Spring 5-18-2023

Mental Health Services: Reaching the Homeless

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Doctor of Nursing Practice Project Brief Report

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Abstract

Background: Serious mental illness (SMI) and substance use disorder (SUD) are two common findings among the majority of those experiencing homelessness in the Stanislaus County.

Local Problem: Emergency shelters typically do not provide mental health services on-site, however, a collaboration between First Behavioral Health Urgent Care Center (FBH) and We Care Program Turlock (WCPT) was established to provide mental health services on-site.

Method: The WCPT case manager as part of a Doctor of Nursing Practice (DNP) quality improvement project implemented Assertive Outreach Model interventions to increase utilization of mental health services and established long-term relationships.

Interventions: Frequent contact with clients; screening for SMI and SUD; and conducting team meetings with key stakeholders were elements implemented within the workflow.

Measures: Client encounter data; number of screenings and referrals completed compared to prevalence of SMI/SUD in Stanislaus County, and semi-structured interviews from key stakeholders were collected between Fall 2021-2022.

Results: 103 individuals connected with the WCPT case manager; 55 of 103 individuals were screened positive for either SMI/SUD; and 75% of referred clients met with the mental health clinician. Key stakeholders believed that the project established consistency because “it ties things together so these guys don’t slip through the cracks.”

Conclusion: Assertive Outreach interventions in emergency shelters is a feasible option to promoting mental health service utilization.

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

Problem

Stanislaus County (2020) Health Services Agency Point-in-Time (PIT) survey reported that 2,107 individuals in Stanislaus County experience homelessness. A total of 512 out of 1,383 (37%) individuals reported SMI or SUD. Nearly half of the 1,383 individuals utilized emergency shelters and transitional housing. Obstacles to access services included transportation, not knowing where to go, and a lack of communication with service agencies (Stanislaus County, 2020). One of the issues with providing care to those experiencing a lack of shelter is the transient nature of homelessness. Shelters and transitional housing provide an avenue for establishing consistent mental health services through a shelter-based model of care (Bradford et al., 2005).

The We Care Program Turlock (WCPT) is an emergency shelter located in Turlock, California. Since its inception as non-profit organization in 2017, WCPT has provided year-round shelter at night, during the hours of 6:15 P.M. to 8:00 A.M. Individuals who utilize the shelter for housing are referred to as clients. The WCPT building capacity is 40 clients. On most nights the average census is 30 clients. From July 17th, 2019, to June 30th, 2020, WCPT served 300 unduplicated clients. Nearly half of the 766 sheltered individuals surveyed during the PIT count potentially stay at WCPT throughout the year (Stanislaus County, 2020). Beds are available on a first-come, first-served basis and there is no maximum number of nights that a client can stay at the shelter over the course of the year. The shelter acts as a form of sustained housing because many of the clients have stayed at the shelter for weeks to months at a time.

To date, there has been no shelter-based mental health services at the WCPT. A recent grant-funded collaboration between First Behavioral Health Urgent Care Center (FBH) and WCPT, as a part of a Doctor of Nursing Practice quality improvement project, focused on

providing on-site mental health services and case management. A mental health clinician from FBH works in the adjacent building Monday through Friday from 8 a.m. to 4 p.m. There is a WCPT case manager that works at night when the shelter is open for the first two hours. Connecting with clients at night was an important element of the collaboration because in the evening the majority of clients can be found under one roof. Incorporating the WCPT case manager into the workflow helped extend promotion of mental health services.

At night the shelter is run by the shelter manager. Six other staff members help with intake, rooming, and night security. The shelter manager and staff were crucial to the success of the project because they are the most consistent presence in the lives of clients. Existing relationships between staff and clients helped to promote mental health services. The inclusion of the shelter manager, shelter staff and executive director formed a continuous care team within the collaboration. Over the course of the project both the shelter manager and executive director were consistently involved in care team meetings and engaged to helping address client needs.

