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Understanding Homelessness: A Call to Action and Curriculum Framework for Psychiatry Residencies

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Homelessness is a critical public health issue that disproportionately affects those with mental illness [1, 2]. The 2018 point-in-time count of homelessness on a given night found that 552,830 people were experiencing homelessness [3]. The total number of people experiencing homelessness over the course of a given year is difficult to evaluate but was estimated at 2.3 to 3.5 million in 2000 [4]. While homelessness nationally has declined over the last decade, it has grown in 12 states and has increased sharply in some regions [5]. Over the past 2 years in California, for instance, homelessness increased 17% in San Francisco, 42% in Alameda, and 43% in Orange County [6]. In Los Angeles, homelessness and deaths among those who are homeless have increased in recent years [7], leading public officials to label it a public health crisis [8]. Even in regions with declining rates of homelessness, issues such as housing insecurity, falling into homelessness due to economic shocks, or doubled-up living arrangements may be relevant [9].

Given the high rates of mental illness among individuals experiencing homelessness [10, 11], psychiatry residents are likely to treat patients who are homeless, even in regions that are not experiencing rising homelessness. The clinical skills and knowledge necessary to care for patients experiencing homelessness go beyond the skills acquired during more broad public psychiatry training. Despite the Accreditation Council for Graduate Medical Education (ACGME) Milestones in psychiatry focused on community-based care [12], only 60% of programs provide education related to homelessness, and only 11% include required clinical rotations focused on homelessness [13].

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A case study by Braslow and Messac [14] published in 2018 in the *New England Journal of Medicine* describes a common scenario during psychiatry residency. The authors describe a patient with chronic homelessness who presents to an emergency department (ED) exhibiting psychotic symptoms and requesting help. The treating psychiatry resident finds on review of the patient's medical record that he frequently comes to the ED with similar complaints, so she decides to discharge the patient. The authors describe a dismal outcome for the patient—he is currently in jail pending trial for felony charges.

In cases like these, there are clinical skills and interventions that can be taught during residency that can result in improved outcomes. In this article, we review the literature on mental illness in people experiencing homelessness. We then review the current state of psychiatry residency program education surrounding homelessness. Finally, we propose a set of educational goals and didactics focused on homelessness for psychiatry residency training programs. For programs without the capacity to implement a new set of didactics, we have also included strategies for programs to incorporate education in homelessness into existing didactics. We hope this article underscores the importance of homelessness education within psychiatry training programs, and serves to call residency directors to action to ensure that future psychiatrists are equipped to care for this important population.

Increased Risks of Mental Illness and Environmental Stress during Homelessness

The mental health field has an important role and long history in leading strategies to address homelessness. Among homeless populations, 28% suffer from chronic mental illness [15]. The prevalence of schizophrenia among people who are homeless is estimated to be between 4.4 and 16% [16], and that of major depression is estimated at 11.4% [17]. People who are homeless are also at serious risk of suicide: a study of individuals with serious mental illness experiencing homelessness found that 37.5% had reported suicidal thoughts in the previous month, and over half reported at least one lifetime suicide attempt (8% within the last month) [18].

Substance use disorders (SUDs) are also prevalent among people who are homeless in the United States (30%–49%) [15], with serious consequences: drug overdose is the leading cause of death among people who are homeless [19]. A study of ED patients found higher rates of alcohol misuse, binge drinking, and illicit drug use among those experiencing homelessness compared with those who were housed [20]. Qualitative studies of older adults experiencing homelessness describe substance use as a means to cope with physical pain or mental distress [21]. Numerous studies have described barriers to access to mental and behavioral health services for people experiencing homelessness [22], despite provisions in the Affordable Care Act defining substance use treatment as an essential health benefit [23] and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) [24].

It is also important to appreciate the unique stressors of homelessness, given that they extend beyond the stressors of living in poverty while housed. A patient that lives in poverty but has stable housing may experience food insecurity, poor health, and crime. However, a loss of housing leaves patients vulnerable to a worsening of all of these circumstances. They may

additionally become isolated from their communities, and perhaps lose employment and sense of purpose (Ijadi-Maghsoodi et al., manuscript in progress). Some patients experiencing homelessness endure an increased risk of violence [25] and may be forced to engage in survival sex, that is, trading sex for basic needs like housing and food (Ijadi-Maghsoodi et al., manuscript in progress). Patients without housing may forgo medical and psychiatric care due to competing priorities or may be hesitant to take sedating night-time medications due to safety concerns while sleeping in unsecured locations. These stressors can impact both mental and physical health.

