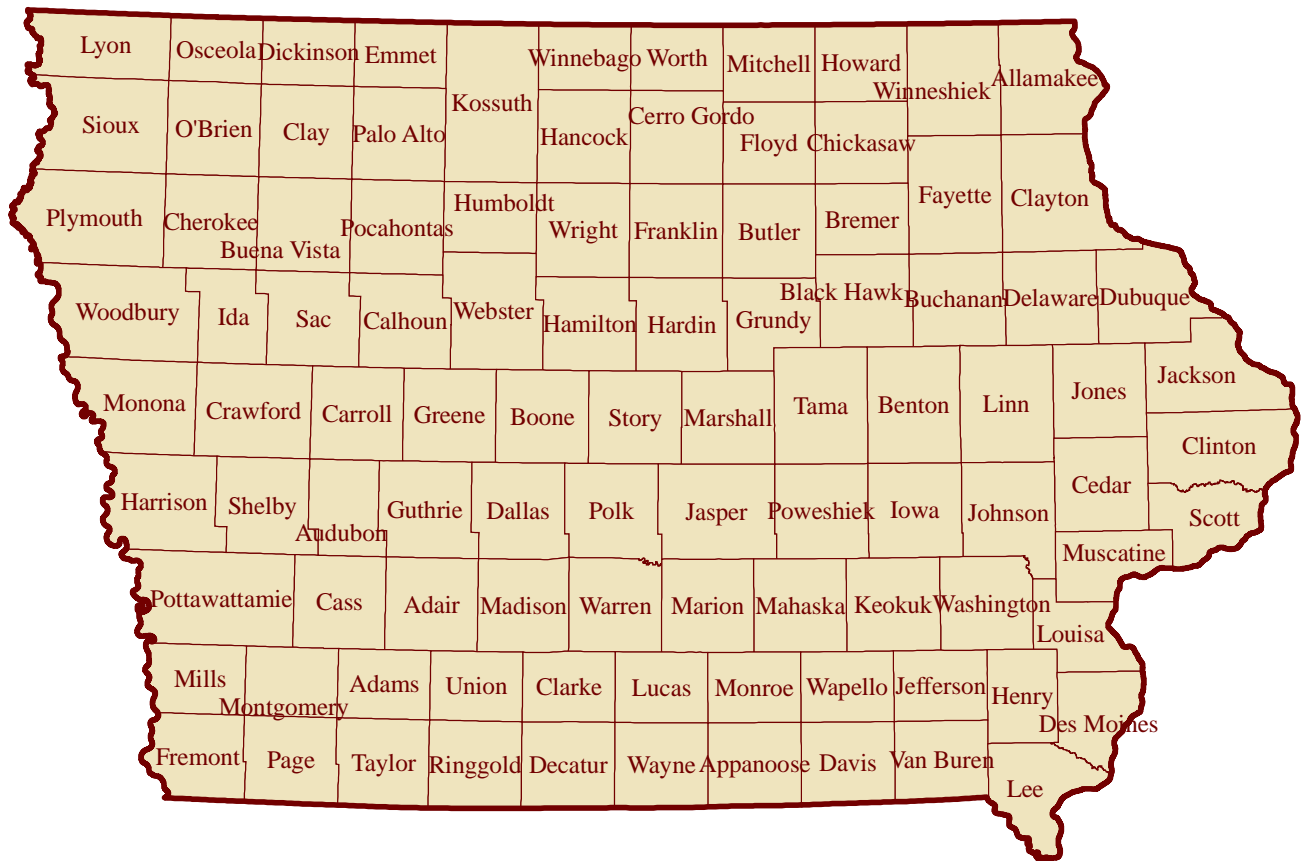


Mental Health and Homelessness in Iowa

This study was commissioned by the Iowa Council on Homelessness, through the Iowa Finance Authority. Established by an Executive Order issued by Governor Thomas J. Vilsack in 2003, the Council is assigned with the mission of identifying causes and effects of homelessness in Iowa, developing recommendations to address homelessness, and fostering greater awareness among policymakers and the general public. The process of conducting this study and the information provided in this report are important steps in fulfilling the Council's mission.



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Acknowledgements

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Chapter 1. Introduction

The purpose of this report is two-fold:

- 1) To drill down into data collected during the 2005 Iowa Statewide Homeless Study and present a more detailed picture of mental health and homelessness in Iowa (Chapters 2 and 3), and
- 2) To present findings from follow-up interviews of service providers in order to learn more about how schools, homeless shelters, and Department of Human Services (DHS) offices collected and reported information for the 2005 Iowa Statewide Homeless Study (Chapter 4).

This is the second report completed for the Iowa Council on Homelessness based on data collected during the 2005 Iowa Statewide Homeless Study. A wealth of information was collected for that study, of which mental health and disability data was only a small part. To read more about other findings and the methodology, please visit: <http://www.iowapolicyproject.org/2006docs/060112-HomelessStudy.pdf>. To view survey instruments, please visit: <http://www.iowapolicyproject.org/2006docs/060112-AppendixII.pdf>

Before presenting our new analyses of mental health problems among Iowa's homeless population, it is useful to recap the major findings from the 2005 Iowa Statewide Homeless Study.

Summary of 2005 Iowa Statewide Homeless Study

Just over 21,000 Iowans were homeless at some point during 2005, an increase of 2,688 people since 1999. The homeless population was largely concentrated in Iowa's most urban counties. In Polk County, which had the largest homeless population, 6,008 Iowans were living in shelters, transitional housing, on the streets or in other places not designed for human habitation. Scott County reported the second largest number of homeless (2,298), followed by Linn (1,875), Clinton (1,678) and Pottawattamie (1,594) counties. In twelve counties, all of which were among Iowa's most populous counties, over 500 persons were homeless during 2005.

Clinton County reported the most homeless persons as a percentage of the total population (3.4 percent), followed by Pottawattamie (1.8 percent), Marshall (1.6 percent), Polk (1.5 percent) and Scott (1.4 percent).

For the first time, school districts reported information on homeless students (including students temporarily living doubled with family or friends) directly to the Department of Education. The Cedar Rapids Community School District reported the most homeless students (550), followed by Des Moines Independent (523), Council Bluffs (447), Davenport (317), and Sioux City (223).

West Sioux Community School District had by far the highest percentage of homeless students at 12.8 percent of total enrollment. In three other school districts, homeless students represented over 5 percent of total enrollment (Allison-Bristow, Perry and Moulten-Udell).

Counties with over 500 Homeless People

County	Annualized Count	Per Capita Homeless
Polk	6,008	1.5%
Scott	2,298	1.4%
Linn	1,875	1.0%
Clinton	1,678	3.4%
Pottawattamie	1,594	1.8%
Johnson	1,257	1.1%
Story	966	1.2%
Black Hawk	957	0.8%
Woodbury	656	0.6%
Marshall	646	1.6%
Dubuque	552	0.6%
Webster	516	1.3%

Note: Population estimates as of July 1, 2004 from the Population Division, U.S. Census

In Iowa, as in the nation, the composition of the homeless population is changing. Families with children now make up the majority of all homeless households in Iowa. Reflecting this shift, women are more likely than men to be homeless and minority groups (who are more likely to have children) have increased as a share of the homeless population. In particular, African-Americans are significantly over-represented in Iowa's homeless population. While making up only two percent of the state population, black Iowans make up almost one-quarter of the homeless.

About 40 percent of homeless persons had a mental health problem, substance abuse problem or some other disability. However, the economic mismatch between earnings and housing costs appears to be of overwhelming significance. Homeless households and service providers concurred that domestic violence, unemployment, low-wage work, and the inability to find affordable housing were the most significant factors contributing to homelessness.

While targeted efforts to improve supportive services to people with health problems and to families (especially victims of domestic violence) are important, without adequate wages and affordable housing, the impact of these improvements *in reducing homelessness* may be limited. While striving to remove these structural barriers to resolving homelessness is important, more shelter beds and transitional housing are needed in the near term to provide for the increasing numbers of homeless Iowans.

Next, we present a summary of the major findings from each chapter of the 2005 Iowa Statewide Homeless Study:

Count

- About 21,280 Iowans were homeless at some point during 2005, an increase of 2,688 people since 1999. This increase is likely related to the recession that ensued in 2001 and the continued weakness in the labor market since then. In 2005, the unemployment rate was almost double the rate of 1999 and 35,000 more Iowans were unemployed.
- The Cedar Rapids Community School District reported the most homeless students with 550. Des Moines Independent was a close second with 523, then Council Bluffs (447), Davenport (317), and Sioux City (223).
- West Sioux Community School District had by far the highest percentage of homeless students at 12.8 percent. In three other school districts (Allison-Bristow, Perry, and Moulten-Udell), homeless students represented over 5 percent of total enrollment.
- Twelve counties had over 500 homeless persons during 2005. Polk County had almost three times more homeless persons (6,008) than the county with the second highest number of homeless, Scott County (2,298). Linn (1,875), Clinton (1,678) and Pottawattamie (1,594) rounded out the top five counties.
- Clinton County had by far the highest percentage of homeless people at 3.4 percent. Pottawattamie (1.8%), Marshall (1.6%), Polk (1.5%) and Scott (1.4%) had the next highest percentages.

Demographics

- Women are more likely than men to be homeless (56 percent versus 44 percent), especially among the African-American population and in rural and low poverty counties.
- African-Americans are significantly over-represented in Iowa's homeless population. While black Iowans make up only two percent of the state population, they make up almost one-quarter of the homeless.

- The majority of homeless African-Americans and Hispanic households have children compared to only 36 percent of white, homeless households.
- Homelessness is overwhelmingly white in rural areas. As urbanization levels increase, the percentage of the homeless who are African-American dramatically increases.
- Families with children make up the majority (61 percent) of all homeless households in Iowa.

Beyond Demographics

- One-fifth or more of all homeless households reported the following four circumstances leading up to or during their current episode of homelessness: The inability to find affordable housing, the closely related factor of eviction or foreclosure, domestic violence, and loss of employment (or continued unemployment).
- About 40 percent of homeless adults and 40 percent of school children had a mental health problem (referred to as a “serious emotional disorder” for children), a substance abuse problem, or some other disability.
- About seven percent of Iowa’s homeless meet the HUD definition for being chronically homeless.
- Almost one-fifth of homeless men in Iowa are veterans.
- The vast majority of homeless people are either uninsured (44 percent) or covered by Medicaid (43 percent). Homeless children are far more likely to be insured (usually through Medicaid) than adults.
- About one-third of homeless adults were employed during the reference week and about half of them worked more than 30 hours per week.
- Sixty percent of the homeless population over 24 years of age has no schooling beyond high school and only one percent has a college diploma.