Project Aim

This DNP quality improvement project was to connect clients staying at the shelter with on-site mental health services using interventions recommended by the Assertive Outreach Model in Appendix B (Firn, 2007). The responsibility of the WCPT case manager was to engage clients consistently from Fall 2021 to Fall 2022 to build social networks; screen and refer clients for SMI and SUD; and participate in care team meetings with key stakeholders on a biweekly basis to measure perception and impact of the DNP project. The long-term goal was to build relationships with clients and promote mental health. If the collaboration were to continue after Fall 2022, then this pilot year would be used as a baseline. For the purposes of this DNP project

the goal was to connect with and screen 37% of clients based on the 2020 PIT count needs assessment for SMI and SUD in Stanislaus County.

Available Knowledge

P.I.C.O.

The literature search was conducted to answer the question "how does assertive outreach and mental health screening affect social networks and mental health service utilization in an emergency homeless shelter?"

Search Methodology

Three databases were used to search for literature pertaining to the PICO 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 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 in Appendix A. 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). Articles were appraised to be Level II-III with good quality evidence.

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). Specific characteristics include services provided directly by the care team both clinical and non-clinical personnel; regular team meetings; frequent and persistent outreach; and focus on everyday problems (Firn, 2007). Assertive outreach is not therapy; however, it is effective in building relationships; helping with non-professional needs along with mental health needs; and reconnecting with family members (Firn, 2007; Marshall et al., 2020). Principles of the Assertive Outreach Model focus on meeting individuals where they are; awareness of mental health needs at all times; and not being restricted to a traditional office style delivery care model for providing services to individuals (Bradford et al., 2005; Hayward, 2007; Rowe et al., 2016). Traditional delivery care models expect the person seeking care to find a care provider; schedule an appointment; arrive at the office; fill out forms; and discuss their needs within an allotted time. The characteristics of the Assertive Outreach Model in Appendix B are intended to reach individuals who are unable to navigate and utilize a traditional delivery of care model. 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). As such, these interventions of the Assertive Outreach Model worked well in adapting to the unique circumstances of participants in both system and single shelter agencies (Starks et al., 2017; Zur et al., 2014; Bradford et al., 200; Hayward, 2007). Essentially, shelter agencies intending to help clients recover will be successful if they assimilate services into the lives of their clients rather than expecting clients to try to utilize a delivery of care model that they failed to navigate once already.

Screening for Risk Factors

Emergency shelters should screen and assess clients which starts the process of addressing mental health needs by inviting dialog between the client and the shelter case manager (Newman & Donley, 2017). Rhoades et al. (2014), found that individuals that screened positive for either depression or PTSD were six to seven times more likely to utilize mental health services. A similar increase in use of treatment among homeless patients that screened positive for substance use disorder was reported in Zur et al. (2014). Engagement with clients about mental health, whenever possible, was helpful in reducing psychiatric morbidity through improved utilization of shelter substance use services (Hayward, 2007). Identifying those with mental health illness remained largely a unique approach based on setting, personnel, and context of interaction between clients and program workers. There was no specific format for screening, assessment, and referral or traditionally structured appointments when engaging individuals consistent with the assertive outreach model (Bradford et al., 2005: Stergiopoulos et al., 2015: Starks et al., 2017). 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.

Purposeful Social Network

Social support means individuals having someone to help them make appointments; a person to speak to when they are upset or lonely; and a constant presence in their lives (Gordon et al., 2021 & Voisard et al., 2021). Both clinical and non-clinical staff played an important role in helping build social support and getting participants to assimilate program resources into their lives (Voisard et al., 2021). Shelter staff were important in programs with multiple clinicians or when there was only one on-site mental health clinician because less resource intensive programs

relied heavily on non-clinical staff to help participants connect with services (Stergiopoulos et al., 2015). 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.