The Current State of Homelessness Education within Psychiatry Residency Training

While any psychiatrist can work with people who are experiencing homelessness, specialized training can help develop the most effective clinicians, researchers, and advocates for these patients. Several educational approaches might include homelessness within psychiatry residency programs. Public psychiatry focuses on publicly-funded, under-resourced populations and services. Public psychiatry training experiences provide residents with early exposure to specialized multidisciplinary services for marginalized populations. Examples relevant to homelessness include street psychiatry rotations at the University of North Carolina [26] and Brown University [26, 27] and an outpatient elective at the Interprofessional Academic Homeless Patient Aligned Care Team (HPACT) at the West Los Angeles VA [28].

Residents can also learn about homelessness by fulfilling the ACGME educational competency for systems-based practice. Educators have adapted this competency to teach residents to leverage health care and other system-level resources for the benefit of patients. A systems-based practice educational intervention, for example, might include a resident quality improvement project to implement a patient screener for housing status [20, 23].

Residency programs may also offer training in structural competency, which urges an awareness of the structures that influence health, such as housing and zoning policies [29]. A structural competency approach to homelessness might encourage advocacy to increase local funding for evidence-based supportive housing or community-academic partnerships to better meet the social needs of those patients experiencing homelessness [29]. Systems-based practice and structural competency curricula are emerging in psychiatry training programs, including Yale [30], UCLA [31], NYU [32], Columbia [33], and the University of California-Davis [34].

Proposed Residency Curriculum in Homelessness: Educational Goals

We propose four resident educational goals and additional specific didactics to guide programs' development of curricula in homelessness (Table 1). These goals and didactics are compatible with existing educational approaches in public psychiatry, systems-based practice, and structural psychiatry. For programs that do not have the resources or room in their didactic schedules to add a new curriculum on homelessness, we have included

suggestions to facilitate implementation of homelessness education into existing didactics (Table 2).

Goal 1

The first goal for resident education is to evaluate patients, including special populations, for housing status and relevant social determinants of health. Understanding the social determinants of health for patients who are homeless will help residents provide sensitive, collaborative, and effective healthcare [28, 35]. Homelessness is a potent social determinant of health. Life expectancy among those experiencing homelessness is greatly reduced, estimated to be 43–47 years of age [36]. People who are homeless are less likely than the general population to get medical care from a primary care doctor [37]; they may have difficulty keeping appointments and proving insurance status or may have negative experiences with health care [38]. In the face of resource scarcity, people experiencing homelessness make individual-level tradeoffs in favor of necessities like food or shelter over health care services, contributing to downstream delays in preventive care and overutilization of acute care services [39, 40]. Residents may need to develop trust and rapport with these patients before they agree to start psychiatric treatment; they may first need to assist their patients with housing or employment needs.

Some subgroups of patients have unique social determinants that residents should recognize. Children are impacted significantly by housing instability, parental substance use and mental health problems, poverty, and witnessed violence. Many of these experiences are considered adverse childhood experiences (ACEs) and are known to affect health. These children have increased risk of academic problems, mental health problems, developmental delay, cognitive outcomes, and homelessness in the future [41, 42].

Residents should also be aware of the social determinants of health among women who experience homelessness. Domestic violence is the leading cause of homelessness for women [43], and a study of mothers who were homeless found that 93% had experienced trauma [44]. They may be at continued risk for sexual victimization because they may engage in survival sex for basic needs; they are also at risk for sexually-transmitted infections [45–47].

Finally, veterans experiencing homelessness have unique social determinants and resources. Veterans are more likely than the general population to be homeless; beyond general risk factors like poverty, they may have also experienced military trauma, traumatic brain injury, and difficulty adjusting to life outside of the military [48]. Conditions such as posttraumatic stress disorder and military sexual trauma may increase the risk of homelessness among veterans [49, 50]. Women veterans experiencing homelessness may be especially vulnerable to a loss of social connections; indeed, women veterans are four times as likely to be homeless than civilian women [49, 51].

Given the high prevalence of trauma during periods of homelessness, individuals experiencing homelessness—especially vulnerable populations such as women, children, and veterans—are at risk for re-traumatization in health care settings. These patients may benefit from a trauma-informed care approach when residents evaluate housing status,

inquire about social determinants of health, and address mental health concerns [52]. Trauma-informed care refers to a set of principles that guide treatment—such as collaboration, trust, empowerment, and safety—with the goal of avoiding distress and re-traumatization [52, 53]. Residents can offer opportunities for patients to rebuild control, at least during the clinical encounter; ensure environmental and emotional safety; and utilize a strengths-based approach to care.