Service Provider Assessments

- During the first quarter of 2005, about half of shelters served the same number of homeless clients and half served more homeless clients compared to the same period in 2004.
- 765 homeless people were turned away from shelters during the two-week study period because of a lack of space. Existing service capacity is especially inadequate in large metropolitan areas.
- Family breakup was perceived as the most significant factor contributing to homelessness across Iowa, just as it was in 1999.
- Substance abuse was the top ranked factor in rural counties and ranked second overall.
- The inability to find affordable housing and unemployment/job loss were also very significant factors, especially in metropolitan areas.
- The lack of living wage jobs and affordable housing were seen as the most significant barriers to resolving homelessness across Iowa.
- Improving access to health and counseling services (family/ domestic violence counseling, mental health services, substance abuse treatment, and medical services) were also seen as important strategies for resolving homelessness, especially in rural and metropolitan counties.
- Parental involvement was seen as the most significant barrier to improving enrollment and school attendance among homeless children, and parent training and involvement is the educational service most in need of improvement.
- Medical care, child care (for students with children or siblings to care for), better coordination between schools and other agencies, and staff development/ training were additional educational services in need of improvement.

Chapter 2. Mental Health among Homeless Adults in Iowa

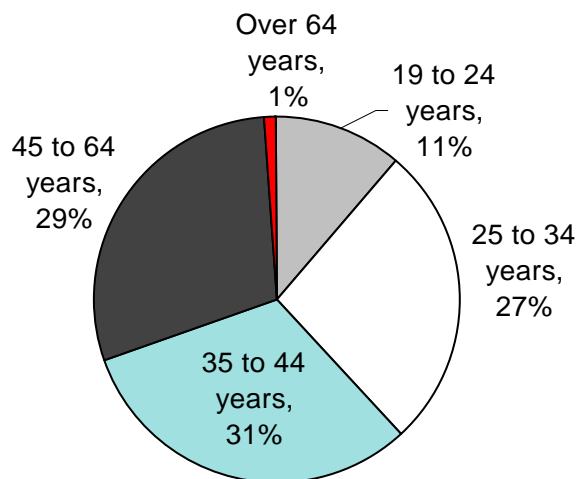
More information about mental health among Iowa’s homeless population was collected than could be analyzed for the 2005 Iowa Statewide Homeless Study. This chapter fills in more details about homeless adults in Iowa with a mental illness. The data for this part of the study came from the Homeless Management Information System (henceforth, called Service Point) and surveys designed by the authors of this report (Iowa Policy Project staff).

Age

Homeless individuals with mental illness are, on average, three years older than homeless individuals without mental illness. The average age for homeless adults with a mental illness is 38.6 years while the average age for homeless adults *without* a mental illness is 35.7 years. This difference in age between homeless adults with and without a mental illness is significant at a 95 percent confidence level.

In the 2005 Iowa Statewide Homeless Study, we reported that 25 percent of Iowa’s homeless adults are older than 45 years old. Among homeless adults with mental illness, about 30 percent are older than 45 years old (Figure 2.1).

Figure 2.1. Ages of Homeless Adults with Mental Illness



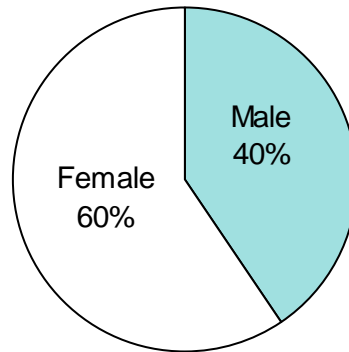
Gender

As reported in the 2005 Iowa Statewide Homeless Study, women make up the majority (56 percent) of Iowa’s adult homeless population. This reflects a shift nationwide whereby families are now the fastest growing segment of the homeless population.

While making up only 56 percent of all homeless adults in Iowa, women make up 60 percent of the adult homeless population with a mental illness (Figure 2.2). Homeless adults with a mental illness are significantly more likely to be female than are homeless adults without a mental illness (60 percent

versus 55 percent).¹ It is important to note that there may be other factors influencing these results. For example, women may be more likely to admit to a mental health problem or to receive a diagnosis compared to men. Our survey cannot account for these potential biases.

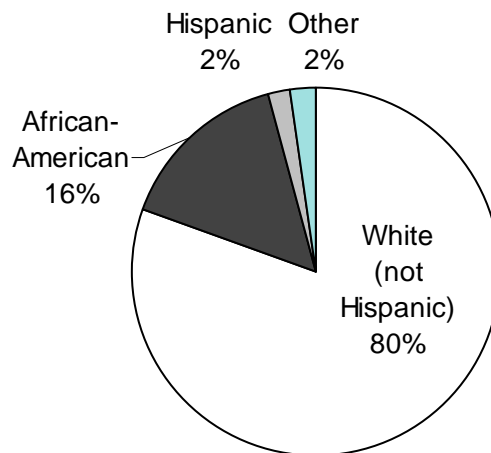
Figure 2.2. Gender of Homeless Adults with Mental Illness



Race and Ethnicity

In the 2005 Iowa Statewide Homeless Study, we reported that African-Americans make up only 2 percent of the state’s population, yet account for 24 percent of the homeless. Among homeless Iowans with a mental illness, however, *white Iowans* are over-represented. While making up only 68 percent of the adult homeless population, white Iowans constitute 80 percent of homeless adults with mental illness (Figure 2.3). Homeless adults with a mental illness are significantly more likely to be white than are homeless adults without a mental illness (80 percent versus 63 percent).²

Figure 2.3. Race and Ethnicity of Homeless Adults with Mental Illness



As we cautioned previously, it is important to note that there may be other factors influencing this data. For example, white individuals may be more likely to admit to a mental health problem or to receive a diagnosis compared to minorities. Our survey cannot account for these potential biases.

¹ This difference between homeless adults with and without a mental illness is significant at a 95 percent confidence level.

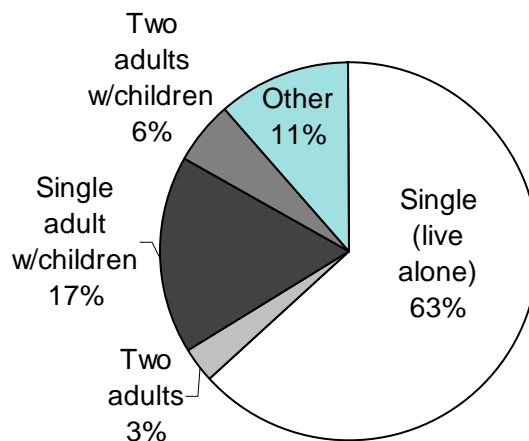
² This difference between homeless adults with and without a mental illness is significant at a 95 percent confidence level.

Household Type

One of the most important findings from the 2005 Iowa Statewide Homeless Study was the large number of homeless families. Families with children make up 61 percent of the total homeless population in Iowa, while single adults make up only 27 percent.

Among homeless adults with mental illness, however, the story is quite different. The vast majority of these individuals — 63 percent — live alone (Figure 2.4). Homeless adults with a mental illness are significantly more likely to live alone than are homeless adults without a mental illness (63 percent versus 42 percent).³

Figure 2.4. Household Type of Homeless Adults with Mental Illness



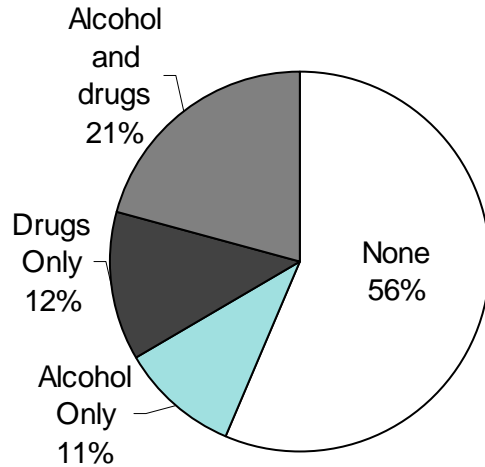
Substance Abuse Problems

In the 2005 Iowa Statewide Homeless Study, we reported that 16 percent of all homeless adults had a substance abuse problem. However, among homeless adults with a mental illness, 44 percent of individuals reported having a substance abuse problem (Figure 2.5). Homeless adults with a mental illness are significantly more likely to have a substance abuse problem than are homeless adults without a mental illness (44 percent versus 10 percent).⁴

³ This difference between homeless adults with and without a mental illness is significant at a 95 percent confidence level.

⁴ This difference in the prevalence of a substance abuse problem is significant at a 95 percent confidence level.

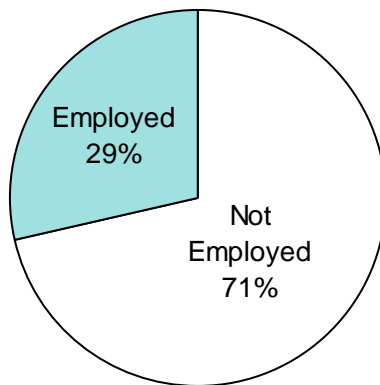
Figure 2.5. Substance Abuse Problems among Homeless Adults with Mental Illness



Employment

In the 2005 Iowa Statewide Homeless Study, we reported that 68 percent of all homeless adults were unemployed. A slightly higher percentage of homeless adults with a mental illness —71 percent — are unemployed (Figure 2.6). Homeless adults with a mental illness are significantly more likely to be unemployed than are homeless adults without a mental illness (71 percent versus 65 percent).⁵

Figure 2.6. Employment Status of Homeless Adults with Mental Illness



Chronic Homelessness and Veteran Status

Adults who are chronically homeless are more likely to have a mental illness than are other homeless adults (35 percent versus 21 percent). This difference between chronically homeless individuals and the rest of the homeless population is significant at the 95 percent confidence level.

Veterans are less likely than the rest of the homeless population to have a mental illness.

Homeless adults who are veterans are *less* likely to have a mental illness than are other homeless adults (16 percent versus 22 percent). This difference between homeless veterans and the rest of the homeless population is significant at the 95 percent confidence level.

⁵ This difference between homeless adults with and without a mental illness is significant at a 95 percent confidence level.

