Practices Related to Providing Care to People Experiencing Homelessness: Challenges and Barriers to Care

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JOHNSON HEALTH CENTER

Objectives

- At the end of this presentation, participants will be able to:
  - Describe the epidemiology of homelessness.
  - Discuss the relationship between homelessness and mental illness.
  - Describe the barriers to treatment of mental illness in unhoused population.
  - Discuss ways to modify practice to better address the needs of the unhoused population.

A Reflection

- Our team is not meant to cut off people from the the mental health center, but to further connect them. We are meant to cross all programs both inpatient and outpatient. We are meant to foster a sense of community and connection. We see clients along the entire treatment continuum, and make great efforts to engage those in need. Out team seeks to be advocates for the disenfranchised and attempt to widen the margins of the people we serve. If it is our belief that all people are valuable, and that mental illness has the potential to impede on one's basic inalienable rights (life, liberty and happiness) - then we are obligated to do what we must to combat it.

  The purpose of the clinic is to engage and transition a person into active treatment. The clinic is time limited, of various duration (depending on the needs of the client). At such time, as the team decides, the patient should be re-connected with the mental health center proper. With targeted interventions, in collaboration with assigned programs.

My Experience

- Current Role:
  - Director of Psychiatry at Johnson Health Center
    - FQHC in Lynchburg, Virginia

- Prior Roles:
  - Associate Training Director @ VT - Carillion
    - Community Psychiatry Tract Supervisor
    - Psychotherapy Curriculum Coordinator
  - Mental Health Director @ Fralin Free Clinic
  - Street Psychiatrist @ Columbia Area Mental Health
  - Psychiatrist in Emergency Psychiatric Services @ Prisma Health

Homelessness in the U.S.

“By going directly to the patient, the nurse or physician immediately establishes the centrality of that person’s reality. This creates trust, and an acknowledgement that ANY HEALTHCARE PLAN WILL BE GROUNDED IN A SHARED RECOGNITION OF REAL CIRCUMSTANCES.”

Screening for Homelessness

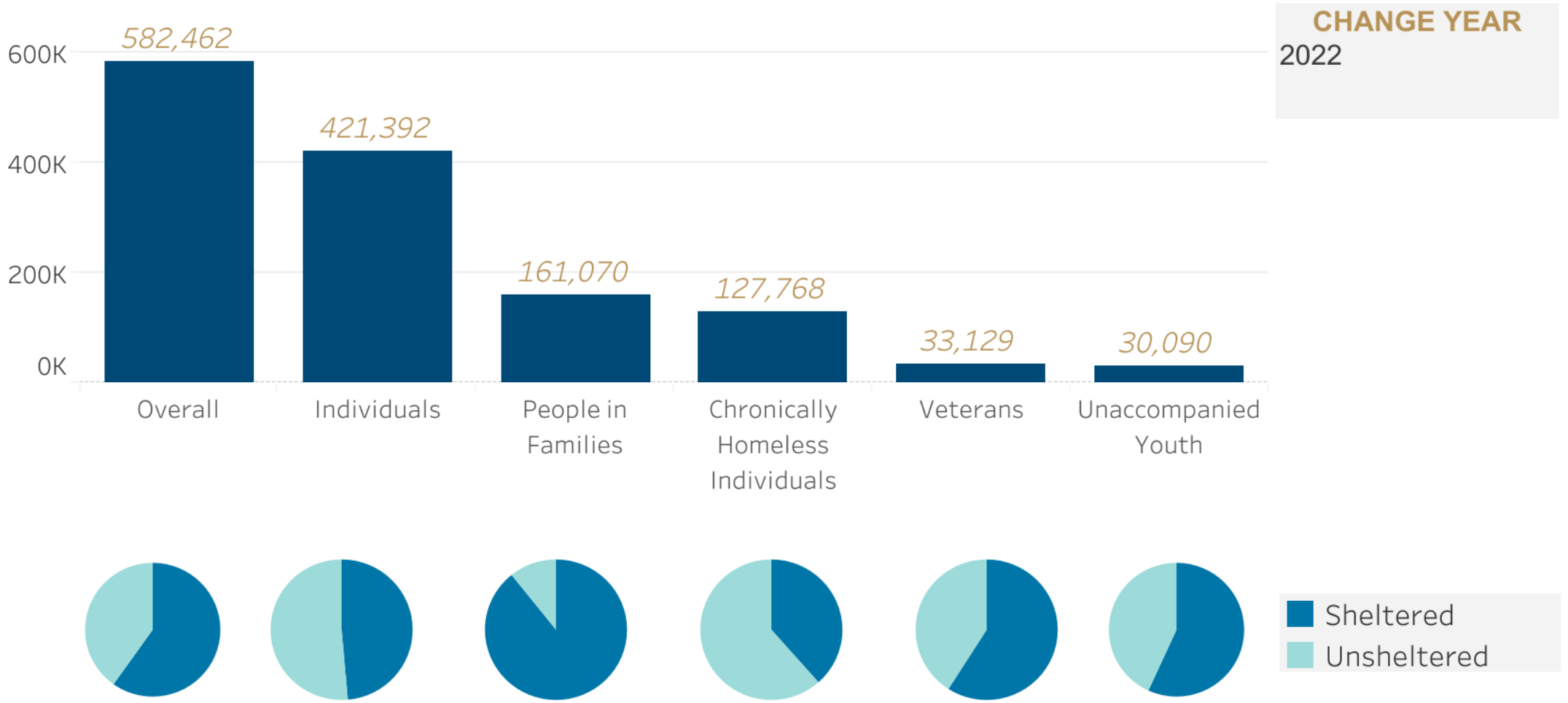
- ED screen based on multiple definitions of homelessness
  - In the last 60 days have you:
    - Changed residences more than twice?
      - *unstably housed*
    - Lived with a friend or family member you do not normally reside with due to financial hardship?
      - *“doubled up”*
    - Slept outside, in an abandoned building, your car, in an emergency shelter or a motel due to financial hardship?

