Case Management: Homeless Persons

What We Know

› Homeless persons are a heterogeneous and vulnerable population that includes persons of all ages, races, and ethnic groups; individuals and families; veterans; and persons who are unemployed or otherwise cannot afford housing(2,4)
  • The United States Department of Housing and Urban Development (HUD) defines(10)
  – a *sheltered homeless person* as a homeless person who is in an emergency shelter, transitional housing program, or safe haven
  – an *unsheltered homeless person* is defined as a homeless person who has as his or her primary nighttime residence a public or private space not intended for housing persons (e.g., bus stop, public park, car)
  – a *chronically homeless person* as a homeless person with a disabling condition who has either been continually homeless for ≥ 1 year or who has had at least four episodes of homelessness during the past 3 years
  – an *unaccompanied homeless youth* as a homeless person < age 25 who is not part of a family
  • The lifetime prevalence of homelessness ranges from 5.6% to 13.9% in the U.S. and Europe(2)
  • HUD’s 2018 Annual Homeless Assessment Report to Congress includes the following statistics:(10)
    – About 552,830 persons were homeless on a given night in January 2018; ~65% were living in emergency shelters or transitional housing programs and ~35% were living in unsheltered locations
    - 37,878 of the homeless persons on a given single night in January 2018 were veterans; this represents a 48% decline in homelessness among veterans during the period 2009–2018
    - 88,640 individuals and 8,273 persons in families experienced chronic homelessness
    – Individuals accounted for 67% of the homeless population; 90% of these persons were over > 24 years old, 9% were 18–24 years of age, and 1% were < 18 years old. An estimated 180,413 persons in families with children experienced homelessness
    – The rates of homelessness and chronic homelessness increased by 0.3% and 2%, respectively, during the period 2017–2018 but the rate of chronic homelessness decreased by 26% during the period 2007–2018
    - California, New York, Florida, Texas, and Washington accounted for 50% of the total homeless population
  › Homelessness is associated with numerous factors that increase risk for health problems and act as barriers to seeking and receiving adequate medical care(2,4)
    • Homelessness exposes individuals to temperature extremes, and crowded shelters contribute to the spread of infectious disease. Rates of trauma, tuberculosis, sexually transmitted diseases (STDs), HIV infection/AIDS, upper respiratory tract infections, mental illness, alcohol and substance use disorder, poor nutrition, dental problems, arthritis, diabetes, hypertension, heart disease, lice, scabies, hypothermia, and skin disorders are high in homeless persons(2,4)
Mental illness is prevalent in the homeless population; depression, psychotic illness, and personality disorders affect 11%, 13%, and 23% of homeless persons, respectively (2).

About 40% of homeless persons are dependent on alcohol and 25% are dependent on drugs (2).

Homeless persons are often uninsured or underinsured and have limited access to health care. They often seek care late in the course of a disease and decline more quickly compared to patients who are not homeless (4).

An estimated 73% of homeless persons have unmet health needs (2).

Case management (CM) has been identified as an important component of health care delivery to meet the complex needs of persons experiencing homelessness (2,11).

- Goals of CM include improving access to and coordination of medical and psychosocial services for the individual, while considering costs, preventing duplication of services, and improving patient outcomes (11).
- Elements of CM include assessment of needs, service planning and facilitation, monitoring, advocacy, skill building, and crisis intervention (2,11).
- The following five major models of CM have emerged in recent decades: (2,11)
  - Standard case management (SCM) focuses on coordination of services over a time-limited period. The case manager has an average caseload of 35 clients.
  - Critical time intervention (CTI) involves moderate-intensity client contact with a focus on continuity of care for homeless persons at critical transitions in their lives. The services are time limited and involve service provision and coordination. The case manager has an average caseload of 25 clients.
  - Intensive case management (ICM) involves more intensive and ongoing services with more frequent client contact that is directed toward individuals with the greatest needs. The case manager has an average caseload of 15 clients.
  - Assertive community treatment (ACT) is similar to ICM but involves shared responsibility for providing client services by a multidisciplinary team that is accessible 24 hours a day, seven days a week. The case manager has an average caseload of 15 clients.
  - Clinical case management (CCM) involves high-intensity client contact and a combination of coordination and acquisition of resources and clinical activities. The case manager has an average caseload of 10 clients.

The authors of a systematic review evaluated the literature on CM for homeless persons published during the period 1985–2011 and found evidence that CM provides numerous benefits for homeless persons, including increased housing stability, increased use of medical and nonmedical services, reduced substance use, reduced use of high-cost services, improved mental status, and improved quality of life (11). Researchers in more recent studies have also reported positive outcomes (3,5,6).

- In a study of 7,235 homeless adults with mental illness, ICM led to improvements in housing, substance use, and psychiatric symptoms (2).
- Researchers in a randomized study of 600 homeless men recently released on parole found that the rate of completion of the hepatitis A and B vaccine series was higher in the group receiving nurse-led CM with peer coaching (75.4%) than in those who received peer coaching with minimal nurse involvement (71.8%) or usual care (71.9%) (6).
- Investigators in Australia studied the effects of a CM intervention in 224 young adults who were experiencing homelessness and unemployment. They concluded that participants with 20 or more contacts with a case manager had significantly better housing and employment outcomes than those with fewer contacts (2).

Recent years have seen a shift away from traditional “treatment first” interventions that require homeless persons to prove readiness for housing (e.g., through sobriety and/or acceptance of psychiatric treatment) toward programs that provide immediate access to independent housing without strict requirements for housing readiness. ICM is an important component of Housing First, an internationally recognized model that provides homeless persons with safe and permanent housing and support services (2).

- Investigators in Toronto, Canada randomized 378 homeless adults with mental illness to Housing First with ICM or usual care and found that Housing First resulted in improved housing stability and community functioning, reduced likelihood of hospitalization, and reduced number of days of alcohol-related problems (5).
- In a study conducted in five Canadian cities, 1,158 homeless persons with severe mental illness received Housing First and 990 received standard care. Housing First was associated with better housing outcomes and quicker improvements in community functioning and quality of life (1).
• Researchers in a study of 2,154 homeless persons in five Canadian cities concluded that Housing First programs were similarly effective in persons with and without substance use disorders(2).

• However, researchers in Vancouver, Canada studied 497 homeless persons with mental illness and found that Housing First did not reduce daily substance use compared to usual care(1).

What We Can Do

› Become knowledgeable about the needs of homeless persons and the role of CM in providing care for homeless persons; share this information with your colleagues
› Collaborate with public and private organizations to identify homeless persons and resources in your community that can provide appropriate and timely services
› Recognize the unique needs of the homeless and provide nonjudgmental, culturally competent care
› Contact the National Health Care for the Homeless Council for clinical resources, research, and updated policies on homelessness; for more information, refer to https://www.nhchc.org/
› For information on becoming trained in CM for homeless persons, refer to https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/case-management
## References


