

A Home for the Spirit: Mental Health Care Delivery and the Homeless

Proposal for JMU Graduate School Showcase

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### Abstract

This proposal supports a poster presentation I hope to make at the upcoming Graduate School Showcase at James Madison University. It incorporates a needs analysis for delivery of mental health care services to homeless people in small cities. The project incorporates a thorough review of the relevant literature with experiential observations from a homeless shelter located in a small, mid-Atlantic city.

Homelessness is a significant and persistent issue in the United States and around the world. With public policy support, integrated care modalities, and new conceptualizations of treatment, those without homes can find help for mental health issues, and those in the helping profession can find rewarding opportunities to contribute to improved prognosis and outcomes for people experiencing homelessness. Nonetheless, there are significant gaps in the delivery of mental health services to this population, due to logistical issues, reimbursement questions, and other factors.

Maslow's hierarchy of needs to is useful to conceptualize the journey from homelessness to re-housing, and an analysis of the micro-economy of reimbursement models that may be a factor in the lack of on-site coverage at homeless shelters.

*Keywords:* Homeless, Mental Health, Counseling, Shelters

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Homelessness affects approximately 7.5% of the U.S. population and at least 3.5 million Americans are homeless in any given year. As of January, 2015, on any given night there were an estimated 564,708 people without housing nationwide. (Henry, Shiva, de Sousa, and Cohen, 2015). Of this group, 69% were estimated to be sheltered, with the remainder living on the streets. Demographically, 90% of homeless people were age 24 or above in 2015, and 1 percent were below the age of 18. Men account for 72 percent of homeless. By race, 54% are white, 26% black, and 17% are Hispanic or Latino.

People who are homeless are at elevated risk for substance abuse, mental disorders, and various other physical ailments and social problems. More than 1 in 10 persons seeking substance abuse or mental health treatment in the public health system in the United States is homeless (Substance Abuse & Mental Health Service Administration [SAMHSA], 2013).

Homelessness is generally viewed as the result of environmental, or systemic factors, and individual circumstances. Public policy can be a source of continued problems, for example through defunding of mental health services or economic policies that can lead to employment dislocation, or in the criminalization of homelessness.

Regardless of the circumstances, the current mental health care delivery system for people experiencing homelessness has multiple shortcomings. A review of the literature and a case study of one representative homeless shelter illustrates several areas of need.

### **Homelessness: The Literature**

In recent years, the U.S. government has backed a sustained resource allocation to reduce homelessness. In June 2010, the Obama Administration released “Opening Doors: Federal Strategic Plan to Prevent and End Homelessness”, a comprehensive plan to prevent and end

homelessness in America. One aspect of this program is the improved provision of behavioral health care to the homeless.

The many obvious barriers to care faced by the homeless loom large when designing methods of care delivery. People dealing with homelessness often are struggling at the basic levels of Maslow's hierarchy of needs. They often have comorbid physical conditions, few resources, and are itinerant within their communities. The task of satisfying basic, physiological needs, is often an all-encompassing effort.

In assessing treatment modalities, SAMHSA has identified the Comprehensive, Continuous, and Integrative System (CCIS) as their recommended model. This integrative and overlapping approach brings elements from social work, counseling, psychiatric services, dental, and mental health together to serve homeless populations. Harrison, Moore, Young, Flink, and Ochshorn (2008) found that "The major components of the CCISC model as outlined by Minkoff and Cline (2004) are system-level change, efficient use of existing resources, incorporation of best practices, and integrated treatment philosophy. (p257). Their study confirmed the effectiveness of the CCIS model both programmatically and systematically.

When applying treatment modalities, it is important to consider homelessness as both a symptom and potentially a source of mental health disorders. To this end, Castellow, Kloos, and Townley (2015) seek to extend the research on whether homelessness itself is a cause or a contributor to serious mental health issues. Extending work done by others in this field, they note research that points to greater severity of symptoms, increased vulnerability, and other elevated risk factors that result from the traumatic experience of homelessness. They compare the outcomes of homelessness to adverse outcomes common to those experiencing post-traumatic stress disorder. Increased susceptibility to substance use disorder is an important

feature, given its high prevalence among the homeless. The study seeks to prove the authors' hypothesis that homeless episodes will increase the incidence of psychiatric disorders, substance use disorders, and will lead to lower rates of recovery. Using interviews and assessment surveys, the authors found after regression analysis that homelessness had "modest" predictive power with respect to the three hypotheses. The results did not point to definitive evidence that homelessness was a cause of mental illness, substance use disorder, or hindered recovery. The authors point to methodological gaps and provide guidance for further research on the topic.