Rationale

Assertive Outreach was an effective delivery of care model for this project attempting to improve utilization of psychiatric services in addition to foundational needs provided by the shelter. Originally called "Training in Community Living," community teams helped chronically disabled psychiatric patients avoid hospitalization (Firn, 2007). Over time, the effects of training wore off, thus requiring community teams to become permanent fixtures within the lives of psychiatric patients. Community teams later conducted Assertive Community Treatment (ACT) by engaging clients regularly and being easily accessible especially in times of crisis. Engaging in constructive relationships; helping clients with symptoms and practical problems; and role flexibility allows team members to provide long term care (Firn, 2007). The Assertive Outreach model was an ideal conceptual framework for emergency shelters because the Continuous Care Team was inspired by the model.

Client tracking and outreach was a crucial role that was fulfilled by the WCPT case manager to ensure proactive and continuous contact is kept with clients. Outreach served as a way to retain clients by helping those with cognitive deficits remember appointments and build trust by being consistently reliable. A persistent presence that was modeled by the WCPT case manager encouraged clients to adopt a new social contact into their personal network. The long-term implications of the project were to move clients toward self-actualizations with the help of a

Continuous Care Team by building stable and reliable relationships with clients rather than delivering traditional care.

Ethical Considerations

Client autonomy and privacy was maintained by first asking for permission to conduct screening of mental disorders. Information regarding screening and specifics about each client's background was only shared between the WCPT case manager and mental health clinician.

The project focused on "promoting the common good by critically, thoughtfully, and innovatively addressing inequities to create a more humane and just world" (University of San Francisco, 2022). The aim of the project addressed inequality and social justice, which are pillars of the Jesuit tradition. Assertive Community Treatment teams aim to improve the *cura personalis,* a Jesuit value, which the shelter team hoped to achieve for clients at the WCPT shelter (University of San Francisco, 2022). The American Nursing Association Code of Ethics: "the nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" was recognized in this project by helping individuals remember their self-worth (American Nurses Association, 2015, p.5).

Intervention

Outreach, initial screening, client retention, and maintenance of continuity care are recommended by the Substance Abuse and Mental Health Services Administration which were used to address findings from the gap analysis in Appendix B (SAMHSA, 2013). Interventions and strategies for serving homeless people in SAMHSA TIP 55 (p.32) entails activities that were used to construct the role of the WCPT case manager and Continuous Care Team and are a part

of milestones for the project that are depicted in Gantt chart (Appendix C). The complete work breakdown of the project initiation to closeout can be found in Appendix D.

Initial screening was less traditional in shelter-based care as previously mentioned in the Assertive Outreach Model (Firn, 2007) which helped to overcome some of the internal weakness of the project discussed in SWOT analysis (Appendix E). If the client expressed interest in mental health services or reported a need for mental health service. then screening was conducted, and a brief summary of the client's response was recorded on the FBH referral form (Appendix F). Conversations were held in rooms where the client would be sleeping for the night, in the case manager office, and occasionally during dinner. Information was gathered over time as rapport was established with the client. Not all encounters required screening tools such as when clients expressed interest in counseling, but the screening tools used are listed in Appendix G. The coordination of care was maintained with monthly meetings between shelter executive director, shelter manager, mental health clinician, and myself. Communication and responsibilities of the Continuous Care Team can be found in Appendix H. The WCPT case manager's salary is 20 dollars per hour. Funding for the WCPT case manager and mental health clinician was through a grant provided by a community foundation. The WCPT case manager worked three nights per week for 1.5 hours each night. Total weekly salary will be $90 dollars per week. Biweekly meetings with the Continuous Care Team were not paid hours for the WCPT case manager.

Outcome Measures

Outcome measures were selected based on the Point-in-Time survey conducted in Stanislaus County (2020); elements of the Assertive Outreach Model (Firn, 2007); and

recommendations by SAMHSA TIP 55 (2013). Results were analyzed using Excel and exported to Appendix I.

- Number of clients who screened positive for SMI/SUD.
- Number of clients who followed up with mental health clinician after referral.
- Number of encounters between WCPT case manager and clients.

Qualitative measurement of the impact of the Continuous Care Team meetings was measured using semi-structured questionnaire that was administered to executive director and shelter manager at the end of the project. Results of the survey were exported from a Word document into Appendix I.