Adapted from tool used by Lehigh Valley Health Network

Homeless Population

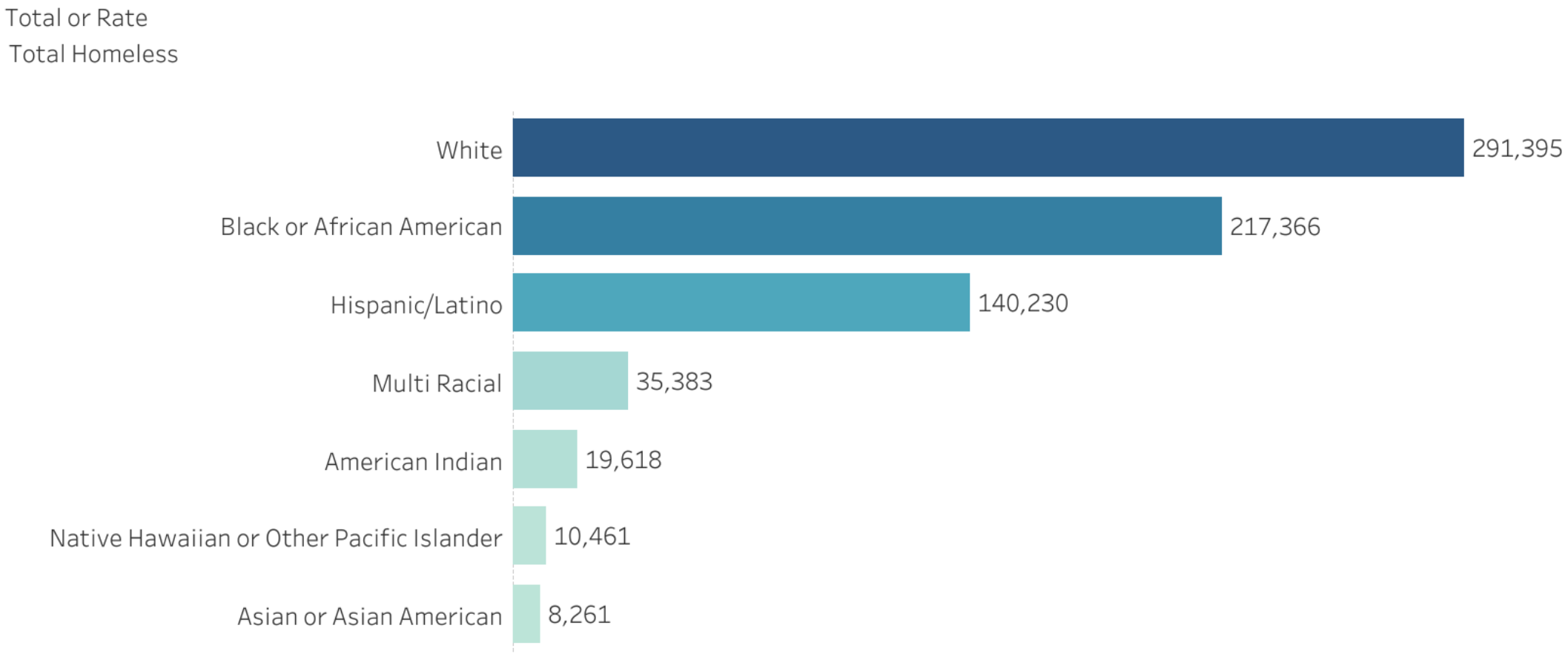
- U.S. (2022): 582,462
  - 421,392 Individuals
    - 127, 768 chronically homeless
  - 161,070 Families with children
  - Approx. 40% are unsheltered
  - AA compose approx. 40% of the homeless population

Total Number of People Experiencing Homelessness per Year by Type, 2007–2022



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR). Note: The Covid-19 pandemic interrupted data collection in 2021 so data for that year is unavailable.