Table 1 identifies two resident lectures on providing compassionate care to homeless persons. The first provides an overview of the social determinants of health for subgroups of people experiencing homelessness; the second focuses on trauma-informed care, ACEs, and adult victimization. Programs in cities with a high burden of homelessness may consider adding lectures focused on unmet health care needs among people who are homelessness and the unique impact of homelessness among veterans. Smaller programs can consider including cases on homelessness in existing case conferences. They can also include trauma-informed care in their existing lectures on high-risk populations or on lectures about trauma (Table 2).

Goal 2

The second goal for resident education is to understand and practice appropriate referrals to evidence-based health care models for patients experiencing homelessness. Patients who are homeless benefit from health care that is tailored to their needs. Residents who are educated on these models will understand the core components and benefits of these programs and will be empowered to practice appropriate referrals to programs that are available in their communities. If such programs are not available in their communities, education on evidence-based models may inspire resident advocacy for such programs. One example is the US Health Care for the Homeless Program (HCHP), a delivery model that includes comprehensive primary care, substance use treatment, and supportive services. The HCHP became a national program in 1987, and today 285 HCHPs are located across the country. The Boston Health Care for Homeless Program (BHCHP) serves over 12,000 people who are homeless in Boston, Massachusetts. Its team of outreach providers see patients in shelters and the streets in an attempt to overcome barriers of stigma in a clinic and of transport and property [54].

Another delivery model that is well suited to the care of patients who are homeless is the patient-centered medical home (PCMH), which is a physician-directed care setting that provides coordinated and continuous care [55]. The Veterans' Administration uses a PCMH model called the Homeless Patient-Aligned Care Team (HPACT), created to provide social services, primary care, and mental health care to veterans who are homeless. HPACT emphasizes using an empathic approach with patients that is cognizant of their barriers to care. For instance, HPACT tries to accommodate walk-ins whenever possible. Six months after implementation of HPACT, emergency department visits decreased by 19% and hospitalizations by 34% [28].

Assertive Community Treatment (ACT) programs also exist for people with severe mental illness and have demonstrated improvements in symptoms and housing status among homeless populations [56]. These programs conduct longitudinal outreach services to people

who are homeless and provide intensive case management and social work in addition to mental health treatment. ACT is well studied and associated with lower rates of psychiatric hospitalization and increased housing stability [56].

Table 1 includes two didactic sessions to help residency programs fulfill this educational goal. The didactics we suggest are an overview of community resources and local delivery models and an overview of ACT programs. These sessions can be led by experienced psychiatrists, social workers, or administrators within these care settings. A relevant clinical experience could consist simply of practicing appropriate referrals under the guidance of a knowledgeable clinician, or even of a rotation at a specialized care model or ACT program if this is possible. Smaller programs can focus on encouraging appropriate referrals from the inpatient unit or ED (Table 2).

Goal 3

The third goal for resident education is to analyze structures that impact housing and to advocate to improve the health of people who are homeless. More broadly, it is helpful for psychiatry residents to understand existing structures that impact homelessness, which can include economic policies, historic practices such as redlining, and current issues such as lack of rent stabilization or other tenant protections, immigration policies and patterns, racism, stigma, and the criminal justice system. Psychiatrists have the opportunity to advocate on behalf of patients experiencing homelessness. In some systems, psychiatrists have specific gatekeeper functions and can help patients secure treatment services, for example with finances (such as disability benefits) and diversion from incarceration, both of which can relate to homelessness prevention. Psychiatrists can also conduct housing evaluations, which are essential components of patients' applications (e.g., HRA 2010e) for permanent supportive housing, such as in New York City's NY/NY III housing system [57]. At UCLA's psychiatry residency, a core curriculum class was developed on homelessness policies (Measures H and HHH) and roles for psychiatrists within local initiatives [58]. The class is taught by a local policymaker.

Cities are starting to implement novel policies to prevent and end homelessness. Measure H in Los Angeles County appropriates \$40 million to such assistance; funds can be used to cover rent or moving expenses for people who may otherwise become homeless [58]. Residents should be aware of low-income housing, Housing First [59], and rapid re-housing programs [60] in their regions such as Section 8 housing vouchers [61], Housing Opportunities for Persons with AIDS (HOPWA) [63], Public Housing, the Low-Income Housing Tax Credit program [64], and other housing available for special populations such as seniors or persons with disabilities.

