence estimates using R^2	Any mental health disorder: 4 low-risk-of-bias studies; random effects prevalence was 75.3% (95% CI 50.2% to 93.6%). Schizophrenia spectrum disorder: 17 low-risk-of-bias studies; random effects pooled prevalence of 10.5% (95% CI 6.2% to 15.7%). Major Depression: 9 low-risk-of-bias surveys; random effects pooled prevalence of 2.6% (95% CI 1.0% to 4.9%). Alcohol Use Disorder: 14 low-risk-of-bias studies; random effects pooled prevalence was 36.9% (95% CI 21.1% to 54.3%). Drug Use Disorder: 13 low-risk-of-bias studies; prevalence of 18.1% (95% CI 10.5% to 27.2%). Personality Disorder: 6 low-risk-of-bias studies; random effects pooled prevalence was 21.0% (95% CI 4.7% to 44.5%). "Homelessness and substance abuse reflects a bidirectional relationship: Alcohol and drug use represent possible coping strategies in marginalized housing situations. Substance abuse and other psychiatric disorders precede the onset of homelessness." "Positive effects on housing stability, but only moderate or no effects on most indicators of mental health in comparison to usual care, including for substance use."	Level III - A **Worth to Practice**: stability for homeless individuals requires attention and integration of mental health services. **Strengths:** large sample size. Depicts a pattern of mental health disorders and burden. **Weakness:** significant heterogeneity. Lack of female participants. Sampling methods not discussed. Diagnostic criteria determined by secondary analysis of interviews. **Feasibility:** possible to implement recommendation based on findings. **Recommendations:** integrate mental health care with other unmet needs to improve overall effectiveness of intervention such as case management. **Conclusion:** DNP project will increase awareness of mental health and improve psychosocial aspect of a person which may help stabilize person in other aspects like housing.

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Study examines need, predisposing, and enabling factors likely to be associated with the utilization of mental health care among homeless men living in the Skid Row area of Los Angeles.	**Design:** non-experimental **Method:** randomly sampled **Conceptual framework:** Gelberg–Andersen Behavioral Model for Vulnerable Populations	305 homeless men Least age 18 13 meal programs	**Service Utilization:** drop-in clinic, job training, alcohol or drug counseling, mental health, legal assistance, or medical assistance. **Predisposing Characteristics:** Age in years, education, & substance use in the last 6 months. **Enabling Characteristics:** characteristics of respondents' personal networks (alters provided them with tangible or advice/informational support in the prior six months). **Mental Health:** Depression PTSD	**Interview:** semi-structured **Depression:** 3-item screening instrument (Diagnostic Interview Schedule & CES-D) **PTSD:** PC-PTSD Screen, a 4-item screener **Substance use:** Composite International Diagnostic Interview Short Form and NIAAA task force recommendations	**Weighted logistic regression models:** differences in all considered characteristics by symptoms of PTSD or depression Estimate the odds of utilizing mental health care services on Skid Row in the prior 30 days.	"26.30 % of the sample utilized mental health care services on Skid Row in the past 30 days." "31 % reported depression and PTSD; 5.36 % depression only, & 11.85 % PTSD only." "Mental health care utilization was higher among those who screened positive for either PTSD or depression." "Those experiencing depression (OR 7.13, CI 2.73, 18.59), PTSD (OR 6.42, CI 2.31, 17.86), or both depression and PTSD (OR 3.75, CI 1.62–8.70) all more likely to have accessed mental health care on Skid Row in the past 30 days." "Association of predisposing and enabling characteristics with mental health care service utilization suggests that there remain areas for improvement within the mental health care system."	Level III - A **Worth to Practice:** Screening is important aspect to addressing unmet mental health needs of homeless individuals. **Strengths:** Very little attrition rate during interviews. Conceptual model reflects experience of homelessness. **Weakness:** Did not use PHQ-9 or PHQ-2 for depression screening. Paid individuals $30 dollars to complete questionnaire. Population was heterosexual males only. **Feasibility:** Highly feasible to implement conceptual framework components and screening tools. **Conclusion:** Study demonstrates that screening is an effective intervention to improve mental health services. **Recommendations:** The conceptual framework will help to develop strategies using the SAMSHA guidelines for outreach. Findings validate the significance of screening for mental health among homeless people.