Counts and Rates by Race / Ethnicity, 2022



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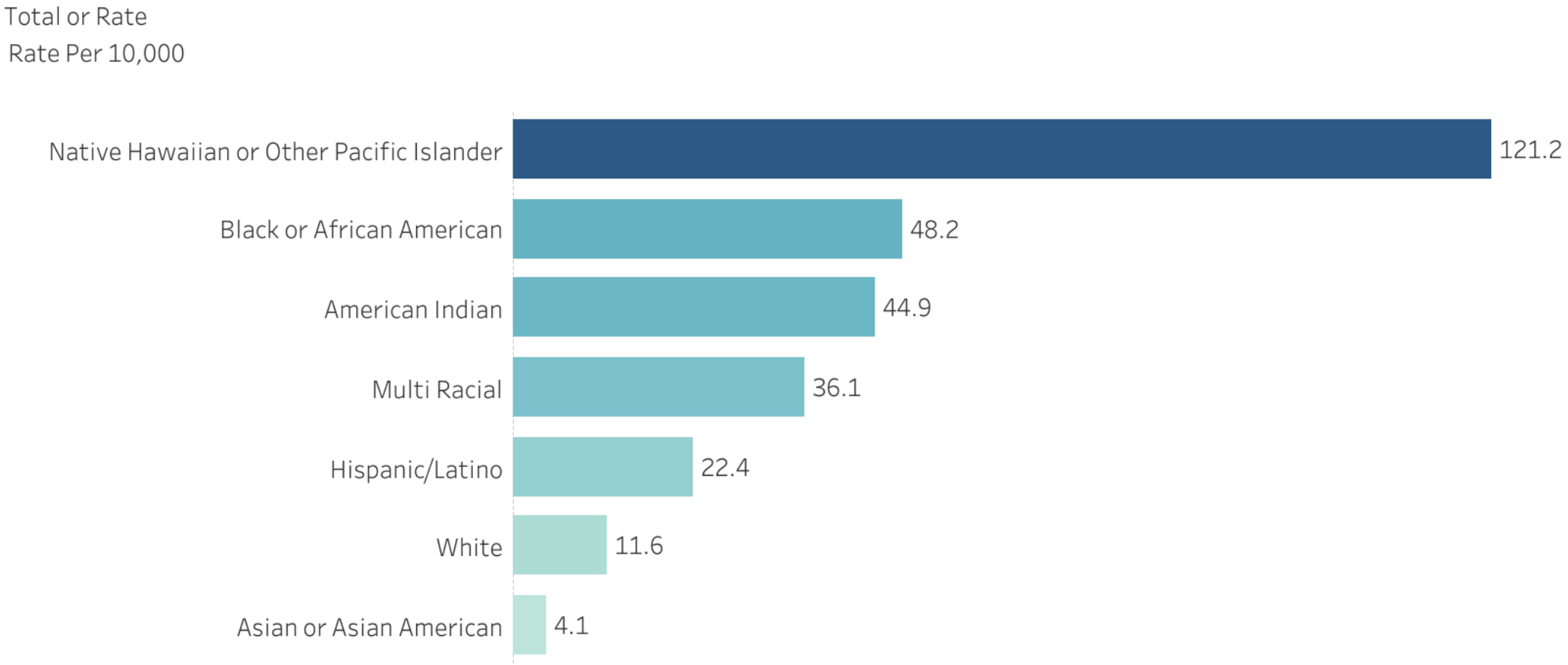
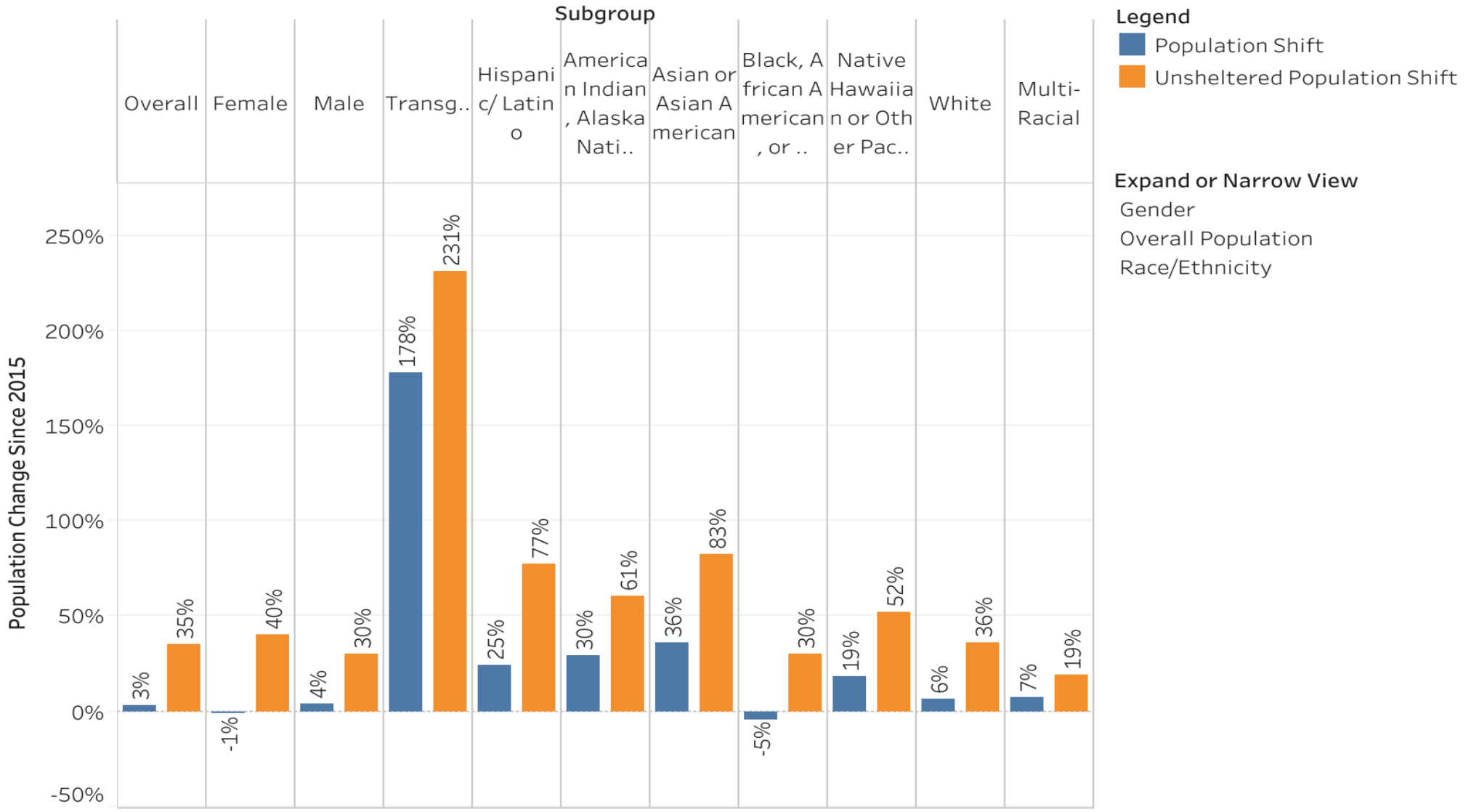