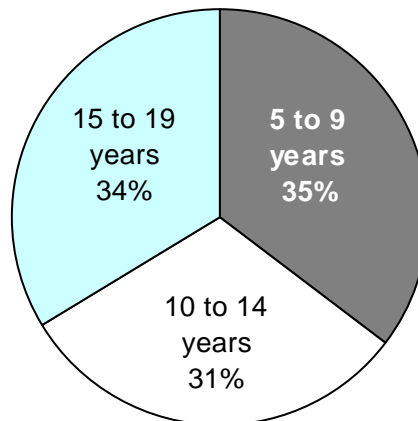
Chapter 3. Mental Health among Homeless School Children in Iowa

More information about mental health among Iowa's homeless school children was collected than could be analyzed for the 2005 Iowa Statewide Homeless Study. This chapter fills in more details about homeless school children in Iowa with a serious emotional disorder (SED). The data for this part of the study came from surveys of 1,269 students in 383 schools. (While all 1,532 schools were surveyed for perceptions about homelessness, only 25 percent of the schools were asked to complete a longer survey form about the mental health, substance abuse, and disability status of each homeless student).

Age

Homeless school children with a serious emotional disorder are, on average, 1.5 years older than homeless school children without SED. The average age of homeless children with SED is 12 years while the average age of homeless children *without* SED is 10.5 years.⁶ Homeless school children with serious emotional disorders are in elementary, middle and high schools (Figure 3.1).

Figure 3.1. Ages of Homeless School Children with SED



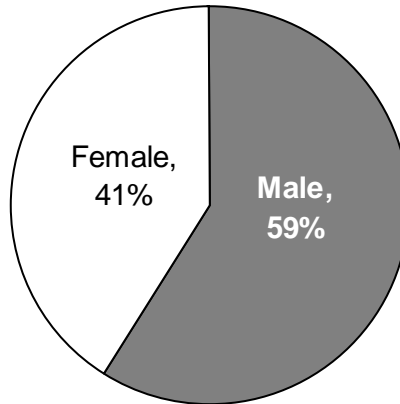
Gender

Among homeless children with a serious emotional disorder, 59 percent are male and 41 percent are female (Figure 3.2). Homeless school children with a serious emotional disorder are significantly more likely to be male than are homeless school children without SED (59 percent versus 46 percent).⁷

⁶ This difference in age between homeless school children with and without a SED is significant at a 95 percent confidence level.

⁷ This difference between homeless school children with and without a serious emotional disorder is significant at a 95 percent confidence level.

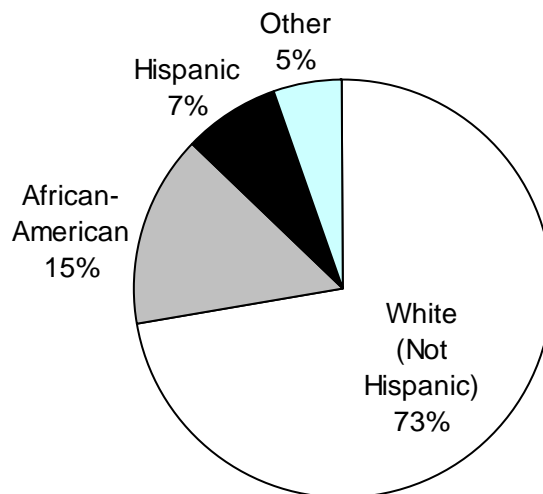
Figure 3.2. Gender of Homeless School Children with SED



Race and Ethnicity

Among homeless school children with a serious emotional disorder, 73 percent are white, 15 percent are African-American, and 7 percent are Hispanic (Figure 3.3). Homeless school children with a serious emotional disorder are significantly more likely to be white than are homeless school children without SED (73 percent versus 58 percent).⁸

Figure 3.3. Race and Ethnicity of Homeless School Children with SED

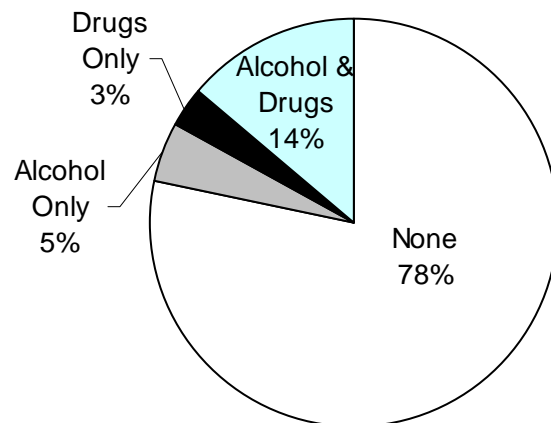


⁸ This difference between homeless school children with and without a serious emotional disorder is significant at a 95 percent confidence level.

Substance Abuse Problems

Among homeless school children with a serious emotional disorder, 14 percent have a problem with both drugs and alcohol, another 3 percent have only a drug problem, and another 5 percent have only an alcohol problem (Figure 3.4). Homeless school children with a serious emotional disorder are significantly more likely have a substance abuse problem than are homeless school children without SED (22 percent versus 4 percent).⁹

Figure 3.4. Substance Abuse Problems among Homeless School Children with SED



⁹ This difference between homeless school children with and without a serious emotional disorder is significant at a 95 percent confidence level.

Chapter 4. Interviews

In order to better understand the quality of our data and to improve the next statewide homeless study, 21 telephone interviews were conducted with individuals at schools, homeless shelters and DHS offices who filled out the surveys for the 2005 Iowa Statewide Homeless Study. Interview questions were tailored to each type of organization and the form of participation in the 2005 Iowa Statewide Homeless Study. In particular, we sought to understand how agencies responded to survey questions about mental health problems among their homeless clients and students.

Emergency Shelters

Interview questions for emergency shelters focused on three areas: how shelters identify mental illness and other disabilities among clients, the need for more staff training to identify mental illness, and how well shelters coordinate with local PATH (Projects for Assistance in Transition from Homelessness) programs. We selected seven emergency shelters for our follow-up interviews and spoke with one person at each shelter (usually either the executive director or a program manager). Six of the shelters are located in towns with a PATH program and all seven participate in Service Point. The seven shelters are Churches United Shelter in Des Moines, Dubuque Rescue Mission in Dubuque, John Lewis Community Services in Davenport, MICA House in Council Bluffs, Salvation Army in Waterloo, Shelter House in Iowa City, and the Waypoint Match Phillips Center in Cedar Rapids.

Our first question asked about the shelter's current method or protocol for identifying disabilities among clients. In all cases, shelters relied on self-reporting from the clients. In one shelter, clients were never directly asked about mental illness or disability. Instead, staff would find out about an issue only if a client volunteered the information. In the other six shelters, staff asked about mental health problems and other disabilities upon in-take. However, the exact wording of the questions varied. Two shelters reported using the wording from Service Point, which asks, "Do you have a long-term disability? If so, what type of disability?" For another shelter, the in-take form simply read: "Mental Health Problem: yes or no." Still another shelter asked if the client had ever been "diagnosed with or treated for a mental illness."

Five shelters also asked clients if they were taking any medications. Shelter staff reported that this was another important way to find out about mental health problems or other disabilities. In four shelters, a case manager or licensed social worker would follow up with clients soon after in-take, which provided another opportunity for mental health problems to be identified. Thus, many of the shelters had several "back up" methods to identify mental illness if the client was not honest up front. For example, Shelter House in Iowa City asks a direct question upon in-take, asks about medications during in-take, and asks mental health questions yet again during the time of assessment by a case manager.

Next, we asked about the need for more staff training to identify and work with individuals with mental illness. The answer came back loud and clear: More training is always beneficial. However, there were some caveats. For example, two shelters noted that training should only be for select staff. For example, accredited training for case managers would be a higher priority than training for other staff. Furthermore, three shelters reported that staff already received some training. For example, the Churches United Shelter in Des Moines has trained staff to identify schizophrenia because that is one of the most common mental illnesses among their clients. At Dubuque Rescue Mission, the business manager was previously an outreach worker for the local PATH program. Thus, he is very capable of identifying and working with individuals with mental illness. At the Waypoint Match Phillips Center in Cedar Rapids, the local PATH outreach worker gives presentations during staff meetings.

The last part of the interview asked about cooperation with the local PATH program and the availability of services for homeless individuals with mental illness in the local community. All individuals reported that their relationship with their local PATH program was good and that the PATH program was doing a good job. However, one individual reported that the PATH outreach worker did not visit regularly.

There were many thoughtful comments concerning the availability of services. One individual said there was a need for case management services for clients once they leave the shelter in order to prevent recidivism and ensure they receive their medication and have transportation. Three individuals noted that the wait time to see a psychiatrist was too long. In Iowa City and the Quad Cities, it can take up to 3 months to see a psychiatrist, which is often longer than a person is allowed to stay in a homeless shelter. The program manager at Iowa City's Shelter House noted that people are "falling through the cracks" because they cannot function in a group environment (and therefore, cannot stay in the shelter) but they are not a danger to themselves or others (and therefore, cannot be admitted to the hospital inpatient psychiatric ward). He also said there was a shortage of transitional housing for mentally ill clients near Iowa City. Two individuals also noted that there was a lack of beds at the state mental health institutions (MHI), which has caused homeless individuals to end up in homeless shelters and prisons. The Executive Director of the Churches United Shelter, noted that "mainstreaming doesn't work for everybody."

DHS County Offices

For the 2005 Iowa Statewide Homeless Study, surveys for each county DHS office were individually packed, then bundled together and mailed to the eight Service Area Offices (SAOs). We then relied on the Service Area Offices to distribute the surveys to each of the county DHS offices in their respective areas. This distribution strategy worked extremely well. The response rate for DHS offices was higher than for any other type of organization (88 percent). In order to accomplish our follow-up interviews, we contacted six of the eight Service Area Offices and spoke with one person in the local DHS office in the same city. The six DHS county offices that participated are Woodbury County, Black Hawk County, Scott County, Story County, Dubuque County and Linn County.

Given the survey logistics, we did not know who eventually received the surveys and how they were administered in each DHS county office. Thus, the first part of our interview with DHS offices asked about who was responsible for the surveys and which DHS workers participated in the study. In all cases, the DHS income maintenance (IM) division participated in the study and DHS income maintenance supervisors were responsible for the distribution and collection of surveys in each office.¹⁰ In Linn County, the service division also participated in completing the surveys.¹¹ (There were no specific directions in the survey materials about which DHS workers should participate in the study.)