For veterans in particular, a cornerstone of the effort to end veteran homelessness is a partnership between the US Department of Housing and Urban Development and VA Supportive Housing (HUD-VASH) [62]. This program is a component of the Section 8 Housing Choice Voucher (HCV) program for civilians. Like all HCV vouchers, HUD-VASH vouchers are exchanged for private rentals and allocated specifically for veterans, and the program includes additional funding to the VA for case management services [62]. In 2018, in addition to renewing existing housing vouchers, the government appropriated \$40 million

specifically to new vouchers for the HUD-VASH program [65]. Typically, veterans can be assessed for homelessness at VA facilities and then referred to housing agencies for vouchers.

Residents can learn how to refer and advocate for their patients through collaborations with local medical-legal partnerships, in which legal experts work together with health care providers to aid patients who are homeless or with local legal aid organizations specializing in housing and eviction defense [66]. Through this cross-sector collaboration, residents can learn to counsel patients to seek legal assistance in the case of an eviction.

Given the complexity of this topic, we suggest three didactic sessions to cover this material: 1) an overview of low-income housing and rapid re-housing; 2) a discussion of the structural causes and consequences of homelessness, as well as strategies for advocating for structural change; and 3) an overview of medical-legal partnerships (Table 1). Smaller programs can consider incorporating these topics into systems-based practice education, such as into existing case conferences or during clinical supervision (Table 2).

Goal 4

The fourth goal for resident education is to exhibit humanism when interacting with patients experiencing homelessness. As illustrated in the aforementioned case study by Braslow and Messac [14], residents may develop cynical attitudes and stigma toward patients experiencing homelessness that can contribute to barriers to care. Patients who are homeless may not establish care in outpatient clinics due to staff who are hostile or dismissive on the basis of a patient's appearance [67]. Some training sites have developed educational initiatives designed to improve provider empathy toward patients who are homeless. One interprofessional clinical curriculum incorporated narrative work and reflective practices, which led to improvements in trainee empathy and helper behavior toward patients who were homeless [68].

The Homeless Aligned Patient Care Team (HPACT) of the Veteran Affairs Greater Los Angeles Healthcare System developed and utilizes the "Humanism Pocket Tool" (HPT) to foster humanism and reduce stigma. This tool includes use of "vivid vignettes" to communicate a patient's aspirations and barriers to achieving those aspirations [69]. The HPT encourages residents and team members to use humanistic language to discuss mutual patients. More research is needed to understand resident attitudes and what drives a hesitancy to treat individuals experiencing homelessness –including possible concerns about available resources, lack of understanding, or lack of support. We suggest one didactic on humanistic clinical interactions with patients experiencing homelessness that would include how to obtain a narrative history and how to investigate personal subjective reactions to patients such as bias and cynicism.

Additional Educational Options

We have suggested didactics as a teaching method, but programs may prefer to incorporate these topics into case-based learning or other educational experiences. For instance, a standardized patient case could demonstrate a patient presenting to the ED for the tenth time

in several months with a chief complaint of auditory hallucinations and a social history that includes chronic homelessness. Existing case conference series could be modified to include housing status as a consideration for all patients.

An educational exercise that could be easily implemented asks residents to balance a budget as would a patient with housing instability. To illustrate, educators can introduce concepts including the housing wage, minimum wage, and Supplemental Security Income (SSI) benefits. The housing wage is the hourly wage that a worker would need to afford a two-bedroom apartment. In 2018, the housing wage was \$22.10/hour for a two-bedroom rental and \$17.90/hour for one bedroom [70]. In contrast, minimum wages are much lower; in California, for example, the minimum wage is \$11 per hour, and the federal minimum wage is \$7.25 per hour. Those who are disabled may also receive SSI benefits. A single adult on SSI would receive a \$771 federal payment (plus \$10-\$200 in state supplemental payments) per month, which is not enough to live in the national average one-bedroom apartment, costing \$931 monthly [70]. Through this exercise, residents can better understand the decisions of their patients.

Programs could also consider site visits to housing options for individuals experiencing homelessness (e.g., permanent supportive housing, emergency shelters, encampments and tent cities, safe parking options for people living out of their vehicles), drop-in centers, and legal aid housing programs for experiential learning to help familiarize residents with their patients' social contexts.

Clinical experiences with patients experiencing homelessness would obviously also be valuable to residents when available and could include clinical rotations at homeless clinics or on ACT or other street outreach teams. When these rotations are not available, residents will undoubtedly care for people experiencing homelessness in the ED and inpatient settings. These experiences can be supplemented with clinical supervision that is mindful of the stressors and burden of homelessness.

