Evaluating the Client Base and Housing Outcomes of a Community Based Organization Serving Unhoused Adults

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EVALUATING THE CLIENT BASE AND HOUSING OUTCOMES OF A COMMUNITY BASED ORGANIZATION SERVING UNHOUSED ADULTS

A Clinical Dissertation Presented to
The University of San Francisco
School of Nursing and Health Professions
Department of Clinical Psychology
PsyD Program in Clinical Psychology

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Psychology

By
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San Francisco
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Abstract

There is a well-documented, bidirectional relationship between mental health and housing instability. When coupled with the complex historical, societal, and political factors contributing to houselessness, the result is a unique set of mental health needs within this community. Despite this, there is a low rate of mental health service utilization and a dearth of research on how to tailor services to meet the needs of unhoused individuals. Additionally, first-hand perspectives are often omitted, as this population is seen as “hard to reach”. The goal of this two-phase mixed-methods program evaluation was to better understand the demographic and mental health profiles of unhoused clients seeking mental health treatment through a community-based organization in the South Bay Area, to identify areas in which services could be adapted to meet the needs of the client base. Additionally, clients receiving mental health services were interviewed, to ensure recommendations provided were based in consumer experience. The first phase of the study was a secondary data analysis of electronic health record data that revealed that female identifying and those living with others endorsed significantly more adverse childhood experiences. The second phase included 6 semi-structured interviews analyzed through thematic analysis, from which 6 themes emerged: (1) “journey” to LifeMoves, (2) seamless connections, (3) importance of trust, (4) dynamic needs of the unhoused, (5) benefits of therapy at LifeMoves, and (6) areas of growth. These findings highlight the need for a reconceptualization of trauma and mental health symptoms within the unhoused community and the importance of including first-hand perspectives in research.
Dedication and Acknowledgements

This dissertation is dedicated to the LifeMoves clients who allowed me to bear witness to their stories, for this study and beyond. Your voices are worthy of being heard.

To my family and friends, who have celebrated every step of the way. When I would have rather put my head down and moved on to the next task, you were there to remind me of the enormity of what I’ve just done.

Chris, your unwavering support is the reason I am still standing. You deserve an honorary doctorate in supportive partnership.

To my cohort, for providing such needed companionship and community throughout this process. I am in awe of each one of you and am honored to have grown alongside you.

I send my deepest gratitude to my chair, committee members, and mentors. I am the clinician and researcher I am because of each of you, and I am eternally grateful for your time, expertise, and passion.

Lastly, to my mom. My biggest cheerleader, during her time on this earth and after. I will never stop working to make you proud.
Specific Aims

People who are unhoused are more likely to experience mental illness and/or substance use issues than those who are housed (Folsom et al., 2005). Psychiatric diagnoses have long been recognized as a risk factor for entering houselessness (Aubry et al., 2021). Additionally, mental health and substance use are associated with leaving temporary programs aimed at providing resources for unhoused individuals and returning to houselessness (Iaquinta, 2016; Pollio et al., 1997; Zlotnick et al., 1999). Conversely, the experience of living unhoused can exacerbate pre-existing mental health conditions or contribute to the development of new symptoms (Sullivan et al., 2000). This interaction between symptomology and environment presents a unique set of circumstances for unhoused individuals living with mental illness.

Despite the high rate of mental health disorders, there are low rates of mental health service utilization due to systemic and individual barriers (Strehlau et al., 2012). Research has identified negative prior experiences when seeking mental health care to be one of these barriers (O’Carroll & Wainwright, 2019). There has been little academic investigation geared towards understanding the unique mental health needs of those experiencing houselessness, resulting in significant obstacles for organizations providing mental health care to this population and attempting to fit treatment to the needs of their clients (Gordon et al., 2019). In turn, this lack of available research may contribute to the negative experiences within the mental health system cited by unhoused individuals as a barrier to accessing care.

This clinical dissertation was a mixed-methods program evaluation of a behavioral health program operating within a community-based organization serving unhoused individuals in the South Bay Area of Northern California. Through secondary data analysis and thematic analysis, four goals were addressed in this study: (1) describe the demographic characteristics of the client
base to detect a need for specialized treatment foci; (2) explore whether participation in mental health services is associated with housing trajectories; (3) investigate the use of selected mental health screeners within the unhoused population; and (4) highlight client perspectives on access to care to ensure that suggestions provided to the program are informed by direct client experience. This was accomplished through three primary avenues of analysis: (1) examining demographic information and symptom profiles as recorded by brief screeners; (2) comparing number of therapy sessions with exits to stable housing; and (3) conducting semi-structured interviews with clients to examine views on access to care.

**Research Questions**

**Quantitative Phase**

1) What are the demographic characteristics of the clients receiving mental health services through LifeMoves?

2) What is the reported prevalence of symptoms of depression, anxiety, and post-traumatic stress disorder among LifeMoves clients receiving mental health services?

3) What are the inter-item reliabilities of the Patient Health Questionnaire-9, Generalized Anxiety Disorder Scale-7, and the Adverse Childhood Experiences scale within a sample of unhoused adults?

4) Do total scores on the chosen screeners vary by gender identity, race/ethnicity, or household size?