The next part of the telephone interview focused on how surveys were administered. In the survey materials, DHS workers were instructed to fill out the surveys only for individuals who voluntarily agreed to participate in the study. The instructions allowed DHS workers to answer some of the questions for the clients, but also stated that some questions may need to be asked directly of the client. These instructions implied that DHS workers should fill out the survey with the help of the client as needed but this was not explicitly stated. In order to learn how surveys were administered, we asked,

¹⁰ The DHS income maintenance division processes applications for FIP, food assistance, Medicaid and IowaCare. They also accept and forward applications for hawk-i and child care assistance.

¹¹ The service division is staffed by social workers providing various services including abuse assessments, subsidized adoption, foster care, and family preservation programs

Did the clients fill out the surveys all by themselves or did DHS workers complete the survey with the client?

In four offices, DHS workers always completed the survey questions with the client. In one office, a combination of methods was employed. Sometimes clients would complete the surveys on their own with little or no assistance from DHS staff and sometimes DHS workers would ask each question of the client and fill in the answer. The chosen method depended on the client's ability to comprehend and write answers for the survey.

One office reported that surveys were always filled out by individuals on their own because DHS staff did not have time to fill out the surveys with each client. Only two completed surveys were returned from this office, which suggests that this is a very poor way of ensuring participation in the study.

In order to learn more about how the mental health questions were answered, we followed up with these questions:

In particular, were the mental health and disability questions...

- a. Asked directly of the clients, using the wording and prompts included in the survey?*
- b. Answered based on the DHS worker's specialized training to identify mental health problems and disabilities?*
- c. Answered based on the DHS worker's knowledge of the client's medical history?*

Individuals in all offices answered “yes” to the first question. Thus, DHS workers always relied on self-reporting by the client to determine whether the client had a mental illness or disability. Individuals in all offices answered “no” to the second question. Thus, DHS workers did not identify mental health problems based on any specialized training. Finally, two offices answered “yes” to both the first question and the third question by noting that they relied on a combination of methods to determine whether an individual had a mental illness or disability. One individual explained that DHS workers also referred to work registration exemptions to determine whether there was a mental health problem or disability. Another individual said that staff usually relied on the client's response, but continued, “If a customer was clearly disabled (receiving SSI or SSD) and the customer stated they did *not* have a disability, DHS staff pursued a more accurate response.”

In the final question, we asked whether DHS staff received any training to identify mental illness and other disabilities. If DHS staff had received training, then we asked for a brief description of that training. If no training had been received, then we asked whether the individual thought it would be important for staff to receive training in the future.

Income maintenance workers did not generally receive any training to identify mental illness and other disabilities. One IM Supervisor, however, mentioned that a local professor gave a full day workshop about learning disabilities. Another individual noted that the IM workers in his office had a good working relationship with the social workers on the service side. As a result, IM workers were kept informed of new policies and training that is generally the domain of social workers. The same individual mentioned that IM workers received training and information through the Bureau SIDS and the SPIRS newsletter.

Supervisors and administrators had mixed reactions about the importance of training to identify mental illness. Here are several direct quotes:

- “Any training that would assist the staff in understanding the needs of customers seeking service would be beneficial.”
- “[Training] is not particularly important for IM workers compared to service workers. Some limited training would be helpful to help clients get verifications for FIP hardship.”
- “Most staff would feel that this is outside the realm of their work. Staff can usually tell if someone has mental health problems but it is not within their job duties to address these problems, except insofar as it affects eligibility for programs.”
- “Some training may be useful but is not necessary to their work.”
- “It is important to be able to communicate with the client to determine disability status so they can determine eligibility for programs and make the appropriate referrals. However, they do not have to and should not have to analyze and diagnose clients.”

Schools

Unlike DHS offices and homeless shelters, schools completed the surveys for the 2005 Iowa Statewide Homeless Study without conferring with any students. Thus, our interviews with schools briefly covered how homeless students were identified and the basis for determining whether a student had a serious emotional disorder. We randomly selected eight of the 383 schools that received the long form of the survey for interviews.

In general, schools do not have a standard process for identifying homeless students. However, with designated “homeless liaisons” in each school building as part of a new state-wide effort to track homeless students through Project Easier, some schools have adopted certain procedures to help identify homeless students. For example, in the Des Moines Independent Community School District, principals at each school provide the definition of homelessness to their staff at the beginning of each school year. When teachers or staff discover that a student is homeless, this information is passed on to the Homeless Liaison in the building. The Building Homeless Liaison then enters that information into the district database and passes along the information to the District Homeless Liaison for entry into Project Easier.

While schools are learning how to track homeless students better, they still rely on parents and students to volunteer information about their homeless status because schools do not generally ask. Most frequently, the school finds out because a family needs transportation services from a shelter or other site that is outside the district. According to federal law (McKinney-Vento Homeless Assistance Act), every school must provide these transportation services to homeless students. Homeless students were also identified through the registration and enrollment process. Based on the address and other information requested, a school could often identify students who were not living at home, students living at a shelter, and students living with a foster family. Finally, one individual noted that homeless status was sometimes revealed through counseling sessions.

In order to determine whether a student had a serious emotional disorder, school counselors and at-risk coordinators were usually counseled. Mental health information was also gleaned from student records connected to an Individualized Education Program (an individualized plan to improve educational results for children with disabilities). Two individuals stated that they reported a student as having a serious emotional disorder only if a known diagnosis had been made.

Conclusion

The purpose of these interviews is to improve the quality and accuracy of our survey data, especially as related to the reporting of mental health problems. Agencies generally must rely upon self-reporting to determine whether an individual had a mental health problem. Yet, individuals may choose to conceal their problem or they may be unaware of their problem because they have not visited a doctor. The social stigma attached to mental illness also makes it more difficult to obtain accurate information through surveys and may lead to underreporting.

The three types of agencies with whom we conducted interviews are very different. Serving individuals with mental illness is not the primary purpose of any of the agencies. In fact, of the three, only emergency shelters have a principal focus on serving homeless individuals. Yet, because of the transient nature of homelessness, it is important to survey a wide range of agencies to obtain an accurate count and description of homelessness in Iowa.

It is not practical for individuals at these agencies to learn how to diagnose clients for mental health problems, nor is this skill considered a prerequisite for their job. Yet for schools and emergency shelters, it is still important that individuals with mental health problems are identified in order to minimize disruption in the learning and communal living environments and to make appropriate referrals for treatment. Thus, it is important — for the accuracy of our survey, for the functioning of the agencies, and for the well-being of the individuals — that mental health problems be identified. This means developing a set of questions or methods that is most likely to result in accurate self-reporting about mental health problems. Indeed, some shelters already have developed fairly sophisticated methods to increase the accuracy of self-reporting on mental health problems. For example, Shelter House in Iowa City asks a direct question upon in-take, asks about medications during in-take, and asks mental health questions yet again during the time of assessment by a case manager.

It may be useful to break down responses by agency type to see if any single type of agency or source of data is underreporting mental health problems.¹² Among Form A surveys returned by DHS agencies during the 2005 Iowa Statewide Homeless Study, only 11 percent of homeless adults (5 out of 46) were reported as having a mental health problem.¹³ Among Form A surveys returned by shelters, 25 percent of homeless adults (24 out of 96) were reported as having a mental health problem.¹⁴ The vast majority of our data on homeless adults came from Service Point data reported by shelters and transitional housing programs. Among those surveys, 19 percent of homeless adults were reported as having a mental health problem (677 out of 3,662). Thus, it appears that DHS agencies may be underreporting mental health problems. On the other hand, it may actually be the case that homeless individuals who access DHS services are truly different on this characteristic from the rest of the homeless population.

The most important question left unanswered is whether Service Point data is underreporting mental health problems. This is the source of the vast majority of our data on homeless individuals. The Service Point survey format currently combines the questions about mental health, substance abuse and other

¹² Another indication of the credibility of the data is the number of non-responses to the mental health question, or “missing data.” Mental health questions were rarely left unanswered in surveys conducted by the Iowa Policy Project. The question about mental health was unanswered (“missing”) for only one individual (or only 1.3 percent of the time) in the DHS surveys, for only seven individuals (or only 5 percent of the time) in the shelter surveys, and for only 31 students (or only 2.4 percent of the time) in the school surveys.

¹³ DHS offices and other agencies surveyed by the Iowa Policy Project were randomly selected to receive either a survey with mental health and disability questions (Form A) or a survey with employment and health insurance questions (Form B)

¹⁴ This includes only shelters that were surveyed by Iowa Policy Project staff because they do not participate in Service Point.

disabilities into a two-part question. The first part asks, “Do you have a disability of long duration?” From a “drop down box” on the computer screen, individuals can choose “yes,” “no,” “refused,” “don’t know,” or leave the question unanswered. The second part of the question is titled “Disability Detail” and allows the respondent to select multiple disabilities from a drop down box. The survey respondent does not have to answer “yes” to the first question in order to select a disability from the drop down box. Thus, many individuals left the first part of the question blank (or sometimes even answered “no”) but still selected a disability in the second part.

In fact, among homeless adults in our final data set, the first part of the question was left blank 58 percent of the time (for 2,120 people). And among those 2,120 people, 27 percent of them (or 567 people) still selected a disability in the second part of the question. Of all the homeless adults who reported having a disability, 44.6 percent were originally missing on the entry question “Do you have a disability of long duration?”

For the 2005 Iowa Statewide Homeless Study, we assumed that individuals who selected “mental illness” or “dual diagnosis” from the drop down box in the second part of the question indeed had a mental health problem even if they left the first part of the question blank or even if they selected “no” for the first part of the question. In order to be consistent, we treated anyone who did not select “mental illness” or “dual diagnosis” in the second part of the question as a “no” even if they left the first question blank. Furthermore, this was consistent with how we had to treat other individuals who selected a disability that was not mental illness. We had to assume that the individual had only the disability listed and did not have a mental illness because the format of the question did not require the respondent to select “yes” or “no” for each type of disability.

In other words, all individuals in the Service Point database were assigned a “no” or a “yes” on the disability questions and no individual was treated as missing. This methodology had to be used because of the format of the disability/ mental health question. Certainly, this methodology led to a more conservative estimate than if we had been able to determine which individuals were “missing” on this question rather than counting them as not having a mental health problem or other disability.