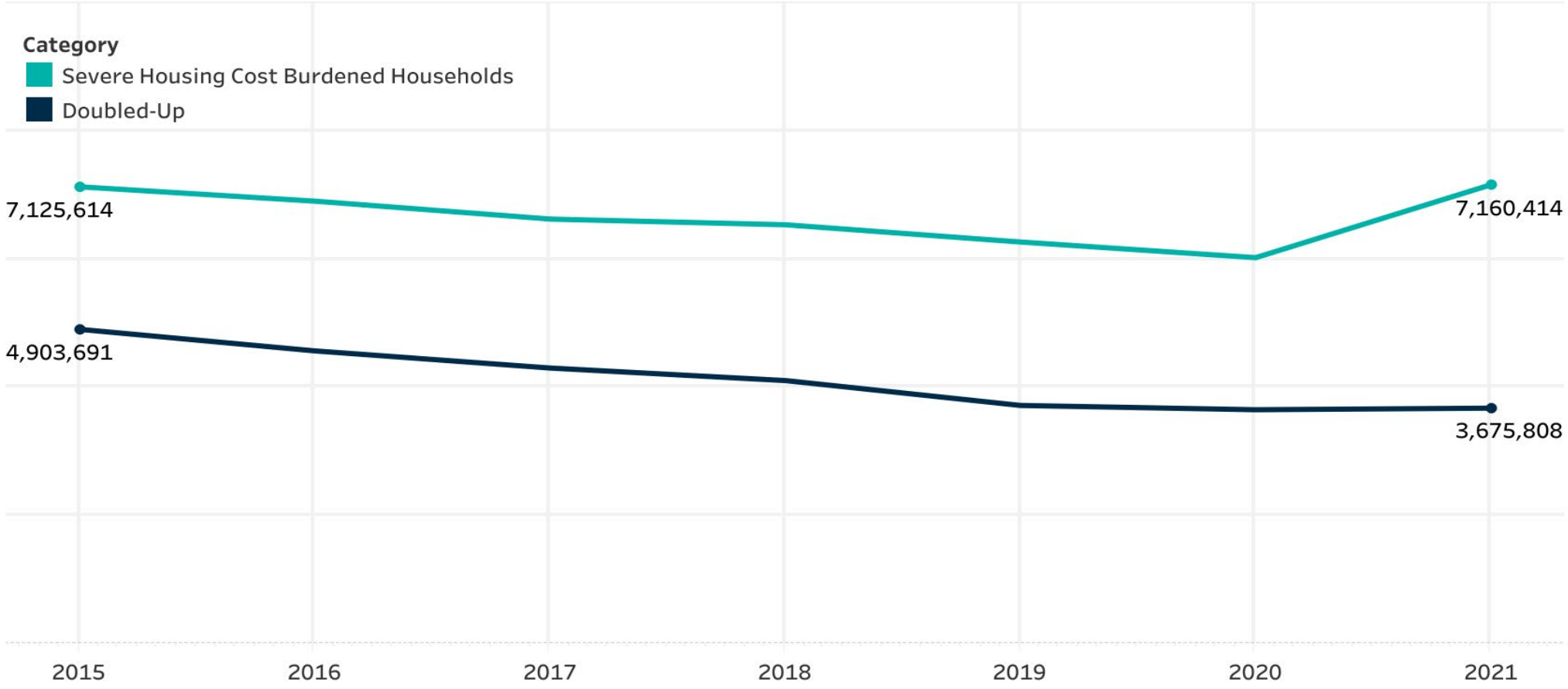
Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR); U.S. Census Bureau, 2022 Population Estimates.

Subgroup Population Shifts Since 2015



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR).

Populations at Risk of Homelessness over Time, 2015 - 2021



Source: 2007-2021 PUMS 1-Year, Accessed February 1, 2023 (Severe Housing Cost Burdened Households); Steven Ruggles, Sarah Flood, Matthew Sobek, Danika Brockman, Grace Cooper, Stephanie Richards, and Megan Schouweiler. IPUMS USA: Version 13.0 2015-2021 ACS PUMS 1-Year. Minneapolis, MN: IPUMS, 2023. https://doi.org/10.18128/D010.V13.0. Molly K. Richard, Julie Dworkin, Katherine Grace Rule, Suniya Farooqui, Zachary Glendening & Sam Carlson (2022): Quantifying Doubled-Up Homelessness: Presenting a New Measure Using U.S. Census Microdata, Housing Policy Debate, DOI: 10.1080/10511482.2021.1981976 (Doubled Up Population). Note: Doubled up data is not available before 2015.

On a given night in Virginia...

- 6529 people experiencing homelessness
  - 685 unsheltered
    - 4234 individuals
    - 2295 families
    - 1142 chronically homeless individuals

National Alliance to End Homelessness

State of Homelessness

State: Virginia

# of Years: Last 5 Years

Click on a Continuum of Care (CoC) or the State Icon on the left to get started. Information about homelessness in the selected State or CoC will appear to the right of the map and below. Data can be viewed for all years through the last two years by clicking the # of Years filter. The Capacity dashboard below shows the bed inventory and capacity to serve people experiencing homelessness.

- VA-500
- VA-501
- VA-502
- VA-503
- VA-504
- VA-505
- VA-507
- VA-508
- VA-513
- VA-514
- VA-521
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- VA-601
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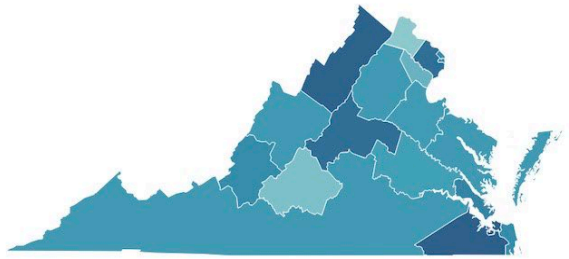
- VA-604