In conclusion, homelessness affects an individual's physical health, mental well-being, and lifespan. Despite valiant efforts of cities to combat homelessness, it continues to be a public health issue in many areas of the US [2]. Without appropriate training, residents may feel cynical and helpless when caring for patients experiencing homelessness in the ED, hospitals, or outpatient settings. Homelessness-related educational experiences within psychiatry residencies have the potential to empower a new generation of providers to address important health and social inequities.

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Table 1.
Psychiatry Residency Curriculum in Homelessness.

We have proposed four educational goals in homelessness for psychiatry residents. All educational goals are relevant to ACGME competencies. The table also provides guidance on necessary resources.

	Proposed Didactic	Instructor / Expertise	Time Required	Relevant ACGME Competencies
Educational Goal 1: Evaluate patients, including special populations, for housing status and relevant social determinants of health.	Overview of social determinants of health for people who are homeless, including the impact on health of a patient's housing status, use of shelters, and use of relevant resources.	Social worker or psychiatrist with experience working with homeless populations	1 hour	IV.A.5.a).(1).(b).(vi) demonstrate competence in formulating an understanding of a patient's biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment. IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
	Overview of ACES and TIC	Child psychiatrist, pediatrician, social worker, or psychologist	1 hour	
Educational Goal 2: Understand appropriate referrals to evidence - based care models for patients experiencing homelessness.	Overview of local community healthcare resources for people experiencing homelessness and mental illness.	Social worker, case manager, or community leader	1 hour	IV.A.6.a).(14) Resident experience in community psychiatry must provide residents with a cohort of persistently and chronically-ill patients in the public sector (a) This experience must include learning about and using community resources and services
	Overview of the benefits of Assertive Community Treatment (ACT) for patients experiencing homelessness.	ACT administrator	1 hour	
Educational Goal 3: Analyze structures that impact housing, and advocate to improve health of people who are homeless.	Overview of low-income housing and rapid rehousing programs in the community.	Social worker	1 hour	IV.A.5.f) Residents must demonstrate an awareness of and responsiveness to the larger context and system of healthcare, as well as the ability to call effectively on other resources in the system to provide optimal healthcare. IV.A.5.f).(4) Residents are expected to advocate for quality patient care and optimal patient care systems.
	Analyzing the causes and consequences of homelessness, and advocating effectively for structural change.	Community leader	1 hour	
	Overview of medical-legal partnerships.	Attorney with expertise in this area	1 hour	
Educational Goal 4: Exhibit humanism when interacting with patients experiencing homelessness.	Humanistic clinical interactions: How to obtain a narrative history from a patient experiencing homelessness; investigating personal subjective reactions to homelessness (e.g., cynicism, lack of self-efficacy, bias)	Social worker, psychiatrist, psychologist, or chief resident	1 hour	IV.A.5.e).(5) Residents are expected to demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Table 2.
Adding Homelessness Education to Existing Didactics.

Some programs do not have the resources or capacity to add an additional homelessness curriculum. These programs can incorporate educational material on homelessness into existing didactics, case conferences, and clinical experiences for residents. These programs may also benefit from the listed additional resources on homelessness.

Opportunities for programs to incorporate homelessness into existing curricula	
Educational Goal 1	Consider including cases on homelessness in existing case conferences. Include TIC in existing lectures on high-risk populations or on lectures about trauma. ACES might be included in existing child psychiatry lectures on childhood trauma.
Educational Goal 2	Encourage attendings and social workers to discuss appropriate referrals for people experiencing homelessness from the inpatient units, outpatient clinics, or ER.
Educational Goal 3	Incorporate educational material on homelessness, housing programs, and medical-legal partnerships into existing systems-based practice education. Programs can also incorporate this information into existing case conferences or during clinical supervision
Educational Goal 4	Identify faculty and staff to reinforce humanism goals in clinics and wards.
Additional Resources	
- National Center on Homelessness Among Veterans: https://www.va.gov/homeless/nchav/index.asp and Veterans Affairs Housing Toolkit: https://www.va.gov/homeless/docs/toolkit/DigitalHousingBody102715_508.pdf - SAMHSA Homelessness Programs and Resources: https://www.samhsa.gov/homelessness-programs-resources - Trauma and Resiliency-Informed Care Toolkit: https://www.downtownwomenscenter.org/wp-content/uploads/2018/12/Trauma-and-Resiliency-Informed-Care-Toolkit-updated-12.10.18.pdf - National Health Care for the Homeless Council: https://nhchc.org/	