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Evaluate effectiveness of shelter-based intervention which include intensive outreach, weekly meetings with psychiatrist at the shelter, and appointments at the community mental health center (CMHC).	Randomized control trial	102 participants 51 intervention group and 51 in control group Homeless shelter	**Dependent:** CMHC appointments, second and third appointments at CMHC, entering substance use rehab, employment, and housing status at exit **Independent:** intervention group saw the same psychiatrists and continuity of care with the psychiatric social worker for referral follow-up to CMHC and case management. Control group was able to get referral to CMHC, but without the PSW assisting and no intensive outreach.	Results of referral to CMHC were directly reported by CMHC clinicians who were blinded from knowing who was in control group and intervention group. Number of visits with psychiatrist Duration of visits Number of case management visits Time spent with PSW	T-tests and pooled variance (continuous variables) Pearson X^2 (categorical variables) Risk difference (RD) Number needed to treat (NNT)	Intervention group individuals were far more likely to attend at least one meeting at CMHC. While not statistically significant, intervention group had twice as many individuals attend 2 meetings at CMHC. Intervention group was far more likely to attend substance use treatment program at CMHC. Access to PSW and regular on-site psychiatrist improved attendance at off-site mental health clinic.	Level I - A **Worth to Practice:** Intensive outreach and consistent presence of mental health clinician within a shelter can improve utilization of services even if they are not on-site. **Strengths:** RCT design with retainment of participants. Intervention was not overly complicated or resource intensive. **Weakness:** Outcomes did not include effect of intervention on existing mental illness or follow-up with on-site psychiatrist. **Feasibility:** Training for PSW role was only 10 hours. Screening portion of role included a survey and used other shelter staff to notify PSW of possible clients to approach. **Conclusion:** Intensive outreach was helpful in improving utilization of mental health services even if they were outside of the clinic. **Recommendations:** Use assertive outreach and have a shelter outreach worker screen clients and refer them to the on-site mental health clinician for treatment.

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Newman, R. & Donley, A. 2017. Best practices for emergency shelters that serve male populations. *Journal of Social Distress and the Homeless*, 26(2), 97-103. https://doi.org/10.1080/10530789.2017.1332559							
Opinions on the best practices of emergency shelters, and barriers that single men face in exiting homelessness.	Snowball survey where the first person interviewed tells the interviewer the next person, they might be able to interview.	Representatives from 21 different organizations that run emergency shelters in 14 different states	Services their facilities offered Security precautions Case management Opinion on best practice for emergency shelters Yes or No if the HEART Act had impact on emergency shelters	Telephone Survey Online Survey	Not specifically stated, however, data from results shows percentage of services offered, open-ended responses analyzed for themes, and prioritization specific services.	Top five services provided were beds, showers, case management, substance abuse rehab, and medical services. One of the least services used was a psychologist. Major barrier facing men at shelters was mental illness, substance use disorder, and no social support system. Those surveyed felt that breaking substance use disorder dependency should be priority at shelters. Clients who receive mental health and rehabilitation often do better when housed through Housing First Initiatives.	Level III - A **Worth to Practice:** Insightful opinions by people that run emergency shelters. **Strengths:** Majority of shelters offered alcohol and drug rehabilitation, case management, and social worker. Study included several states with well-known shelter programs. **Weakness:** California was not one of the states represented. Only person from management was able to fill out survey. Use snowball sampling which is highly bias because depending on who is referring interview for next interview location. **Feasibility:** Study provides direction for which services should be established at emergency shelters. **Conclusion:** Mental health services and social support can play an important role in rehabilitation. **Recommendations:** Priority should be placed on establishing mental health program and social support system for individuals staying at a shelter.