Service Point may want to consider changes to the wording of their survey and survey format in order to better distinguish a “no” response from a “missing” response in the future. For one, the survey could allow individuals to select a disability type only if they answer “yes” to the first part of the question. However, this may lead to even more under-reporting. Many agencies, like some of the emergency shelters that we interviewed, may use their own questions and methods to determine a mental health problem. These agencies may purposefully or accidentally leave the first part of the question blank and only select the type of disability. It is also possible that individuals are confused by the first question and what exactly is meant by “long duration.” This could lead individuals to leave that question blank even though they have a disability. Another possible change to the survey format is to force persons to select “yes” or “no” for each type of disability, although this would certainly add to the length of the survey. The agency that is responsible for the Service Point data should collaborate with participants in order to determine how their survey format could be adapted or how shelters should adapt their reporting methods to ensure a consistent set of responses to these questions.

In order to improve the accuracy of data collected for future state-wide homeless studies, the most important factor is improving the accuracy of data reported to Service Point because this is the source of the vast majority of data on homeless individuals. This means improving the survey design for questions about disabilities and working with shelters and transitional housing programs to develop “best practices” for pursuing an accurate response from clients about their mental health status. As mentioned

previously, some emergency shelters already have developed fairly sophisticated methods to increase the accuracy of self-reporting mental health problems. All Service Point agencies should consider a similar protocol of asking not only about mental health, but about medications. Agencies should also consider re-visiting these questions after in-take. Developing a process that relies on multiple methods of identifying mental health problems is probably more important than the exact wording used to ask about such problems.

Appendices

I. Shelter Interviews

Churches United Shelter

1. Please describe your current method /protocol (if any) for identifying mental health problems and disabilities among the clients you serve (self-reporting, using Service Point questions, observation, etc...)? (Prompt with follow up questions as needed).

They rely on self-reporting during in-take. They recently changed their in-take forms regarding mental health and disability questions. The form now reads:

- Mental health problems? yes or no.
- Chronic? yes or no.

The in-take form used to say “Do you or have you had a mental health diagnosis?” They are constantly tinkering with the wording. The staff changed this wording partially because so many people with a mental health problem would never have been diagnosed anyway.

Many people will not admit to having a mental illness even if they have been diagnosed. A case manager will follow up with individuals soon after in-take. If the case manager believes an individual has a mental health problem or disability that was not noted upon in-take, the case manager will update the in-take form and Service Point.

One problem the shelter faces is that they cannot access other agency’s records on Service Point. There is not enough sharing of information.

Do you ask if the individual has ever been diagnosed with or treated for a mental illness?

They used to but not anymore.

Do you ask if the individual has ever been hospitalized for a mental illness?

NO.

Do you ask if the individual is or has ever been on any medications for a mental health condition (anxiety, depression, bi-polar disorder, mood disorder)?

NO.

Do you feel that your staff needs more training on how to identify mental illness?

More accredited training for case managers would be good, but this is not a priority for most staff. Staff are already trained to identify the symptoms of schizophrenia. Staff cannot diagnose the type of mental illness but they can usually identify if someone has a mental health problem.

Do you feel that your staff needs training on how to work with individuals with mental illness?

Staff could always use more training on how to work with folks with mental illness. However, the shelter already does some training in this area. At Churches United, training on how to work with individuals with mental illness is more important than training on how to identify mental illness. The Executive Director roughly estimates that 90 percent of clients have mental illness, so the staff are very used to it. Community providers provide some training about working with individuals with mental illness. Schizophrenia is one of the most common mental illnesses among their clients. Staff are taught about the symptoms of schizophrenia and how to deal with folks that are acting out. Staff are asked to be more lenient with folks who have mental illness.

If you participate in Service Point, do you input the information about a client's mental illness into Service Point?

YES.

Do you require referral forms before accepting anybody into your shelter?

NO.

Do health care providers visit your shelter to evaluate clients for health problems, including mental illness (psychiatric nurse, mental health therapist, etc...)? If so, how frequently?

Primary Health Care outreach workers come every Wednesday to the shelter. They, in turn, make referrals to Eyerly Ball Community Mental Health Services, which provides mental health diagnosis and treatment.

If you believe or know that someone has a mental illness, what do you do?

Refer the individual to the PATH outreach workers. Case managers follow up to make sure that clients are going to their appointments but they don't pretend to be mental health providers.

2. For agencies located in the same town as a PATH (Projects for Assistance in Transition from Homelessness) program, ask: Describe how you work with the PATH program in your community? How do you feel your collaboration could be strengthened?

The provider recently changed from Broadlawns to Primary Health Care. Primary Health Care providers come every Wednesday. They also come when they call. It is a win-win situation. The transition has been smooth.

3. Do you feel that you are very familiar with all of the available services in your community for individuals with mental illness?

YES.

4. What services for homeless individuals with mental illness are lacking in your community, either they don't exist or the services are insufficient?

In crisis situations, Eyerly Ball is flexible. These people are on the street because the mental health institutions throughout the state have effectively closed down. Mentally ill persons are either in prison or in homeless shelters. Mainstreaming doesn't work for everybody. There is a lack of beds at the mental health institutions.

Basic Information

Number of beds

116 beds (biggest shelter in the state).

Location

Des Moines

Type of shelter

102 emergency beds and 14 veterans/ transitional beds for adult men and women only. No children allowed.

Length of stay

30 days with extensions provided.

Website

www.Churchesunitedshelter.org

Primary Sources of Funding

Private donations, federal HUD dollars, everything.

Participate in Service Point

Yes

Dubuque Rescue Mission

1. Please describe your current method /protocol (if any) for identifying mental health problems and disabilities among the clients you serve (self-reporting, using Service Point questions, observation, etc...)?

The in-take form is not real involved. There is no question about mental health. Clients have to offer information about mental health problems or disability because staff will not directly ask. Staff observations are sometimes used to identify mental illness as well.

Do you ask if the individual has ever been diagnosed with or treated for a mental illness?

NO.

Do you ask if the individual has ever been hospitalized for a mental illness?

NO.

Do you ask if the individual is or has ever been on any medications for a mental health condition (anxiety, depression, bi-polar disorder, mood disorder)?

NO.

Do you feel that your staff needs more training on how to identify mental illness?

The Business Manager is the primary staff contact regarding mental health problems because he used to work for the Gannon Center so he is well trained. Some specific staff could certainly use more training although they would not want to train all shelter staff and volunteers.

Do you feel that your staff needs training on how to work with individuals with mental illness?

SAME ANSWER AS ABOVE.

If you participate in Service Point, do you input the information about a client's mental illness into Service Point?

YES.

Do you require referral forms before accepting anybody into your shelter?

NO.

Do health care providers visit your shelter to evaluate clients for health problems, including mental illness (psychiatric nurse, mental health therapist, etc...)? If so, how frequently?

A free clinic with volunteer physicians and nurses comes to the shelter ever week to address general health problems. The shelter has a grant to help pay for medications. However, they don't work with psychotropic drugs. Labs in Dubuque and diabetes clinic will help as needed.

Hillcrest Family Services (PATH) does not come regularly, but at least a couple of times per month. The Business Manager used to work for Gannon so he does a lot of the work that a PATH outreach worker would do. Someone on staff will work to get individuals into the mental health system at Hillcrest Services if needed. If a situation becomes intense, they will call Hillcrest right away.

They have an excellent continuum of care program.

If you believe or know that someone has a mental illness, what do you do?

If people are actively psychotic or depressed, they would connect them to mental health services (Hillcrest), or if necessary take them to Mercy Hospitals Mental health unit or ER. If there are serious problems, the individual is taken to the ER. There is an inpatient mental health unit at Mercy Hospital.

After it is established that a client has a mental health problem and that they need to be on the medications or see a therapist, this will be required to stay in the shelter.

2. For agencies located in the same town as a PATH (Projects for Assistance in Transition from Homelessness) program, ask: Describe how you work with the PATH program in your community? How do you feel your collaboration could be strengthened?

They would like to see the PATH outreach workers at the shelter on a more regular basis.

3. Do you feel that you are very familiar with all of the available services in your community for individuals with mental illness?

YES.

4. What services for homeless individuals with mental illness are lacking in your community, either they don't exist or the services are insufficient?

The transition from Gannon Center closing to Hillcrest opening went about as smooth as it could possibly go. It takes about 3 weeks to get an appointment with a therapist at Hillcrest. Services are pretty good and the cooperation with agency providers has been super. Everybody is on a first name basis. You just pick up the phone and call someone to make an appointment. Mercy, Hillcrest, and their shelter all work together well.

Basic Information

Number of beds

26 beds. Most are single rooms.

Location

Dubuque

Type of shelter

Adult Men

Length of stay

Guaranteed 3 nights every 30 days. If a person gets into one of their employment program, their stay will be extended.

Primary Sources of Funding

Private individuals, religious organizations, some income from a thrift store, and some grants.

Participate in Service Point

Yes, but not very consistently.

John Lewis Community Services

1. Please describe your current method /protocol (if any) for identifying mental health problems and disabilities among the clients you serve (self-reporting, using Service Point questions, observation, etc...)?

Shelter managers are the first point of contact. They do the in-take and ask the first question about mental health using the question from the Service Point system. [Do you have a long-term disability?] If the client answers yes, then they ask a follow-up question about the type of disability.

The reality is that the vast majority of people self-report that they have no problems at all. After in-take, a licensed social worker does a DSM (diagnostic and statistical manual) assessment.

Do you ask if the individual has ever been diagnosed with or treated for a mental illness?

NOT THESE WORDS EXACTLY.

Do you ask if the individual has ever been hospitalized for a mental illness?

NO. They are more concerned about the present state of the person, not past hospitalizations.

Do you ask if the individual is or has ever been on any medications for a mental health condition (anxiety, depression, bi-polar disorder, mood disorder)?

YES. They ask everybody about medications.

Do you feel that your staff needs more training on how to identify mental illness?

YES.

Do you feel that your staff needs training on how to work with individuals with mental illness?

YES.

If you participate in Service Point, do you input the information about a client's mental illness into Service Point?

YES.

Do you require referral forms before accepting anybody into your shelter?

NO. However, in order to live at the shelter, you have to verify that you are homeless (this is a requirement of their HUD funding).

Do health care providers visit your shelter to evaluate clients for health problems, including mental illness (psychiatric nurse, mental health therapist, etc...)? If so, how frequently?