Increasingly, mental health professionals are volunteering at homeless shelters, often on a rotating basis as pro bono service outside of their regular practices. There are some systematic reviews of the ways in which these outreach programs seek to achieve their goals. Bradford, Gaynes, Kim, Kaufman, and Weinberger (2005) in a randomized, controlled trial, showed that a shelter-based outreach program by a mental health professional significantly increased the likelihood that individuals suffering from homelessness would follow-up with one or more scheduled meetings at community mental health centers. The study also demonstrated significantly higher rates of treatment for substance abuse in the intervention group. In addition, the treatment group had higher, although not statistically significant, rates of employment and housing success than the control group. The study did not conclude that interventions led to consistent use of community mental health services beyond a second visit, and its authors suggested that study design limitations (the control group had access to on-site counseling), and that more research was needed to understand why this was the case, and to identify methods to improve the likelihood of sustained use of available services.

At the street level, McBride (2012) conducted one of the few peer-reviewed phenomenological studies of homelessness. Using a criterion and snowball method, the author

worked with 8 individuals experiencing homelessness over a year in semi-structured interviews, and a subset of 3 in a focus group. The author found that unmet needs in employment, social support, health care, and housing were the primary concerns of the population surveyed. The author noted that substance abuse was cited as a frequent coping mechanism, and encouraged counselors to be aware of this, as well as of the need to have knowledge of local services to help meet the other unmet needs of the homeless population.

In a recently published article, Zur and Jones (2014) found in an analysis of the Health Center Patient Survey that while people experiencing homelessness were just as likely to access and have their needs for medical and dental care services met, those who were homeless were less likely to access mental health care services. They studied users of Federally Qualified Health Centers (FQHC), which collectively have 1.1 million visits by people experiencing homelessness each year. Many of these centers are eligible for Healthcare for the Homeless (HCH) subsidies. These centers are the primary methods of health care delivery for many the homeless. Despite this, the homeless population that use this delivery method report significant gaps in their access to dental, medical, and medical health care. Zur and Jones focus on the unmet health care needs of homeless and non-homeless users of FQHCs that also receive HCH subsidies. Their findings, in comparing the unmet needs of those suffering from homelessness versus those in stable housing, showed a significant difference only in the category of access to mental health services. The level of significance is striking. In Zur and Jones' unadjusted model, homeless clients were 2.35 times more likely to have delays in obtaining mental health services. After adjusting for a variety of demographic and socioeconomic features, their model identified a 7.33 times higher likelihood that homeless clients would report being unable to receive any mental health services from the FQHC.

While this population has been the subject of previous research, Zur and Jones attributed this difference to two major factors: cost and lack of information on how to access behavioral care. They further note that Federal Qualified Health Care clinics with HCH grants are not required to have mental health professionals on staff as an obstacle to providing such services to the population of homeless individuals who use these facilities as their primary health care centers. The unstated implication in these findings is that more proximate and better connected mental health care services at the point of contact, i.e. on the streets or in shelters, could address this gap.

The topic of how to conceptualize homelessness from a counseling standpoint is a logical next step beyond simply making services available. To this end, Dykeman (2011) identified over 40 different models of homelessness, and proposed a biopsychosocial model to assess homelessness through an integrative framework. His four-stage model includes consultation, collaboration, counseling, and advocacy. The third stage, of counseling, incorporates a clinically-based, holistic approach to self-awareness and success in interpersonal relationships. He also notes the importance of family therapy in dealing with homelessness that extends beyond the individual and incorporates family units.

Along these same lines, but with a different lens, the American Counseling Association has published several research papers on effective counseling services for the homeless. In one such study, Baggerly and Zalaquett (2006) used a social justice framework and a combination of literature review, period-prevalence research, and counseling strategy guidelines to call counselors to action to reduce the gaps in mental health services to the homeless. They note a dearth in literature and research in the field of mental health counseling to the homeless, despite it affecting at least 1% of the U.S. population, and the fact that over 10% of Americans live at or

below the level of federally defined poverty. Their review points to the complexity and interconnected nature of causes of individual and family homelessness. They note the significantly elevated incidence of substance use disorders among those in a condition of homelessness. By using a period-prevalence study, the authors seek to overcome a bias toward attributing homelessness to deviance that they believe exists in point-prevalence studies. They follow a homeless population in a single setting for two years, and while many of the demographic findings were similar to point-prevalence studies, the authors found that mental health issues and substance use disorders were substantially higher in their study than had been previously reported in large-scale point-prevalence studies. In their discussion, the authors highlighted the need for on-site mental health care providers who could offer care over extended periods. In their strategies section, Baggerly and Zalaquett urge counselors to take several steps: increase their awareness of homelessness, support people experiencing homelessness with wellness and goal-oriented counseling, and finally advocacy on behalf of mental health care access for the homeless.