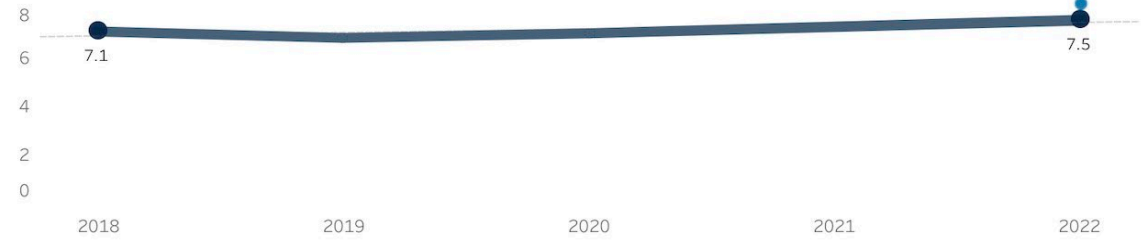
Virginia

6,529
People Homeless on a Given Night in 2022

7.5
Homeless Per 10,000 People in the General Population

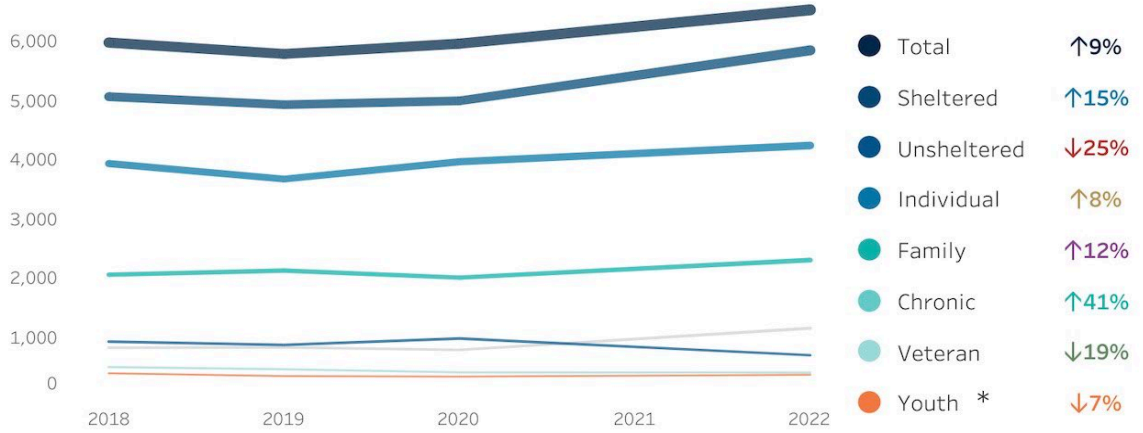
Homeless Populations

State Rate of Homelessness



State Homelessness by Population

Between 2018 and 2022, **Virginia**'s **Total** homeless population changed by ↑**9%**, the **Sheltered** population changed by ↑**15%**, and the **Unsheltered** population changed by ↓**25%**. See list for statistics on other populations.



Homeless Populations

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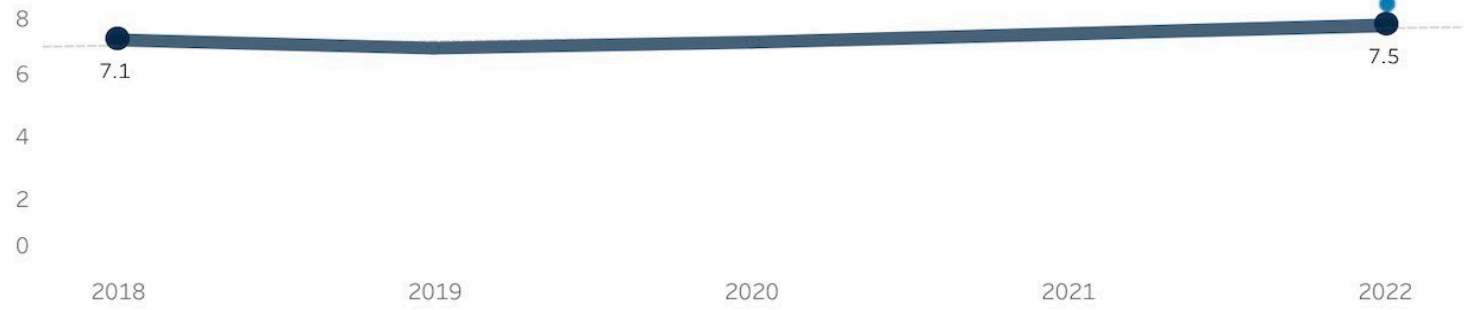

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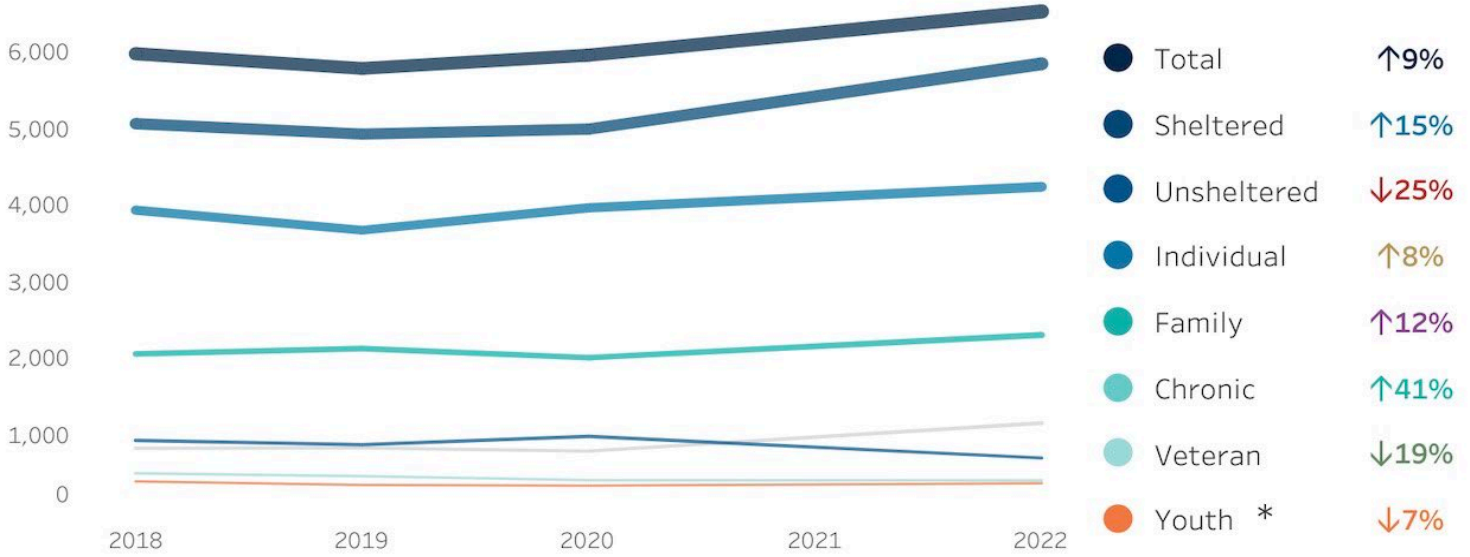