Results

There was a total of 103 individuals who were interviewed at least once over the course of the project. This rough equates to 33% of the total number of clients who use the shelter over the course of one year. Time constraint in the evening was the biggest factor in not being able to connect with more clients. There was a small window of about 1 hour each night for the WCPT case manager to connect with clients. All clients at intake were approached and offered an interview, however, a small portion were willing to have a conversation about available services. Yet, 55 of the 103 individuals that the WCPT case manager encountered were screened and referred to the mental health clinician. At the end of the project, nearly 75% of clients who were referred met with the mental health clinician. Due to patient privacy the results of the follow-up are not a part of the results. Overall, 41 out of 103 (39.8%) of clients utilized mental health services on-site which nearly matches the 37% of individuals with SMI/SUD in Stanislaus County (2020). These quantitative

The benefit of repeat encounters played an important role in not only initial screening, but follow-up too because 56 individuals had at least two encounters with the WCPT case manager. As the WCPT case manager, I found that repeat encounters helped to remind clients of mental health services, but also to ask about other needs they might have because those needs could be discussed at the Continuous Care Team biweekly meeting. Assistance with other needs, such as housing applications or making phone calls to the Social Security Office, were provided by members of the Continuous Care Team were not a part of the outcome measures which were an important part of building social support with clients. Perceived impact did capture the significance of addressing all client needs besides mental health and is an important outcome that deserves attention in future improvement projects.

Conclusion

According to the PIT count Stanislaus County (2020), 9% of individuals surveyed did not have transportation; 7% did not know where to go; 5% did not have identification; and 4% were placed on a wait-list, but never contacted. The project was able to help clients overcome transportation barriers because it was on-site, while the Continuous Care Team's collective effort helped clients access services regardless of proper healthcare documentation. This DNP project was built upon the ideas of the Assertive Outreach Model which focuses on providing care in a non-traditional approach. Providing mental health services within an emergency shelter was beneficial not only because barriers were removed, but also because services were provided in a space and by people who were trusted by clients. Advantages of building social networks within the context and situation of the client improved the chances of mental health service utilization possibly because clients trusted that services would continue to exist into the future based on their past experience with the WCPT emergency shelter.

Implications for Improvement and Limitations

Reaching one-third of clients is considered a success, however, there was no standardized process other than a brief encounter at intake between the WCPT case manager and clients to assess interest in further dialog. Therefore, replicating the actions and process taken by the WCPT case manager is difficult map for other shelter agencies. The project did not capture the perceived benefit and impact from client perspectives because the scope of the DNP project was limited to quality improvement. Generalizability of the results is also difficult to establish because national data is lacking on such projects and utilization cannot be compared to standard primary care practices since interventions were implemented in an emergency shelter. Using local data from the Point-in-Time Survey does provide a realistic standard of comparison which does substantiate the work done during this DNP project.

Sustainability

While it is uncertain that mental health services will continue to be offered at WCPT emergency shelter, the role of the WCPT case manager and Continuous Care Team will continue to operate on Assertive Outreach and SAMSHA principles. Presently, the team continues to work together to address the needs of clients in terms of medical, mental, and social issues.

Implications for Practice

The opportunity to provide mental health services on-site at an emergency shelter was successful, in part, by adopting Assertive Outreach interventions. Numerous homeless men were helped by proactively engaging them where they were and remaining available to them at their time of need. All this was insured by the diligent work of the Continuous Care team which was made up of mostly non-clinical personnel. One important take away from this project is that for mental health services to be successful there must be a framework in place that promotes social

network building between clients and staff members. If that relationship is established clients will readily adopt services into their lives which is typically the opposite of how traditional healthcare services are delivered in a fee-for-service model or a Merit-Based Incentive Payment System (MIPS). The demand for profit is removed which allows care team members to truly focus the needs of the client. The results of this project are a promising argument for a non-traditional approach to improving mental health services utilization among those that are homeless.