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Voisard, B., Whitley, R., Latimer, E, Looper, K., & Laliberte, V. 2021. Insights from homeless men about PRISM, an innovative shelter-based mental health service. *Public Library of Science One*, 16(4), 1-17. https://doi.org/10.1371/journal.pone.0250341							
Gain understanding of service-user experience within this program. Apply these impressions to a broader reflection concerning how to best serve the needs of homeless people living with severe mental illness.	**Design:** In-depth interviews **Methods:** stemming from grounded theory to analyze themes emerging from the interviews. **Framework:** qualitative methods stemming from Glaser and Strauss' grounded theory and adapted by Paille.	20 clients Welcome Hall Mission (WHM) Montreal, Canada PRISM is a program that houses those with instable housing and provides psychiatric services, social services, and shelter manager. The program focuses on recovery and re-integration into society.	Sociodemographic questionnaire containing information about their age, educational level, sexual orientation, housing history, substance use history and criminal justice history.	**Semi-structured intake interview:** 1) can you tell me about the first time you found yourself in a homeless situation? 2) can you tell me about the services (social and mental health) you have received since you started experiencing housing instability? 3) what have been your biggest obstacles, and on the contrary, what have you found to be helpful? **Exit Questions:** 1) can you tell me generally if/what impact the program had on you? 2) can you tell me about your experience at the PRISM? 3) can you tell me if/how the program impacted your integration within society?	Interviews conducted by a graduate student in clinical psychology and diagnosis made by psychiatrist. MAXQDA 2018: computer assisted qualitative data analysis software Graphic representation was used as a brainstorming tool to explore how these themes were connected to PRISM and to more general realities of homelessness.	**Accommodating informal networks:** importance of the balance achieved by PRISM between the maintenance of some of these personal patterns and a simplified access to formal resources as participants. **A Space for Recovery:** simultaneous removal of some of the pressures of home lessness and the opportunity for flexible mental healthcare, participants were able to take some time for themselves and become engaged and involved in the development of their treatment plan. **Multimodal approach at the PRISM (compared to unimodal approach in the hospital):** participants were able to address a variety of issues in their lives; not only concerning their medication and housing, but also the general quality of their mental health and everyday lives.	Level III - A **Worth to Practice:** Individualized care is important take away because recovery takes time and is unique to each person. **Strengths:** A program should take the time to help clients realize their mental health needs rather than force them to take medications. Providing services under one roof helps improve chances of utilization. **Weakness:** The program was essentially permanent housing that was open 24 hours a day. Shelters are only open in the evening and close in morning. Small sample size. **Feasibility:** Providing flexible services can be done at the shelter. **Conclusion:** Relationship building is important because it adds to the informal network of resources which clients use to survive on the streets. **Recommendations:** The shelter can be a place for recovery and a place where mental health is viewed and addressed differently than traditional care.

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Hayward, M. (2007). Psychiatric morbidity and health service use among attendees at a winter shelter. *Psychiatric Bulletin*, *31*(9), 326-329. https://doi.org/10.1192/pb.bp.106.011601							
Assess psychiatric morbidity of attendees at medical center of open access at shelter and examine if there was an association between psychiatric symptoms and treatment rendered.	Retrospective chart review	597 attendees at a winter shelter in London 410 individuals had no current psychiatric morbidity while 187 existed symptoms.	Screening and triage of drug use, psychiatric history, presenting symptoms and diagnoses Outcome of current psychiatric morbidity i.e., immediate treatment or referral	Attendees were initially triaged by nurses used a standardized medical form to record demographic and housing information, usual sources of healthcare, past medical and psychiatric history, and presenting complaint.	Outcomes were compared between those with psychiatric symptoms and those without psychiatric symptoms using Pearson Chi-squared test	Of the 187 attendees that were triaged to have symptom 28 were referred to the shelter substance misuse team. 73 attendees presented again during the week who were suffering from psychiatric morbidity when they received consultation. Opportunities to identify and treat mental health problems must be taken whenever possible. Training should aim to increase engagement with mainstream mental health services as the first step.	Level III - A **Worth to Practice:** Shelter staff should be educated on how the significant prevalence of mental illness and substance use disorder among homeless persons staying at the shelter. **Strengths:** Data collection on both medical and psychiatric history is extensive. Records of re-presentation are important finding that indicate increase use of shelter services by those with psychiatric morbidity. **Weakness:** No diagnostic or formal screening done by staff was recorded. Findings are retrospective which means they might not be generalizable. No data on how referrals helped reduce burden of mental illness. **Feasibility:** Possible to teach and apply lessons about being aware of psychiatric needs of client within the shelter even if it is not the priority. **Conclusion:** There is a large number of homeless individuals suffering from mental illness. Therefore, it is necessary to establish procedures to identify and treat mental health issues. **Recommendations:** Educate shelter staff so they can be aware of mental health needs of clients. Screen and conduct outreach on a regular basis to promote mental health awareness.