- Correlation with increased homelessness
  - Decrease in available, affordable housing stock
  - Deinstitutionalization

VIRGINIA #17*

In **Virginia**, the Fair Market Rent (FMR) for a two-bedroom apartment is **$1,396**. In order to afford this level of rent and utilities — without paying more than 30% of income on housing — a household must earn **$4,652** monthly or **$55,821** annually. Assuming a 40-hour work week, 52 weeks per year, this level of income translates into an hourly Housing Wage of:

$26.84
PER HOUR
STATE HOUSING WAGE

FACTS ABOUT VIRGINIA:

STATE FACTS	
Minimum Wage	$12.00
Average Renter Wage	$23.38
2-Bedroom Housing Wage	$26.84
Number of Renter Households	1,083,561
Percent Renters	33%

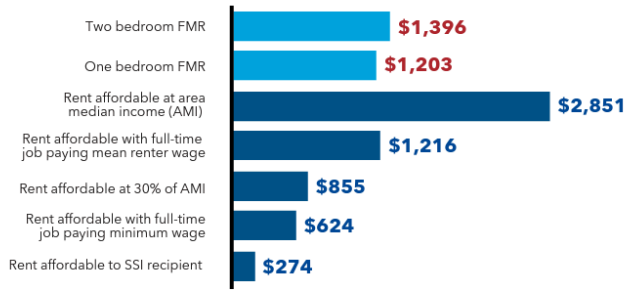
MOST EXPENSIVE AREAS	HOUSING WAGE
Washington-Arlington-Alexandria HMFA	$35.35
Charlottesville MSA	$26.94
Richmond MSA	$25.69
Virginia Beach-Norfolk-Newport News HMFA	$25.56
Winchester MSA	$23.60

89
Work Hours Per Week At **Minimum Wage** To Afford a **2-Bedroom Rental Home** (at FMR)

77
Work Hours Per Week At **Minimum Wage** To Afford a **1-Bedroom Rental Home** (at FMR)

2.2
Number of Full-Time Jobs At **Minimum Wage** To Afford a **2-Bedroom Rental Home** (at FMR)

1.9
Number of Full-Time Jobs At **Minimum Wage** To Afford a **1-Bedroom Rental Home** (at FMR)



MSA = Metropolitan Statistical Area; HMFA = HUD Metro FMR Area.
* Ranked from Highest to Lowest 2-Bedroom Housing Wage. Includes District of Columbia and Puerto Rico.

HOMELESSNESS AND MENTAL ILLNESS

"A clear understanding emerged that those with psychiatric disorders, including chemical dependence, need aggressive and integrated psychiatric rehabilitation, BUT THAT ACCESS TO HOUSING IS PREREQUISET TO ANYTHING ELSE."

Prevelance

- Rate of severe psychiatric illness ranges from one-third to one-half.
  - Mood disorder = 20% - 30%
  - Schizophrenia = 10% - 15%
    - Persons with schizophrenia have risk of becoming homeless 10x greater than general population
- Substance use is a huge issue
  - Substance use = 20% - 30%
  - Alcohol = ~60%