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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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Rhoades, H., Wenzel, S. L., Golinelli, D., Tucker, J. S., Kennedy, D. P., & Ewing, B. (2014). Predisposing, enabling, and need correlates of mental health treatment utilization among homeless men. *Community Mental Health Journal*, 58, 942-952. https://doi.org/10.1007/s10597-014-9718-7							
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.

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) /
Bradford, D. W., Gaynes, B. N., Kim, M. M., Kaufman, J. S., & Weinberger, M. (2005). Can shelter-based interventions improve treatment engagement in homeless individuals with psychiatric and/or substance misuse disorders? A randomized controlled trial. *Medical care*, *43*(8), 763–768. https://doi.org/10.1097/01.mlr.0000170402.35730.ea							
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.

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) /
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.

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) /
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.

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) /
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.

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) /
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.

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) /
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.

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) /
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.

Appendix B

Assertive outreach interventions

- Maintaining regular and frequent contact with patients
- Engagement – developing long-term therapeutic relationships with patients who are hard to engage with services
- Symptom management (regular monitoring and adjustment of treatments)
- Direct community medication administration, daily when needed
- Practical assistance and problem-solving
- Psychosocial interventions: cognitive–behavioural therapy, family work and support for carers
- Developing daily living and life skills. Encouraging the use of normal social resources
- Retaining and maximizing patient strengths
- Vocational rehabilitation/supported employment

Characteristics of an assertive outreach team

- Discrete multidisciplinary team able to deliver a comprehensive range of interventions
- Service focused on those with severe mental illness and greatest needs
- Most services provided directly by team, not brokered out
- Team approach with caseloads shared across clinicians
- Daily team-planning meetings
- Low patient:staff ratios (maximum 12:1)
- Most interventions provided in community settings
- Frequent visits and persistent, assertive-outreach approach to engagement
- Focus on symptom management and everyday problems in living
- Ready access in times of crisis
- Individualized services
- Time-unlimited services

Appendix C

Gap Analysis

Best Practice	**Best Practice Strategies**	**How Current Practice Differs**	**Barriers to Best Practice**
Assertive Outreach Model & SAMHSA TIP 55 interventions improve service engagement with individuals who are homeless.	Collaboration between WCPT case manager and mental health clinician. • Screen and Referral Process • Frequent contact with clients. • Team-based care with key stakeholders • Develop long-term relationships with clients.	No previous mental health services provided on-site. WCPT case manager helps clients find resources outside of shelter.	• Lack of time in the evening to have lengthy conversations with clients. • Competing client needs. • Transient nature of homelessness

Appendix D

GANTT

	2021				2022				2023
Project Timeline	Spring	Summer	Fall	Winter	Spring	Summer	Fall	Winter	Spring
Literature Review									
SAMHSA TIP 55									
SWOT Analysis									
Stakeholder Meeting									
AIM/Goal/Objectives									
Process for Tracking and Supporting Referrals									
Create Intake Form									
Communication Plan w/ Mental Health Clinician									
WCPT Case Manager Role									
Standardized Screen Tool Forms									
Process for Tracking and Supporting Referrals									
Screen and Refer to Mental Health Clinician									
Follow-up with Clients									
Communicate with Clinician about Referrals									
Continuous Care Team Meetings									
Retention and Active Outreach Goals									
Conduct Bi-Weekly Meetings w/ Stakeholders									
Address Issues									
Review Current Cases									
Collaborate to Overcome Client Barriers									
Adapt Process/Focus on Individual Client Needs									
Develop Plan for Sustainment of Services									
Collect Data and Outcomes for Each Referral									
Analyze Data									
Report Outcomes to Stakeholders									
Discuss Impact of Project									
Continuing MH Services									
Write Up									
Present									