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Starks, S. L., Arns, P. G., Padwa, H., Friedman, J. R., Marrow, J., Meldrum, M. L., Bromley, E., Kelly, E. L., Brekke, J. S., & Braslow, J. T. 2017. System transformation under the California mental health services act: Implementation of full-service partnerships in Los Angeles County. *Psychiatric Services*, 68(6): 587–595. https://doi.org/10.1176/appi.ps.201500390							
Evaluate the effect of California's Mental Health Services Act on the structure, volume, location, and patient-centeredness of Los Angeles County public mental health services.	Quasi-experimental Prospective mixed-methods study	Five Los Angeles County public mental health clinics Three of 5 clinics had Full-Service Partnerships (FSPs) Participants included 21 FSP and 63 usual care providers. Clients included 41 FSP and 62 usual care clients.	**Dependent:** outpatient services received, organizational climate, recovery orientation, provider-client working alliance **Independent:** FSP providers and clients compared to usual care providers and clients.	surveys and semi-structured interviews LA County Department of Mental Health (LACDMH) clinical/utilization data Client-Provider Working Alliance: Working Alliance Inventory, Short (WAI-S) Recovery Orientation: Recovery Self-Assessment Scale, Revised (RSA-R) Mental Health Services Utilization: LACDMH database	Outpatient Services: minutes spent with clients Organizational Climate, Recovery Orientation, Working Alliance: random effects (Stata's mixed) with random intercept for individual and standard error adjustment for within-clinic clustering.	Clients rated FSP programs higher on 5 of 6 subscales and overall (3.8 vs. 3.5, $p<.001$) "It's a great relationship. They support me a lot. They are almost like family to me because of what they try to do." FSPs' small caseloads, daily team meetings, and mandate and resources to "do whatever it takes," vs. usual care's large caseloads and contact restricted to brief scheduled appointments—shaped not just service volume, but clients' treatment relationships and experiences.	Level II - A **Worth to Practice:** On a systems level this is an important article that looks at the priority set by the state regarding how mental health services are carried out by organizations for unhoused people. **Strengths:** Prospectus study that took place over 3 years. Insight into both clients and provider perspectives. Combined quantitative and qualitative data. **Weakness:** Data analysis was limited to effect size. Analysis was not explained well. Significant number of participants dropped out. **Feasibility:** It is possible to use the client-centered approach to the DNP project, but without the intensity of "whatever it takes." **Conclusion:** It will be important to work on a provider-client alliance to ensure the best chances for mental health utilization at the shelter. **Recommendations:** Build relationships that offer more than traditional care. Focus on recovery and positives rather than on the negatives that cause clients to be homeless and suffer from mental illness.

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Zur, J. & Jones, E. 2014. Unmet need among homeless and non-homeless patients served at health care for the homeless programs. *Journal of Health Care for the Poor and Underserved, 25(4),* 2053-2068. http://doi.org/10.1353/hpu.2014.0189							
Compared the level of unmet need for medical, dental, mental health (MH), and substance use disorder (SUD) treatment between homeless and non- homeless patients served at Health Care for the Homeless programs.	Cohort Study	471 patients from national federally qualified health centers that are Health Care for the Homeless (HCH) grantees. 358 were homeless out of 471	**Variables:** homelessness patients, demographic and contextual characteristics, self-reported health, chronic health conditions, Dental problems, mental distress and serious mental illness, substance use disorder, perceived need, unmet need, reasons for unmet need	Surveys	Weighted data to compute descriptive statistics Bivariate analyses: associations between homelessness and socio- demographic and health characteristics, as well as unmet need. Unmet need variables were dependent variables in bivariate logistic regression models.	**Health status and perceived need:** 71% of sample met criteria for mental distress. **Unmet Need:** 29% of patients who perceived a need for MH counseling were delayed. 31% were unable to receive it. **Homelessness and unmet need for MH counseling:** homeless patients had 2.35 times the odds of being delayed in getting MH counseling. 3.87 times as likely to report being unable to receive MH counseling. 55% stated that it was because they could not afford it, with an additional 26% indicating that it was because they did not know where to go to receive care. Homeless patients who were screened for SUD were less likely to have unmet needs for treatment compared to non-homeless patients.	Level III-A **Worth to Practice:** Important findings that justify screening and highlight the need to provide mental health services outside of healthcare facilities. **Strengths:** Identifying unmet needs of homeless individuals within a system that is supposed to help homeless people is an important indicator that a unique approach is required to deliver mental health services to individuals living without permanent shelter. **Weakness:** Majority of patients were homeless, so data is significantly skewed. **Feasibility:** It is possible to implement a screening intervention at the shelter to promote utilization of mental health services at the shelter. **Conclusion:** It would have been better to do a bivariate comparison of unmet needs for homeless individuals rather than trying to compare to a smaller number of non-homeless patients. **Recommendations:** Emphasize screening to improve utilization of services within the shelter setting as it addresses reasons for unmet needs among homeless people.