Higher risk of homelessness

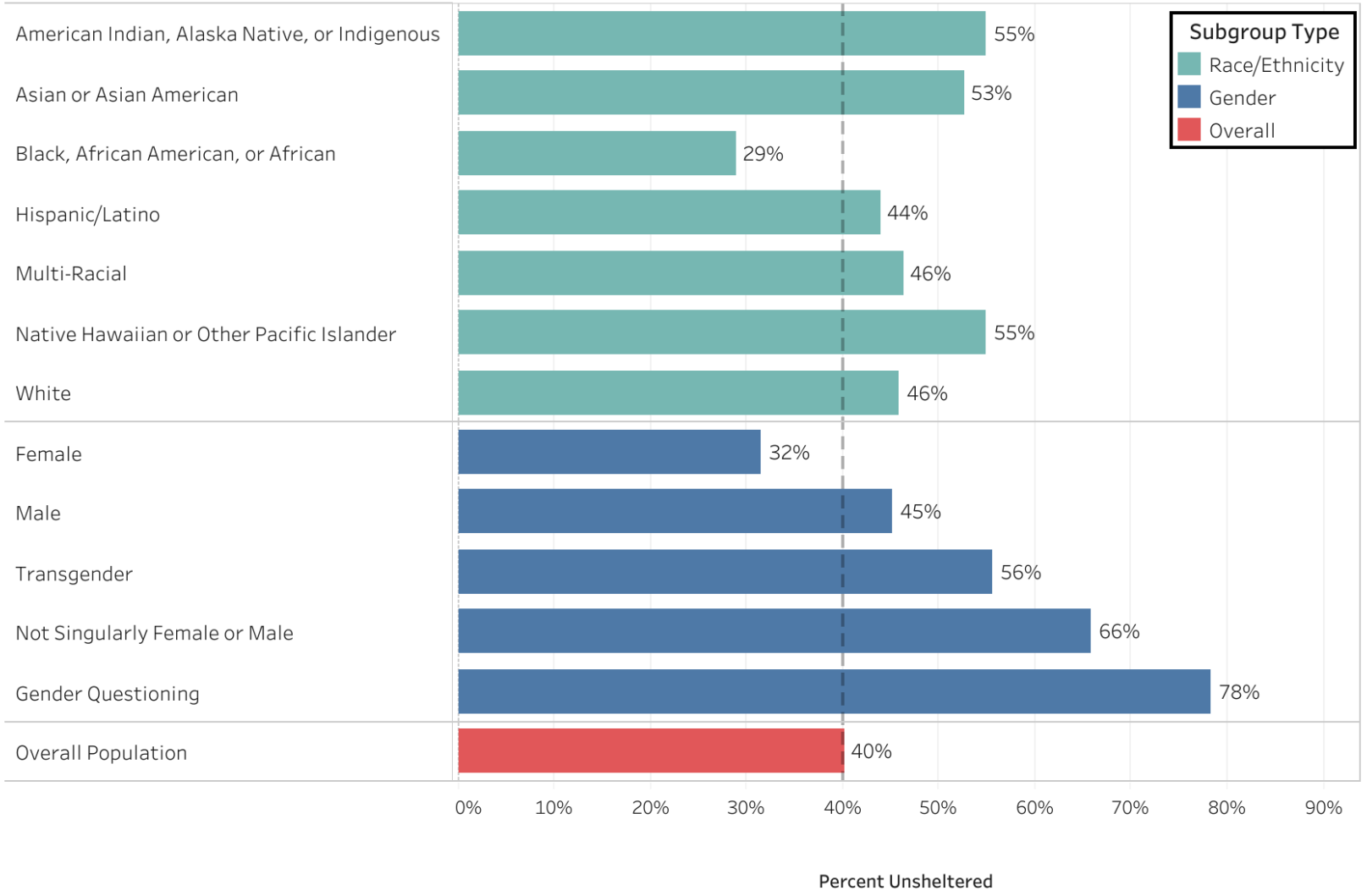
- In 2005, San Diego Co. conducted a study looking at factors associated with homelessness using their adult mental health database
  - >10,000 patients
    - AA > than other ethnicities
    - Lack of Medicaid
    - Substance use (4x non-users)
    - Increased use of inpatient and emergency services

- “Homeless” is not a homogenized population
  - Sheltered vs. unsheltered
  - The incarcerated

“Homeless”

- Unsheltered
  - Older
  - Male > female*
    - Significant increase in transgender population
  - Higher rates of psychotic disorders
  - Higher rates of substance use disorders
  - More time spent homeless
  - Less likely to receive services
    - Behavioral health and medical

Share of Subgroup Living Unsheltered, 2022



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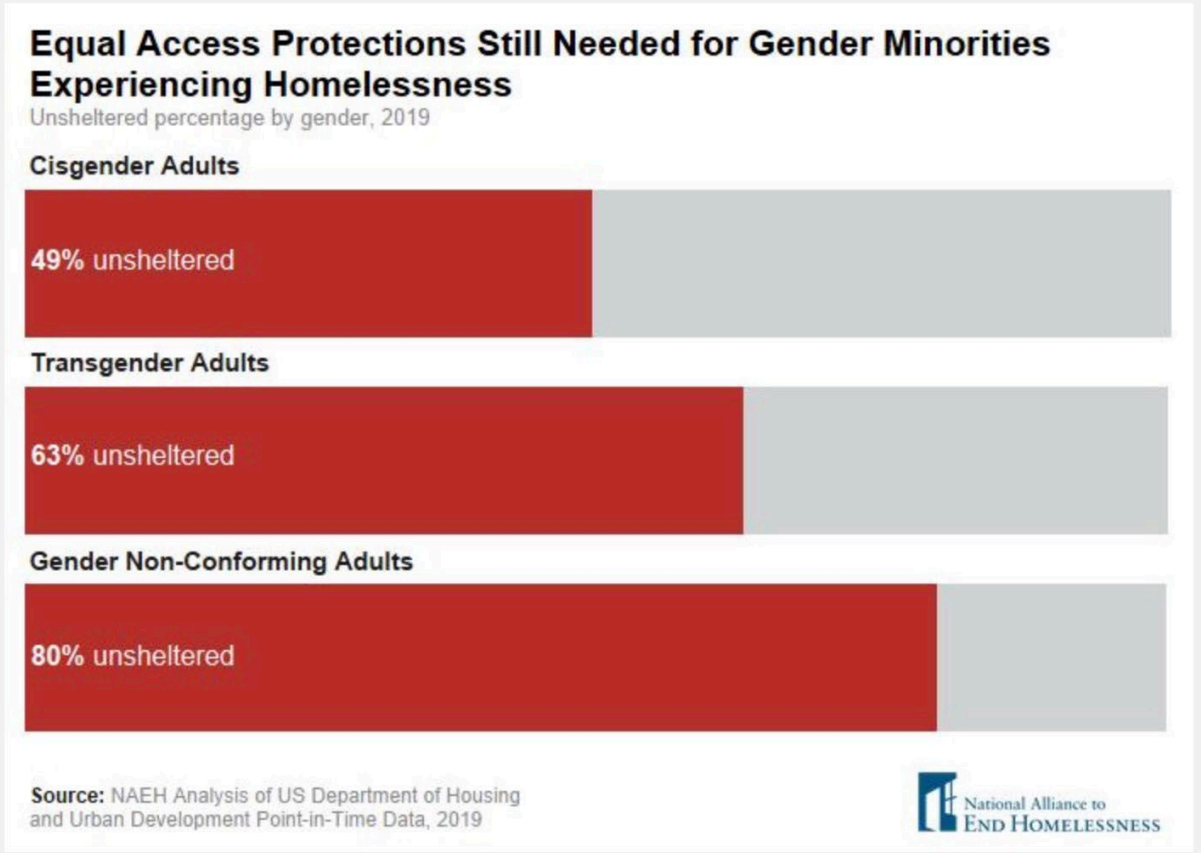
Equal Access Protections Still Needed for Gender Minorities Experiencing Homelessness
Unsheltered percentage by gender, 2019
Cisgender Adults
49% unsheltered
Transgender Adults
63% unsheltered
Gender Non-Conforming Adults
80% unsheltered
Source: NAEH Analysis of US Department of Housing and Urban Development Point-in-Time Data, 2019
National Alliance to End Homelessness