Finally, the emotional implications for helping professionals working with homelessness are an important ingredient in getting the delivery model right. Changing the structure without considering human behavior will only deal with part of the challenge in the delivery system. In considering this, Ferris, Jetten, Johnstone, Parsell, and Cameron (2016) posited the “Florence Nightingale Effect” to account for the results of a recent study. In the course of interviewing workers at homeless shelters, the researchers found that there was a correlation between perceived suffering of clients and dedication to the job, as well as a correlation between the perception of clientele’s suffering and the employee’s identification with the organization itself. In addition, they did not find a statistically significant correlation between the employee’s



emotions in dealing with the perceived suffering of the clientele and the level of burnout among employees serving them. Using social psychology, they seek to identify whether organizational coping mechanisms would be part of counselors' professional frameworks. They found that the recognition of the suffering of their clients per se was sufficient to raise job satisfaction and control burnout, and that organizational identification served a constructive mediating role.

### **Case Study: The Shelter**

The author has spent considerable time as a volunteer at a homeless shelter located in a small, mid-Atlantic city. The shelter operates during the day, open from breakfast until noon. The shelter has a very diverse clientele. Its guests are approximately 40% Black, 40% White, and 20% of other ethnicity (Hispanic, Asian, Arab, and others). Approximately 60% of the shelter's guests are male, and 40% female.

On any given day, from 60 to 90 people will register at the shelter. Most guests will eat breakfast, nap, shower, check for mail, retrieve belongings from their personal bins, use the internet, socialize, or meet with staff. The facility is a "wet" shelter, and welcomes all to use its services, as long as house rules (no violence, foul language, drugs, or alcohol on the premises) are followed. From this starting point, the shelter has diversified its services along a continuum of complexity and needs. The first big step for a new guest is a coordinated intake and assessment interview, which is designed to help guests who may have health concerns, need access to emergency shelter, or connect to other social services that are provided in the community. Guests are then introduced to relevant services, which are generally provided by allied agencies unless they are housing-related. The shelter's deepest expertise is in rapid rehousing, whereby the individual's time without a home is kept as short as possible. It has won

multiple grants and is successfully placing homeless guests in apartments and homes in and around the city.

There is significant change underway in services for the homeless, a nationwide phenomenon that is apparent at the shelter. A variety of incentives and best practices have come together to change the focus from on-site services for the homeless, which represents the traditional shelter model, toward permanent housing for the chronically homeless, and rapid re-housing for those in crisis. While the shelter services remain in place, the professional staff is being challenged to deal with homelessness by finding homes. This major focus has employees excited, and brings new challenges, both in their day-to-day assignments and the complexity of managing caseloads. As the shelter has grown and extended its mission into re-housing, its operations have become necessarily more compartmentalized. That leads to some standardization of roles, which employees note has positive and negative impact on their morale. The ability to move off the front lines to focus on administration can be a welcome break from the emotionally taxing work with clients, but it can also feel detached from the population being helped.

### **Method**

This section summarizes a needs analysis and outlines an enhanced delivery system for mental health care to people experiencing homelessness in small cities. The current system imposes excessive logistic and economic barriers on both clients and mental health care providers. The analysis combines interviews with individuals involved in providing services to the homeless, a review of literature, and a conceptualization that combines the humanistic dimension of Maslow's Hierarchy of Needs with an economic model that mirrors the non-profit world, rather than the health care reimbursement model that currently predominates in this arena.

To summarize the main categories of need, they include on-site availability of clinical mental health counseling, integrated case management including mental and physiological health care, housing, employment, social services, and related support, primarily logistical in nature. Homeless shelters offer excellent training opportunities for counselors working through residency, and with proper supervision, could provide valuable experience to counselors in training, while helping meet the needs of this population.

The funding model for clinical mental health services at homeless shelters needs to be addressed. At present, there is no systematic source of funding for such services. As a result, clients seek help at community service agencies, or in acute situations, at local hospitals. A grant-based approach to funding could provide a more stable and reliable source of reimbursement for counselors who wish to provide services at homeless shelters.

### **Discussion**

The combination of public policy support, integrative delivery models, appropriate conceptualization of care, and motivated counseling resources presents a positive outlook for raising the level and quality of mental health care services for the homeless. More research is needed to identify organizational models and career pathways for helping professionals who choose to make this important population their life's work. Having said that, a review of the literature indicates that on-site care in homeless shelters, even via rotating volunteer mental health workers, has been helpful in meeting client needs more effectively than through referrals alone.

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