Appendix E

Work Breakdown Structure

Level 1	Level 2	Level 3
Mental Health Services Screening and Referral Project	1.1 Initiation	1.1.1 Literature Review 1.1.2 Review SAMHSA TIP 55 1.1.3 SWOT Analysis 1.1.4 Stakeholder Meeting 1.1.5 AIM/Goal/Objectives
	1.2 Planning	1.2.1 Create Screening & Referral Algorithm 1.2.2 Create Intake Form 1.2.3 Communication Plan w/ Mental Health Clinician 1.2.4 WCPT case manager role 1.2.5 Standardized Screen Tool Forms 1.2.6 Process for Tracking and Supporting Referrals
	1.3 Execution	1.3.1 Educate Staff of Project 1.3.2 Introduce Case manager to Clients 1.3.3 Start Building Relationships 1.3.4 Screen and Refer to Mental Health Clinician 1.3.5 Follow-up with Clients 1.3.6 Communicate with Clinician about Referrals 1.3.7 Retention and Active Outreach Goals 1.3.8 Treatment Plan for Each Client
	1.4 Control	1.4.1 Conduct Bi-Weekly Meetings w/ Stakeholders 1.4.2 Address Issues 1.4.3 Review Current Cases 1.4.4 Collaborate to Overcome Client Barriers 1.4.5 Adapt Process/Focus on Individual Client Needs 1.4.6 Develop Plan for Sustainment of Services
	1.5 Closeout	1.5.1 Collect Data and Outcomes for Each Referral 1.5.2 Analyze Data 1.5.3 Report Outcomes to Stakeholders 1.5.4 Discuss Impact of Project 1.5.5 Continuing Mental Health Services

Appendix F

S.W.O.T. Analysis

	Favorable/Helpful	Unfavorable/Harmful
Internal	**Strengths** • Mental health clinician and case manager have contract to work in shelter. • Shelter manager has worked with clients over two decades. • Shelter is open every night to serve food and provide shelter for the night. • Clients can stay at shelter for as long as they would like as long as they follow rules. • Biweekly meetings between stakeholders. • Mental health clinician's office is next door to the shelter.	**Weaknesses** • Shelter opens at 6 p.m. and closes next day at 8 a.m. • Limited staff interaction in the morning when clients leave for the day. • Screening process needs to become a part of intake and nightly check-in process. • Priority given to check-in process and serving dinner. • Short amount of time allotted to Shelter Navigator to speak with new clients. • Clients arrive under the influence of substances like alcohol.
External	**Opportunities** • Shelter has a positive long-standing relationship with city and homeless population. • Partnership established with California State University Stanislaus Nursing program. • Shelter has partnership with United Samaritan Center, Salvation Army, and Turlock Gospel Mission. • Shelter is a part of the Homeless Management Information System (HMIS) within Stanislaus County. • Ongoing relationship with other CSU Stanislaus academic departments like anthropology.	**Threats** • Grant funding for mental health clinician cut from Legacy Foundation. • Stanislaus Health Services Agency disconnected with shelter regarding mental health services. • No partnership with surrounding mental health organizations like Stanislaus Rehabilitation Center or Doctors Behavioral Center. • No partnership with surrounding hospitals and primary care clinics. • Clients move from shelter to shelter within the county. • Consistent communication needs to be established with clients when they leave shelter in the morning.

Appendix G

Referral Form

First Behavioral Health Urgent Care Center
We Care Program Referral Form

Use this form to refer someone to counseling services at First Behavioral Health Urgent Care Center (FBHUCC). Once complete, please submit via email to Antonio Ruezga at xx@fbhucc.org.

Referred by:		Date:	
Client Name:		DOB:	
Gender:		Age:	
Address:		City:	
County:		Zip Code:	
Phone Number:		Preferred Language:	
Insurance:			

Reason for counseling (provide as much information as possible):

Appendix H

Screening Tools

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

Generalized Anxiety Disorder Screener (GAD-7)

Scoring and Interpretation:

GAD-2 Score*	Provisional Diagnosis
0-2	None
3-6	Probable anxiety disorder
GAD-7 Score	**Provisional Diagnosis**
0-7	None
8+	Probable anxiety disorder