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Gordon, A., Liu, Y., Tavitian, K., York, B., Finnell, S. M., & Agiro, A. 2021. Bridging health and temporary housing services for Medicaid members experiencing homelessness: Program impact on health care utilization, costs, and well-being. *Journal of Health Care for the Poor and Underserved,* 32(4), 1949-1964. http://doi.org/10.1353/hpu.2021.0175							
This study was conducted to determine the effect of participation in the BT program on health care utilization, health services costs, and self-reported overall well-being.	Quasi-experimental study Difference-in-differences comparison to weigh the change in BT participants' health care utilization, paid health care cost and self-reported wellbeing.	181 participants 81 were enrolled in Blue Triangle Program 100 were on waitlist Blue Triangle Residence Hall, Indianapolis USA	**Dependent:** Enrollment into the Blue Triangle Program for at least 6 months. **Independent:** program impact on utilization, program impact on self-reported well-being and functioning	**Utilization:** Administrative medical and pharmacy claims from the Medicaid health plan all-cause counts of hospitalizations ED visits; office visits, including visits with a primary care physician. Utilization with a diagnosis code for a psychiatric/ behavioral health condition. **Survey:** joining the BT program and joining the BT program. Included perceived health and well-being, PHQ-9, social support, understanding benefits/navigating the health system.	Unadjusted difference-in-differences analyses were conducted to compare changes in per person per month (PPPM) health care utilization and cost measures among participants with changes in non-participants after program entry. Sensitivity analysis for 52 individuals that completed pre-six-month index and post-six-month index. Post paired t-tests changes in survey metrics. Priori two-tailed level of significance (alpha value) was set at the 0.10 level because of small sample size.	Inpatient admissions decreased among both groups. However, BT participants decreased utilization of ER by 32% No statistically significant improvement in utilization of office visits for BT group. Health-related functioning appeared to improve slightly, but only small number of BT participants completed post-survey. Participants reported improved social support by the time they exited the program. Diagnosis for psychiatric complaint decreased for ER visits and increased for office visits which was statistically significant. Depression scores decreased in BT group, but not statistically significant.	Level II-A **Worth to Practice:** Social support was a positive finding that was provided by non-clinical staff. This is an encouraging finding that can be replicated within a shelter. **Strengths:** Study design and data analysis paint an accurate picture of how difficult it is to improve utilization of healthcare even after providing temporary housing. **Weakness:** Duration of program was only one year which may not be long enough to see changes in mental health outcomes. Study was underpowered. Psychiatric illness was not the focus of this study. **Feasibility:** Shelters provide stable housing, essentially, which can be utilized to implement aspects of the BT program interventions, but specifically focusing on mental health. **Conclusion:** Rather than focusing on cost reduction there is an opportunity to improve social support which clearly had beneficial effect on mental health and overall wellbeing in this study. **Recommendations:** Implement the social support aspect of this study within a program that is focused on improving mental health utilization within a shelter.

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Rowe, M., Styron, T., & David, D. H. (2016). Mental health outreach to persons who are homeless: Implications for practice from a statewide study. *Community mental health journal*, *52*(1), 56–65. https://doi.org/10.1007/s10597-015-9963-4							
Identify key functional elements needed to effectively address the multiple needs of these persons.	Qualitative and observation study Exploratory approach using thematic analysis	Six shelter sites in Connecticut 28 outreach staff and 37 clients	What is outreach as a practice and what are the principles? Do you work with substance use disorder clients or dually diagnosed? What is outreach and who is it for? Do you work with other agencies? What things are helpful that outreach workers do for you? What issues do you ask for help with?	Semi-structured key informant interviews with outreach team directors and supervisors. Review of written policies, procedures, and other material; focus groups with outreach workers and clients at each site. Shadowing of outreach workers on their rounds.	(1) researcher familiarization with transcribed data, (2) generation of initial codes, (3) collating codes into potential themes, (4) reviewing themes in relation to coded extracts, and (5) defining and naming theme	Outreach should be guided by positive regard for clients and commitment to outreach. A psychiatrist or APRN time on outreach teams merit consideration for future federal and state funding programs. Outreach workers felt ill equipped to identify and assist with mental health needs of clients. Standards of practice regarding how mental health outreach is conducted needs to be constructed for workers. Not having health care workers and mental health workers can make it difficult for outreach workers to connect clients to services or to help them make appointments to the appropriate agencies.	Level III-A **Worth to Practice:** Study provides important guide to developing outreach strategy through assertive model. **Strengths:** Incorporates management, workers, and clients in exploring the concept and practice of outreach. **Weakness:** Study conducted in only one state and there may be differences in government oversight. Results were limit to only a portion of outreach teams so results may not be generalizable. **Feasibility:** It is feasible to tailor the goals of a project to reflect the values of these outreach teams. Outreach is possible but being able to connect clients with appropriate services is important to having an effective program. **Conclusion:** Outreach team themes are helpful in guiding how other programs establish attitudes towards clients. **Recommendations:** By adding mental health and health care personnel outreach teams would be able to address problems like mental illness and medical problems.