They have a licensed social worker on staff. A substance abuse counselor also comes to meet with veterans. Nurses from Community Health Care come once a month to help people feel comfortable. They have applied for a SAMSA grant to have a mobile treatment team on staff at the shelters for substance abuse and mental health counseling.

If you believe or know that someone has a mental illness, what do you do?

The difficulty in the Quad Cities is that the wait time to see a psychiatrist is 10-12 weeks. They could make a referral to the local community health center but clients are not going to see anyone in a timely manner. John Lewis makes the referrals but the reality is that clients will be seen by the licensed social worker that they have on staff. There are no rules about taking medication or seeing a therapist. They certainly encourage that their clients take their medication but they cannot force anyone to do so.

2. For agencies located in the same town as a PATH (Projects for Assistance in Transition from Homelessness) program, ask: Describe how you work with the PATH program in your community? How do you feel your collaboration could be strengthened?

One of the Vera French outreach workers comes once a week to facilitate getting persons into the mental health system. However, getting an appointment at Vera French is a 10-12 week wait. The collaboration is fine, the problem is the wait at Vera French.

3. Do you feel that you are very familiar with all of the available services in your community for individuals with mental illness?

YES.

4. What services for homeless individuals with mental illness are lacking in your community, either they don't exist or the services are insufficient?

Again, the main problem in the Quad Cities is the wait time at Vera French (10-12 weeks). 10,000 Iowans are served at the Vera French MHC. The services are in place. The entire continuum is in place but it doesn't have the capacity to reach everyone. There is not enough funding to provide the services to all who need it. The tragedy in Scott County is that they have reached the ceiling with their MMR/DD funding streams. The Frontier Club program is closing. This will have an impact on the homeless service providers and on the entire community.

Basic Information

Number of beds

12 bed capacity for women and 45 bed capacity for men

Location

Davenport

Type of shelter

Emergency, General Use (One shelter for men and one shelter for women)

Length of stay

30 days without real expectations. It can be extended if they're working toward goals.

Primary Sources of Funding

HUD

Participate in Service Point

Yes.

Website

www.jlcs.org

MICAH House Emergency Shelter

1. Please describe your current method /protocol (if any) for identifying mental health problems and disabilities among the clients you serve (self-reporting, using Service Point questions, observation, etc...)?

Before people are admitted, staff must fill out a screening form with clients. The screening form has these questions about disabilities, medications, and mental health:

- Do you or anyone in your household have any disabilities?
- Are you or anyone in your household on any medications?

The screening form does not specifically ask about mental health. Staff also ask follow-up questions about disability payments in order to dig deeper to identify disabilities and whether someone is living with a mental health issue. This is important because the shelter wants to figure out whether someone has a mental health issue before admitting them, but persons will often deny the mental health issue if you ask directly.

Do you ask if the individual has ever been diagnosed with or treated for a mental illness?

NO.

Do you ask if the individual has ever been hospitalized for a mental illness?

NO.

Do you ask if the individual is or has ever been on any medications for a mental health condition (anxiety, depression, bi-polar disorder, mood disorder)?

YES.

Do you feel that your staff needs more training on how to identify mental illness?

YES. The staff definitely needs more training. There are only two case workers. There is not a licensed mental health therapist or clinical social worker on staff.

Do you feel that your staff needs training on how to work with individuals with mental illness?

YES. However, training to identify mental illness is more important then training on how to work with individuals with mental illness.

If you participate in Service Point, do you input the information about a client's mental illness into Service Point?

YES.

Do you require referral forms before accepting anybody into your shelter?

NO.

Do health care providers visit your shelter to evaluate clients for health problems, including mental illness (psychiatric nurse, mental health therapist, etc...)? If so, how frequently?

A nurse from the Visiting Nurses Association (VNA) comes once a week. The VNA only provides general health screenings. A mental health therapist from Heartland Family Services comes every other Wednesday and whenever needed.

If you believe or know that someone has a mental illness, what do you do?

First step is to sit down and talk to the person, figure out what is going on, and suggest to them to see the therapist. If the person is taking medications, they are asked to bring the medications with them into the shelter.

If a person is not seeing a therapist or not taking medications, they may not be allowed to stay at the shelter. A therapist from Heartland Family Services will determine whether that person needs services beyond what the shelter can handle. If medication or therapy can help and the person agrees to it, the individual will be admitted into the shelter.

2. For agencies located in the same town as a PATH (Projects for Assistance in Transition from Homelessness) program, ask: Describe how you work with the PATH program in your community? How do you feel your collaboration could be strengthened?

N/A

3. Do you feel that you are very familiar with all of the available services in your community for individuals with mental illness?

YES. Spring Center, Community Alliance, Mercy Hospital, Heartland Family Services, The Pottawattamie County Homeless Link outreach office, and Mom's place to name a few.

4. What services for homeless individuals with mental illness are lacking in your community, either they don't exist or the services are insufficient?

There is not enough in-patient beds and not quick enough access to mental health services. There is also a gap in services for children. There is not enough beds or access to therapists for children.

Basic Information

Number of beds

48 person capacity, 15 separate rooms

Location

Council Bluffs

Type of shelter

Emergency Shelter. Single women, couples, and 1 and 2 parent families (not single men and unaccompanied youth)

Length of stay

4-6 weeks

Website

<http://www.themicahouse.org/about.asp>

Primary Sources of Funding

Individual donations, federal and foundation grants.

Participate in Service Point

Yes

Established

1987

Salvation Army Waterloo

1. Please describe your current method /protocol (if any) for identifying mental health problems and disabilities among the clients you serve (self-reporting, using Service Point questions, observation, etc...)?

Upon in-take, persons are asked about their mental health history. If a person has a history of mental health issues, they are usually forthcoming.

Do you ask if the individual has ever been diagnosed with or treated for a mental illness?

YES.

Do you ask if the individual has ever been hospitalized for a mental illness?

YES.

Do you ask if the individual is or has ever been on any medications for a mental health condition (anxiety, depression, bi-polar disorder, mood disorder)?

YES.

Do you feel that your staff needs more training on how to identify mental illness?

Couldn't hurt but individuals are usually forthcoming about any mental health problems. Individuals are referred to Black Hawk Grundy for services.

Do you feel that your staff needs training on how to work with individuals with mental illness?

That is always advantageous because it is such a fluid, changing environment.

If you participate in Service Point, do you input the information about a client's mental illness into Service Point?

YES.

Do you require referral forms before accepting anybody into your shelter?

NO, but they do a thorough background check.

Do health care providers visit your shelter to evaluate clients for health problems, including mental illness (psychiatric nurse, mental health therapist, etc...)? If so, how frequently?

No. A Black Hawk Grundy outreach worker comes every day to facilitate the entry into the mental health system but mental health services are not provided at the shelter.

If you believe or know that someone has a mental illness, what do you do?

The Salvation Army coordinates with Black Hawk Grundy by referring clients to their outreach worker. Individuals must be on their medications to stay at their shelter. Black Hawk Grundy, People's Clinic and DHS may help pay for medications. Seeing a therapist is not required.

2. For agencies located in the same town as a PATH (Projects for Assistance in Transition from Homelessness) program, ask: Describe how you work with the PATH program in your community? How do you feel your collaboration could be strengthened?

It is going very well. Black Hawk Grundy has very competent individuals who come every day to the shelter. They provide good services.

3. Do you feel that you are very familiar with all of the available services in your community for individuals with mental illness?

YES.

4. What services for homeless individuals with mental illness are lacking in your community, either they don't exist or the services are insufficient?

The coordination with Black Hawk Grundy is good.

Basic Information

Number of beds

32 person capacity for women and children. 14 person capacity for men.

Location

Waterloo

Type of shelter

Emergency.

Length of stay

21 days, but if someone is effectively trying to find employment, they can extend it.

Primary Sources of Funding

Private individuals, religious organizations.

Participate in Service Point

Yes.

Shelter House

1. Please describe your current method /protocol (if any) for identifying mental health problems and disabilities among the clients you serve (self-reporting, using Service Point questions, observation, etc...)?

Upon in-take, they fill out the Service Point questionnaire, including the question: “Do you have a disability of long duration?” If yes, they ask what that disability is. Immediately upon in-take, someone may be in a state of trauma or may not yet trust the shelter staff, to answer the question honestly. However, most people are honest about it and will tell the staff if they have any problems.

The client will also be asked if they are taking any medications, which can indicate a problem. Then, at the time of assessment, the case manager will again revisit the mental health question. Staff will also carefully observe the behavior of clients to watch for signs of mental health problems.

Do you ask if the individual has ever been diagnosed with or treated for a mental illness?

At time of assessment, but not on in-take.

Do you ask if the individual has ever been hospitalized for a mental illness?

NO.

Do you ask if the individual is or has ever been on any medications for a mental health condition (anxiety, depression, bi-polar disorder, mood disorder)?

YES.

Do you feel that your staff needs more training on how to identify mental illness?

Staff could always use more training. Experience is often times worth more than training.

Do you feel that your staff needs training on how to work with individuals with mental illness?

YES. Same answer as above.

If you participate in Service Point, do you input the information about a client’s mental illness into Service Point?

YES.

Do you require referral forms before accepting anybody into your shelter?

NO.

Do health care providers visit your shelter to evaluate clients for health problems, including mental illness (psychiatric nurse, mental health therapist, etc...)? If so, how frequently?

A mobile health clinic from University Hospital regularly visits the shelter about general health problems. The PATH Outreach Worker from the Community Mental Health Center for Mid-Eastern Iowa, comes every Wednesday at 5 PM and also as needed. The PATH Outreach Worker facilitates getting people into the mental health system. The problem lies in that it can take more than 90 days to see a psychiatrist and the shelter only allows people to stay for up to 90 days. Plus, these psychiatrists are not free. They need to be paid and there are not enough psychiatrists who accept the lower fees that are paid for seeing these patients. If it is an emergency, they call the UI outpatient clinic.

If you believe or know that someone has a mental illness, what do you do?

Refer the person to the Outreach Worker for the local PATH program.

If it is a serious mental health issue, they will put rules on the person (must take medication and/or see a therapist). However, they do not require that a person with mental illness see a therapist before being admitted. This would be unreasonable because of the time it takes to see a therapist.

2. For agencies located in the same town as a PATH (Projects for Assistance in Transition from Homelessness) program, ask: Describe how you work with the PATH program in your community? How do you feel your collaboration could be strengthened?