*GAD-2 is the first 2 questions of the GAD-7

The Mood Disorder Questionnaire

INSTRUCTIONS: Please answer each question as best you can.	**YES**	**NO**
1. Has there ever been a period of time when you were not your usual self and...		
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	O	O
... you were so irritable that you shouted at people or started fights or arguments?	O	O
... you felt much more self-confident than usual?	O	O
... you got much less sleep than usual and found that you didn't really miss it?	O	O
... you were more talkative or spoke much faster than usual?	O	O
... thoughts raced through your head or you couldn't slow your mind down?	O	O
... you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
... you had much more energy than usual?	O	O
... you were much more active or did many more things than usual?	O	O
... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	O	O
... you were much more interested in sex than usual?	O	O
... you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	O	O
... spending money got you or your family in trouble?	O	O
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	O	O
3. How much of a problem did any of these cause you - like being able to work; having family, money or legal troubles; getting into arguments or fights?		
O No problem O Minor problem O Moderate problem O Serious problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	O	O
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	O	O

POSITIVE SCREEN
All three of the following criteria must be met:

Scoring: Question 1:
7/13 positive (yes) responses

+

Question 2:
Positive (yes) response

+

Question 3:
"moderate" or "serious" response

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?
   YES NO
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
   YES NO
3. been constantly on guard, watchful, or easily startled?
   YES NO
4. felt numb or detached from people, activities, or your surroundings?
   YES NO
5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
   YES NO

Scoring

The measure begins with an item designed to assess whether the respondent has had any exposure to traumatic events. If a respondent denies exposure, the PC-PTSD-5 is complete with a score of 0.

If a respondent indicates a trauma history – experiencing a traumatic event over the course of their life – the respondent is instructed to answer five additional yes/no questions (see below) about how that trauma has affected them over the past month.

Preliminary results from validation studies suggest that a cut-point of 3 on the PC-PTSD-5 (e.g., respondent answers "yes" to any 3 of 5 questions about how the traumatic event(s) have affected them over the past month) is optimally sensitive to probable PTSD. Optimizing sensitivity minimizes false negative screen results. Using a cut-point of 4 is considered optimally efficient. Optimizing efficiency balances false positive and false negative results. As additional research findings on the PC-PTSD-5 are published, updated recommendations for cut-point scores as well as psychometric data will be made available.

Annual questionnaire

Once a year, all our patients are asked to complete this form because drug and alcohol use can affect your health as well as medications you may take.
Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol: One drink =

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

Scoring and Interpreting the AUDIT:

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a risk zone, which can be circled on the bottom left corner.

Score	Zone	Explanation	Action
0-3	I – Low Risk	"Someone using alcohol at this level is at low risk for health or social complications."	Positive Health Message – describe low risk drinking guidelines
4-9	II – Risky	"Someone using alcohol at this level may develop health problems or existing problems may worsen."	Brief intervention to reduce use
10-13	III – Harmful	"Someone using alcohol at this level has experienced negative effects from alcohol use."	Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available)
14+	IV – Severe	"Someone using alcohol at this level could benefit from more assessment and assistance."	Brief Intervention to accept referral to specialty treatment for a full assessment

Positive Health Message: An opportunity to educate patients about the NIAAA low-risk drinking levels and the risks of excessive alcohol use.

Brief Intervention to Reduce Use: Patient-centered discussion that uses Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhance his/her motivation to change behavior. Brief interventions are typically 5-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Brief Intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: Patients with numerous or serious negative consequences from their alcohol use, or patients who likely have an alcohol use disorder who cannot or are not interested in obtaining specialized treatment, should receive more numerous and intensive BIs with follow up. The recommended behavior change is to cut back to low-risk drinking levels or abstain from use. Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the patient to accept a referral to specialty treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Which recreational drugs have you used in the past year? (Check all that apply)

- ☐ methamphetamines (speed, crystal)
- ☐ cannabis (marijuana, pot)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ tranquilizers (valium)
- ☐ cocaine
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse (use) more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Do you inject drugs? No ☐ Yes ☐