Incarcerated

- 1999, DOJ estimated 16% of detainees had contact with the mental health system
- Compared to those without a diagnosed mental illness, 30% were homeless when they entered custody
  - Without a mental illness = 17% homeless

- 1999 study looking at predictors of homeless 3 months after d/c from hospital
- After discharge (patients w/ psychotic d/o):
  - Co-morbid substance use disorder
  - Elevated psychiatric symptoms (measured by BPRS)
  - Poor global functioning @ d/c (GAF <43)

- Exposed to:
  - Psychological stress
  - Violence
  - Poor nutrition
  - Infections

BARRIERS

Cognitive Difficulties

- Impairments in global cognition w/o SPMI
  - MSE (cut-off of 24) = approx. 21%
  - With examination in other cognitive batteries upwards of 80%
- Observed decreases in IQ w/ SPMI
  - Average to low-average in the general homeless pop.
- Focal deficits in verbal and visual memory, attention, speed of information processing, and executive functioning

- 2021 study
- 100 shelter residents in San Diego shelter
- 65% met the criteria for cognitive impairment
- Rate of impairment greater than the general population
- High rates of ”functional impairment”
  - “crystalized knowledge and processing speed”

- Likely multifactorial etiology:
  - Substance use
  - Head trauma
    - 2022, study of 115 persons experiencing homelessness
      - 71% of total participants reported a significant history of TBI, and of those, 74% reported a TBI prior to experiencing homelessness
  - Influence of poverty
    - Consumption of cognitive capacity
  - Malnourishment
  - Mental illness

- According to 1993 study, 45% of patient's in a homeless inpatient unit identified as having cognitive deficits on MSE had abnormal brain imaging
  - Non-specific cerebral atrophy
  - 26% with abnormal EEG's

- Impairments may influence social functioning
  - Ability to adapt and reintegrate
    - Problem solving and skill acquisition
  - Adherence to outpatient medical services
  - Maintenance of independent housing
- Possible impact on the effectiveness of skills training and rehabilitation programs

Systemic

- Not meeting criteria for services at local mental health center
- Lack of insurance
- Providers not treating mental illness in the the context of substance use
- Fractured and inflexible system design
- Lack of provider clinical comfort and bias
  - Studies have shown that medical providers become less compassionate during their training

Individual

- Non-adherence/poor adherence to treatment recommendations
- Co-morbid substance use disorders

PROVIDING CARE TO THE UNHOUSED WITH MENTAL ILLNESS

"If we are to be relevant to those we serve, we must begin to work with the reality in which they live and die"

Challenges

- Working with the unhoused presents significant difficulties
- Requires self reflection
  - Destitute
  - Disenfranchised
  - Have extreme trauma histories

Challenges

- Determination and maintenance of boundaries
- Psychological impact on the clinician
  - Guilt, anger, depression, loss of empathy or unrealistic optimism/expectations
    - Excessive coercion, therapeutic withdrawal, idealization
- Balancing self determination vs. paternalism
  - Participation/success in treatment more likely to sustain if made self determinately, but must balance safety concerns

- Oftentimes some of the sickest people will refuse care

Why?

Trust

- Studies have show than many “unsheltered” homeless have a pervasive mistrust of outreach workers
- “Accordingly, the first goal of treating homeless mentally ill people must be establishing oneself as acceptable to homeless people”

Why don’t you trust me?

- Involuntary Treatment
- Paranoia/Hypervigilance/Guardedness
- Stigma
  - Mental illness
  - Medications
- Experiences of families
- Side Effects

Confidence

- Lack of confidence in the services provided
- There won’t be follow-through

Stigma

- Dehumanization
- Power Differentials and Stereotyping
- Internalized/anticipated stigma and care avoidance

Relationship

“I have come to learn that no other transformational change can occur unless the person is willing to enter into a relationship that recognizes the dignity and worth we each possess”

- Often first objective in to establish a relationship
  - Will they talk to me or someone else, that day or the next day or the next week
  - It often rests on providing basic needs
  - Treatment plans and medications aren’t brought up
- Development of safe space

Reconnection

“For those with distorted thinking, pervasive mistrust, and the sometimes extreme resulting behavior, the palpable estrangement from the human community is extreme and not easily bridged”

Reconnection

- Lost connection to the relationships that make up the fabric of society
  - Leading to vulnerability of being dehumanized
  - Seeking to reconnect with a community of care

Recovery

“The street outreach team should play less and less of a role as the person recovers their unique identity, an identity that is no longer based upon labels such as homeless or mentally ill”

Recovery

- Greater self-direction and self-care
- Collaboration in treatment
- Desire to establish or re-establish relationships
- Maintaining housing

Suggestions

- May benefit from frequent reminders, clear/concise/specific instructions written and verbal
  - Consider assessing for health literacy
  - Consider routine cognitive assessment
- Establishment of more flexible, collaborative and/or integrated care models
  - Medical + psychiatric care + substance abuse
  - Street Medicine

- Psychiatrist and other behavioral health providers are uniquely positioned to have a meaningful role in the transformation of public health systems
- Opportunities for leadership in community-based care systems beyond mental illness

Questions?

References

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