PATH is doing a good job. The problem is a lack of money to pay for medicines and psychiatrists, and the wait time to see a psychiatrist. The PATH Outreach Worker comes every Wednesday and as needed.

3. Do you feel that you are very familiar with all of the available services in your community for individuals with mental illness?

YES.

4. What services for homeless individuals with mental illness are lacking in your community, either they don't exist or the services are insufficient?

There are people who are falling through the cracks because they cannot function in a group environment (and therefore, cannot stay in the shelter) but they are not a danger to themselves or others (and therefore, cannot be admitted to the hospital inpatient psychiatric ward). There is no where for them to go. There is no money to pay for psychiatric care and medicine, or they have to wait too long. There is not enough transitional housing for mentally ill clients.

Shelter House regularly refers clients to Successful Living, but they have a waiting list and the county will only pay for people in specific categories.

“If you change the income and resources available, you will change the outcome.”

Basic Information

Number of beds/Capacity

29

Location

Iowa City

Type of shelter

Emergency, General Use.

Length of stay

90 days

Primary Sources of Funding

United Way, faith communities, state, city, county, and federal governments, and private donations.

Participate in Service Point

Yes.

Website

www.shelterhouseiowa.org

Waypoint Match Phillips Center

1. Please describe your current method /protocol (if any) for identifying mental health problems and disabilities among the clients you serve (self-reporting, using Service Point questions, observation, etc...)?

There is a couple of ways that the shelter could identify a mental health problem. Waypoint requires a professional reference (someone not friend or family) before admitting someone to their shelter. So, the shelter may find out from the reference.

Second, they may find out from their in-take forms. Waypoint has tried to tweak in-take forms to match Service Point questions. On the in-take form, they ask directly if they have been diagnosed with a mental illness. Then they follow up with questions about whether they are on any medications or receiving any services related to the mental illness.

Case managers will do “service planning” to figure out client’s needs and barriers, and goals. So, the case manager may also identify any problems that were missed before.

Do you ask if the individual has ever been diagnosed with or treated for a mental illness?

YES. This is on the in-take form

Do you ask if the individual has ever been hospitalized for a mental illness?

NO.

Do you ask if the individual is or has ever been on any medications for a mental health condition (anxiety, depression, bi-polar disorder, mood disorder)?

YES.

Do you feel that your staff needs more training on how to identify mental illness?

More training is always helpful. She is always interested in finding trainings to help staff learn the most effective way to deal with different mental illnesses and identify mental illnesses. The PATH Outreach Worker from the Abbe Center comes to talk at the staff meeting about borderline personality order.

Do you feel that your staff needs training on how to work with individuals with mental illness?

YES. Same answer as above.

If you participate in Service Point, do you input the information about a client’s mental illness into Service Point?

YES.

Do you require referral forms before accepting anybody into your shelter?

YES (professional references).

Do health care providers visit your shelter to evaluate clients for health problems, including mental illness (psychiatric nurse, mental health therapist, etc...)? If so, how frequently?

The PATH Outreach Worker from the Abbe Center comes whenever they need him and is usually at the shelter more than once a week. He helps get Waypoint clients set up for services and access funding for services and medications. Sometimes, Waypoint can help fund a prescription through a White Cross grant.

There are no general health screenings at the shelter. Individuals have to go to the free health clinic to access general health services.

If you believe or know that someone has a mental illness, what do you do?

They call the PATH Outreach Worker at the Abbe Center. However, they cannot force someone to get mental health services. If the mental health problem is significantly affecting communal living, then the individual may have to leave. It is on a case by case basis. No formal mental health assessments are provided by staff.

2. For agencies located in the same town as a PATH (Projects for Assistance in Transition from Homelessness) program, ask: Describe how you work with the PATH program in your community? How do you feel your collaboration could be strengthened?

Their collaboration with the Abbe Center is going very well. The outreach worker comes by whenever they need him. Abbe Center's outreach worker is given certain appointment times and days that he can get people in for emergencies. The case managers arrange transportation and make sure clients get their meds.

3. Do you feel that you are very familiar with all of the available services in your community for individuals with mental illness?

YES.

4. What services for homeless individuals with mental illness are lacking in your community, either they don't exist or the services are insufficient?

Outreach case management services for clients once they leave the shelter in order to prevent recidivism and make sure they still get their meds and transportation.

Basic Information

Number of beds/Capacity

47

Location

Cedar Rapids

Type of shelter

Emergency shelter for single women and women with children

Length of stay

90 days

Primary Sources of Funding

United Way, individuals, religious organizations, IFA grant for Service Point

Participate in Service Point

Yes.

Website

www.waypointservices.org

II. DHS Interviews

Woodbury County DHS office

1. Who was asked to administer the surveys? Income maintenance workers, service workers or both?

Income maintenance (IM) workers only.

2. Who in your office was responsible for distributing the surveys and collecting the surveys from all the DHS workers?

An income maintenance supervisor.

3. Did the clients fill out the surveys all by themselves or did DHS workers complete the survey with the client?

When a DHS worker took a client into their office, then the DHS worker would ask the client if they were willing to participate in the survey. If yes, then the DHS worker asked the questions directly from the form and wrote the client's answers on the form for them.

4. In particular, how were questions about mental health and disabilities answered? Were the mental health and disability questions...

a. Asked directly of the clients, using the wording and prompts included in the survey?

YES.

b. Answered based on the DHS worker's specialized training to identify mental health problems and disabilities?

NO.

c. Answered based on the DHS workers' knowledge of the client's medical history?

NO.

5. Does your staff receive any training to identify mental health problems or other disabilities among clients? If yes, what type? If no, do you feel that this it would be important to receive training to identify mental health problems?

There has been one training in the last couple years. A college professor spent two half days teaching DHS workers about learning disabilities. They have not done any training sponsored by the state.

Black Hawk County DHS office

1. Who was asked to administer the surveys? Income maintenance workers, service workers or both?

Income maintenance (IM) workers only.

2. Who in your office who was responsible for distributing the surveys and collecting the surveys from all the DHS workers?

The income maintenance supervisor handed out the surveys to all staff and volunteers and collected the surveys when they were complete.

3. Did the clients fill out the surveys all by themselves or did DHS workers complete the survey with the client?

Surveys were filled out by the individuals on their own. Staff had no time to fill out the surveys with each client. Volunteers also handed out the surveys to clients in the sitting room. They did not get very many responses and clients did not want to admit to being homeless.

4. In particular, how were questions about mental health and disabilities answered? Were the mental health and disability questions...

a. Asked directly of the clients, using the wording and prompts included in the survey?

YES. (Clients filled out surveys on their own)

b. Answered based on the DHS worker's specialized training to identify mental health problems and disabilities?

N/A. (Clients filled out surveys on their own)

c. Answered based on the DHS workers' knowledge of the client's medical history?

N/A. (Clients filled out surveys on their own)

5. Does your staff receive any training to identify mental health problems or other disabilities among clients? If yes, what type? If no, do you feel that this it would be important to receive training to identify mental health problems?

No. Most staff would feel that this is outside the realm of their work. Staff can usually tell if someone has mental health problems but it is not within their job duties to address these problems, except for insofar as it affects eligibility for programs.

Other comments:

In order to provide services, clients have to provide an address, usually at a shelter. Shelters are the best place to identify homeless individuals. Many of their clients live at the Catholic Worker House and the Salvation Army.

Scott County DHS office

1. Who was asked to administer the surveys? Income maintenance workers, service workers or both?

Income maintenance (IM) workers only.

2. Who in your office who was responsible for distributing the surveys and collecting the surveys from all the DHS workers?

All four income maintenance supervisors.

3. Did the clients fill out the surveys all by themselves or did DHS workers complete the survey with the client?

Staff went through the survey with clients.

4. In particular, how were questions about mental health and disabilities answered? Were the mental health and disability questions...

a. Asked directly of the clients, using the wording and prompts included in the survey?

YES.

b. Answered based on the DHS worker's specialized training to identify mental health problems and disabilities?

NO.

c. Answered based on the DHS workers' knowledge of the client's medical history?

YES. DHS workers also referred to work registration exemptions to see if clients had been visiting Vera French for mental health problems. So, workers could have filled out these questions based on work registration exemptions as well as based on the direct answers from clients. Case loads are alphabetical in Davenport so case workers get to know their cases well (as well as you can with over 350 cases per worker).

5. Does your staff receive any training to identify mental health problems or other disabilities among clients? If yes, what type? If no, do you feel that this it would be important to receive training to identify mental health problems?

NO. It is not particularly important for IM workers compared to service workers. Some limited training would be helpful to help clients get verifications for FIP hardship. But as far as training to screen for a disability, that would not be part of the DHS workers job. They will never be able to make a diagnosis of course. But there does need to be some cross-reference to the service side. Workers need to have enough training to recognize when someone may need help and to get people help, instead of just sending them out on the street with nothing.

Story County DHS office

1. Who was asked to administer the surveys? Income maintenance workers, service workers or both?

Income maintenance (IM) workers only.

2. Who in your office who was responsible for distributing the surveys and collecting the surveys from all the DHS workers?

The income maintenance supervisor.

3. Did the clients fill out the surveys all by themselves or did DHS workers complete the survey with the client?

To the extent that clients agreed to participate in the survey, DHS workers helped them fill it out.

4. In particular, how were questions about mental health and disabilities answered? Were the mental health and disability questions...

a. Asked directly of the clients, using the wording and prompts included in the survey?

YES.

b. Answered based on the DHS worker's specialized training to identify mental health problems and disabilities?

NO.

c. Answered based on the DHS workers' knowledge of the client's medical history?

NO. Even if the DHS worker knows that a client has a disability, because they are receiving social security income for it, DHS workers will not typically know the nature of the disability.

5. Does your staff receive any training to identify mental health problems or other disabilities among clients? If yes, what type? If no, do you feel that this it would be important to receive training to identify mental health problems?

No. They're definitely more knowledgeable than the "man on the street" because they have a human services background and are accustomed to being around individuals diagnosed with mental illness. Some training may be useful but is not necessary to their work.

The staff is good at identifying problems but they can't identify specific medical conditions. They try to keep that role away from their workers. If someone identifies a need, they want to help but they are not doctors. If someone has a disability, they are interested in the status, but not necessarily the type of disability.

It is important to be able to communicate with the client to determine disability status so they can determine eligibility for programs and make the appropriate referrals. However, they do not have to and should not have to analyze and diagnose clients. There is a fine line.