Have you ever been in treatment for a drug problem? No ☐ Yes ☐

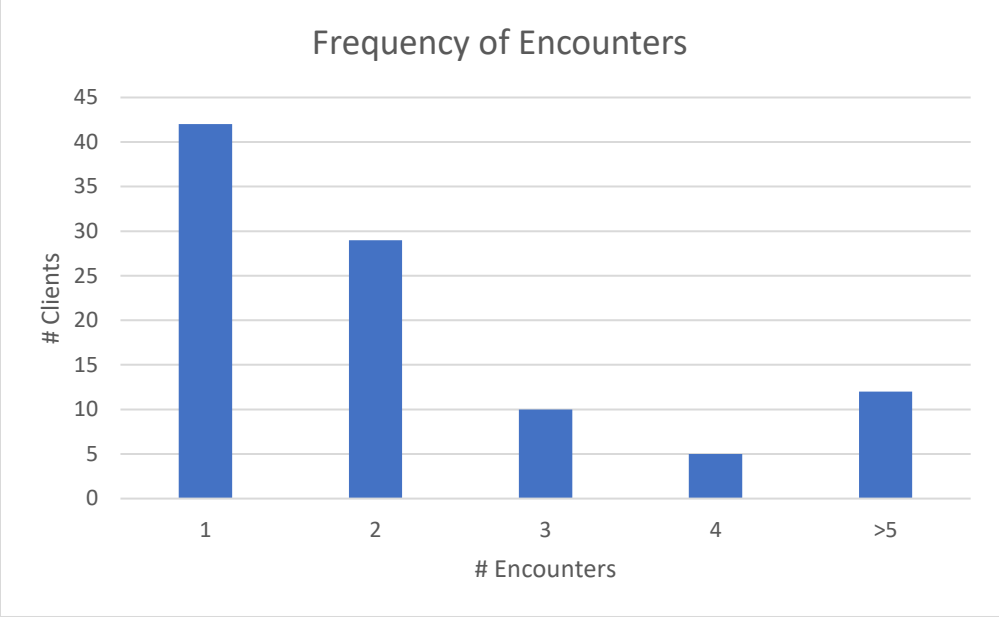
I	II	III	IV
0	1-2	3-5	6

Appendix I

Communication/Responsibilities

Name	Role	Responsibility	Communication Method
Gurdeep Mann	Project Leader WCPT Case Manager	• Screening and Referring Clients • Communicating with Mental Health Clinician • Continuous Care Team	• Referral Form • Face-to-face meetings • Texting • Email • Monthly Continuous Care Team Meetings
Antonio Ruezga	Mental Health Clinician	• Counseling • Referral to Psychiatrist • Case Management	• Face-to-face meetings • Texting • Email • Monthly Continuous Care Team Meetings
Maris Sturtevant	Executive Director	• Continuous Care Team • Addressing other client needs i.e., housing	• Face-to-face meetings • Texting • Email • Monthly Continuous Care Team Meetings
Debbie Gutierrez	Shelter Manager	• Continuous Care Team • Communicating client needs	• Face-to-face meetings • Texting • Email • Monthly Continuous Care Team Meetings
Continuous Care Team	• Discuss goals for clients and their specific needs including mental health. • Expertise of executive director and shelter manager of community resources and local county agencies used to help clients. • Follow-up on referrals and plan for maintaining communication with clients • Discuss future goals and objectives of WCPT		

Appendix J



What are the qualities of the Continuous Care Team that had a positive impact on client services?

- Executive
  - Ties things together.
  - Opens other doors up.
  - Focus on one particular.
  - Consistency is the most important thing,
  - “Appointments don’t work.”
  - We have to show that we are readily accessible when they need us.
- Shelter manager
  - “It’s about communication and consistency”
  - “A lot of these guys slip through the cracks”
  - “We become the people that they trust, like Pam, I’ve known for years now.”
  - “I don’t get paid to get certified in notarizing, but it helps the guys get moving as far as identification.”
  - “Then Covid-19 happened, but we were still working here at the shelter.”
  - “We have to meet them where they are.”