Dubuque County DHS office

1. Who was asked to administer the surveys? Income maintenance workers, service workers or both?

Income maintenance (IM) workers only.

2. Who in your office who was responsible for distributing the surveys and collecting the surveys from all the DHS workers?

The income maintenance supervisors.

3. Did the clients fill out the surveys all by themselves or did DHS workers complete the survey with the client?

They followed the directions exactly. DHS workers filled out the surveys with their clients.

4. In particular, how were questions about mental health and disabilities answered? Were the mental health and disability questions...

a. Asked directly of the clients, using the wording and prompts included in the survey?

YES.

b. Answered based on the DHS worker's specialized training to identify mental health problems and disabilities?

NO.

c. Answered based on the DHS workers' knowledge of the client's medical history?

NO.

5. Does your staff receive any training to identify mental health problems or other disabilities among clients? If yes, what type? If no, do you feel that this it would be important to receive training to identify mental health problems?

NO. There is very open communication between IM workers and the social workers and social work supervisors. The social workers share new policies and new training on mental health with the IM staff. IM and service staff interact together, email regularly, eat lunch together, etc... This helps both sides stay informed of new policies and know their cases better.

IM supervisors do a good job of sharing information with all the IM staff. The income maintenance staff receive training through the Bureau SIDS. IMTA, IM supervisors and policy folks in Des Moines all share information through Bureau SIDS. A statewide newsletter, SPIRS, and Mr. Jim Krogman (head of field office support unit), also help make sure IM staff are well informed about new policies and new information.

Linn County DHS office

1. Who was asked to administer the surveys? Income maintenance workers, service workers or both?

Both income maintenance (IM) and service workers completed the survey. All income maintenance (financial assistance) and service (social worker) staff who have contact with customers were asked to complete these surveys with their customers. The contact could be direct (in-person) or indirect (phone interview/contact).

2. Who in your office who was responsible for distributing the surveys and collecting the surveys from all the DHS workers?

The five income maintenance supervisors.

3. Did the clients fill out the surveys all by themselves or did DHS workers complete the survey with the client?

Both. Customers attempted to complete the surveys on their own and staff were available to assist with questions as needed. Some staff completed the survey for the household by asking the household for the information requested. The process depended on the household's ability to comprehend and understand the survey.

4. In particular, how were questions about mental health and disabilities answered? Were the mental health and disability questions...

a. Asked directly of the clients, using the wording and prompts included in the survey?

YES.

b. Answered based on the DHS worker's specialized training to identify mental health problems and disabilities?

NO.

c. Answered based on the DHS workers' knowledge of the client's medical history?

YES. Staff usually went with the customer's response to these questions. However, if a customer was clearly disabled (receiving SSI or SSD) and the customer stated they did not have a disability, DHS staff pursued a more accurate response.

5. Does your staff receive any training to identify mental health problems or other disabilities among clients? If yes, what type? If no, do you feel that this it would be important to receive training to identify mental health problems?

NO. IM staff do not receive training in this area. Any training that would assist the staff in understanding the needs of customers seeking service would be beneficial.

Service staff (social workers) are exposed to some training/information on mental health problems thru college course work. However, Linn County DHS does not offer service staff formal training in identifying mental health problems.

III. School Interviews

Lovejoy Elementary School Des Moines Independent Community School District

1. How were homeless students identified (Did you refer to a school database/ Project Easier, consultation with school psychiatrists, school counselors, etc...)?

Homeless status is not asked at the time of enrollment. The Principal provides the definition of homelessness to staff. Usually, staff will find out that a family is homeless because of frequent absences and tardies or because of a transportation issue. If a family ends up being evicted and can't find housing, they may end up on the other side of town so they will contact the school to try to set up transportation. The school will try to keep the kids in the same school district.

Some parents or students will volunteer the information. Elementary students are more likely to volunteer the information than older students.

When teachers and staff find out that a student is homeless, the information is passed on to the Homeless Liaison in the building. The Building Homeless Liaison then enters that information into the district database and passes along the information to the District Homeless Liaison for entry into Project Easier.

2. What process was used to determine whether a student had a serious emotional disorder (Did you consult with the school psychologist, do you have first hand knowledge, did you refer to a school database for information)?

SUCCESS program case managers work with homeless students to identify service needs. These case managers were counseled to help answer questions about serious emotional disorders among homeless students. SUCCESS case managers do a lot of referrals for serious emotional disorder counseling to Child Guidance Orchard Place. School counselors were also consulted.

**Phillips Middle School
Fort Dodge Community School District**

1. How were homeless students identified (Did you refer to a school database/ Project Easier, consultation with school psychiatrists, school counselors, etc...)?

Two counselors, two principals and two secretaries worked together to identify homeless students because they are a large school with 650 students. It must be a team effort because no one person has all of the pieces of information.

Sometimes homeless students are identified during the registration process because you can glean information from their address. It is also picked up in counseling sessions. The counselors and secretaries keep track of homeless students in their own files and records as they learn of homelessness. Phillips Middle School has some students that live at the YWCA and other shelters. Also, they have migrant workers. According to federal law, they must offer transportation services to school for homeless students. This was a main reason they started keeping track of homeless students.

2. What process was used to determine whether a student had a serious emotional disorder (Did you consult with the school psychologist, do you have first hand knowledge, did you refer to a school database for information)?

The school counselors have master's degrees in counseling so they were fairly well prepared to identify learning disabilities and other problems. There is no school psychologist. Mental health information was also gleaned from records that indicate whether the student had been referred to mental health facilities, social service agencies, adolescent psychiatrists, outpatient/inpatient substance abuse treatment centers, and similar agencies. Students with mental health problems are often diagnosed during middle school.

**Central Middle School
Waterloo Community School District**

1. How were homeless students identified (Did you refer to a school database/ Project Easier, consultation with school psychiatrists, school counselors, etc...)?

The Guidance Secretary filled out the surveys. Parents have to volunteer the information. Most often the school finds out when parents call to set up bussing from homeless shelters. The school then enters this information into a database, which they use to complete Project Easier.

2. What process was used to determine whether a student had a serious emotional disorder (Did you consult with the school psychologist, do you have first hand knowledge, did you refer to a school database for information)?

If they had an individualized educational plan (IEP), which showed diagnostic testing outside of the school that confirmed a serious emotional disorder. Unless a diagnostic testing confirmed a problem, no problem was indicated on the survey.

**Winterset Senior High School
Winterset Community School District**

1. How were homeless students identified (Did you refer to a school database/ Project Easier, consultation with school psychiatrists, school counselors, etc...)?

The Juvenile Court Liaison and the Technical Coordinator for the district worked together to fill out these surveys. Generally, families have to volunteer the information in order for the school to identify a student as homeless. During the year, the Juvenile Court Liaison keeps her own running list of homeless students based on information she finds out through her own work. The Juvenile Court Liaison consulted with all building guidance counselors and at-risk coordinators. The Technical Coordinator helped identify possible homeless students by searching the list of students signed up for free lunch.

Sometimes, homeless students are also identified through school registration forms. For example, if it is revealed that a student is not living with his family, the school does an investigation.

2. What process was used to determine whether a student had a serious emotional disorder (Did you consult with the school psychologist, do you have first hand knowledge, did you refer to a school database for information)?

The Juvenile Court Liaison answered these questions in consultation with counselors and at-risk coordinators. The Juvenile Court Liaison also relied on her first hand knowledge from working with students during the school year through the juvenile court system and DHS. Yes was selected if she knew there had been a diagnosis and there was documentation to support it.

**Gilbert Elementary School
Gilbert Community School District**

1. How were homeless students identified (Did you refer to a school database/ Project Easier, consultation with school psychiatrists, school counselors, etc...)?

The School Secretary filled out the survey and checked for homeless students by looking at the school database to see if any students had been flagged as homeless. They track homeless students as part of their responsibilities for Project Easier. Usually, parents have to volunteer the information in order for the school to know that a student is homeless.

2. What process was used to determine whether a student had a serious emotional disorder (Did you consult with the school psychologist, do you have first hand knowledge, did you refer to a school database for information)?

They did not have any homeless students and so she did not have to answer the questions about serious emotional disorder. The Secretary is not trained on issues related to serious emotional disorder and would not be in a good position to answer those questions.

**North Scott Senior High School
North Scott Community School District**

1. How were homeless students identified (Did you refer to a school database/ Project Easier, consultation with school psychiatrists, school counselors, etc...)?

The School Counselor filled out the survey. Parents have to volunteer the information, which they often don't. So he has to read between the lines. They often find out because a student needs transportation. When the School Counselor received the survey, he talked to teachers, three other counselors, and administrators to find out which kids were homeless. They started tracking homelessness this year.

2. What process was used to determine whether a student had a serious emotional disorder (Did you consult with the school psychologist, do you have first hand knowledge, did you refer to a school database for information)?

Based on their own counseling background and their knowledge of the student's situation, the three counselors usually knew whether a student had a serious emotional disorder. The School Counselor also referred to the records of students who were receiving special education services.

**Northwest Junior High School
Iowa City Community School District**

1. How were homeless students identified (Did you refer to a school database/ Project Easier, consultation with school psychiatrists, school counselors, etc...)?

The School Secretary and the Principal filled out the survey. The School Secretary followed up with teachers who she had talked to earlier in the year about homelessness as part of her duties to track homelessness for Project Easier. She asked teachers and counselors if they had identified any homeless students. Usually, a parent has to volunteer the information in order to know that a student is homeless.

2. What process was used to determine whether a student had a serious emotional disorder (Did you consult with the school psychologist, do you have first hand knowledge, did you refer to a school database for information)?

The School Secretary relied on school counselors to identify whether particular students had a serious emotional disorder.

**Riverside Community High School
Riverside Community School District**

1. How were homeless students identified (Did you refer to a school database/ Project Easier, consultation with school psychiatrists, school counselors, etc...)?

The Superintendent worked with the building administrator at the High School to fill out the survey. All of their homeless students are foster children. They identify students who are foster children through the enrollment process. Plus, they are a small school so they are familiar with all the foster families and the students who are living with them.

2. What process was used to determine whether a student had a serious emotional disorder (Did you consult with the school psychologist, do you have first hand knowledge, did you refer to a school database for information)?

If a student is in a therapeutic program, inside or outside the district, to treat a behavior disorder, then they would answer yes, the student had a serious emotional disorder. Often, there are records of whether a student is attending such program as a result of a student being enrolled in special education classes and having an individualized education plan.