5) Is there a relationship between the number of sessions a client attends and whether they exit to stable housing?

**Qualitative Phase**

6) What are the client experiences accessing mental health services through LifeMoves?
Identification of Problem

LifeMoves is a community-based, non-profit organization in the South Bay Area serving the unhoused community. Within LifeMoves, clients can receive voluntary mental health services through the Behavioral Health Program at no cost. This program at LifeMoves also serves as a training site for doctoral and masters-level mental health and psychology interns. At this time, there has been no formal examination of client demographic information, symptom profiles, or how currently utilized assessment measures function within the LifeMoves client base. With this information, the Behavioral Health Program can make informed decisions about how to structure clinical training to fit the specific needs and characteristics of their clients. Determining how brief screening measures operate within the population will indicate whether new assessment tools should be incorporated to adequately capture symptom severity. Additionally, it has not been determined whether there is a relationship between number of therapy sessions and the likelihood clients exit the LifeMoves program into stable housing. If this association were positive, service providers can direct efforts to improve client retention rates in therapy. Lastly, including client perspectives ensures recommendations made at the conclusion of the project are communicated in a way that takes into account the lived experience of the stakeholders. This is an effort to avoid enacting a top-down change process and instead move towards a model of collaboration and transformation grounded in client experience.

Alignment with Jesuit Mission of Social Justice

This clinical dissertation aligns with the Jesuit Mission of social justice by seeking to understand whether mental health treatment impacts unhoused adults’ ability to exit houselessness. Unhoused individuals are traditionally overlooked in the mental health field and community mental health organizations are typically under-resourced. This dissertation aims to
add to a field of research that is significantly under-represented and investigate best practices pertaining to a unique subset of the population. This project provides a platform for the realities of those living unhoused and receiving mental health treatment to be uplifted, through both quantitative data and communication of direct experience.
Critical Literature Review

Definition of “Homelessness”

The U.S. Department of Housing and Urban Development established four categories of “homelessness”, attempting to capture the range of experiences of individuals living unhoused\(^1\) (Moore & Reinauer, 2020). The first category is those who are “Literally Homeless”: living in a public or private location not meant for habitation (Legal Information Institute, n. d.). This also includes individuals currently residing in congregate shelters and transitional housing units (Moore & Reinauer, 2020). The second category is those who are at “Imminent Risk” of losing housing within the next 14 days, have not identified an alternative housing situation, and do not have the social or financial resources to obtain replacement housing (Legal Information Institute, n. d.). Category Three consists of individuals who have not had a lease within the past 60 days, experience persistent housing instability, and can expect to continue experiencing that instability due to their current life circumstances (Legal Information Institute, n. d.). The final category is reserved for those fleeing or attempting to flee domestic violence (Legal Information Institute, n. d.). In these cases, the definition of domestic violence is expanded to include instances of stalking, trafficking, trading sex for housing, and perceived threat of physical violence because of an individual’s sexual orientation (Moore & Reinauer, 2020).

These four categories are insufficient to capture the totality of houselessness as an experience resulting from a complex combination of factors (Frederick et al., 2014). For

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\(^1\) Throughout this dissertation, the terms “unhoused” and “houseless” will be used to describe individuals typically thought of as “homeless” except when referring to official reports that still use terms such as “homeless”. This is an effort to move away from the stigmatizing discourse associated with the term “homeless” and to acknowledge that in some cases, living without a house does not indicate a lack of community, belonging, or sense of home.
example, various health conditions have long been identified as precursors to the onset of houselessness (Committee on Health Care for Homeless People, 1988; Sullivan et al., 2000). While physical health issues can impact one’s ability to maintain stable housing, mental health conditions can complicate cases of houselessness as well (Committee on Health Care for Homeless People, 1988). The following literature review will examine the empirically noted connections between mental health and living unhoused. It assesses available mental health symptom measures for this population and conclude with a review of the correlates of stable housing and mental health.

**Houselessness in California**

In 2019, California had the highest number of individuals experiencing houselessness and 27 percent of the nation’s unhoused population resided within the state (California Legislative Analyst’s Office, 2021). Although it is notoriously difficult to estimate, the number of people living unhoused in 2019 was approximately 150,000, representing a 21% increase from 2018 (California Legislative Analyst’s Office, 2021). Explanations for the increase in houselessness include the prominent cultural beliefs that the unhoused are inherently different from the housed (Hamid et al., 1993). More specifically, the current narrative often attributes houselessness to poor individual choices or moral flaws, fueling stigma towards the unhoused population (Belcher & DeForge, 2012; Rayburn & Guittar, 2013). Most explanations fail to take into consideration the complex external factors contributing to the experience of living unhoused. However, policy makers in California cite the low availability of affordable housing coupled with increasing housing prices and static wages as the catalyst to the growing population of unhoused people within the state (California Legislative Analyst’s Office, 2021). As housing prices have risen, residents are forced to choose among a limited supply of affordable housing options. Eventually,
those who cannot afford to buy into the expensive housing market are pushed into unstable housing (Quigley et al., 2001). Job losses during the COVID-19 pandemic have increased the number of individuals and families facing housing instability, as 6 in 10 renter households pay more than half of their income to maintain housing (Davalos et al., 2021). Among those households, Black and Hispanic individuals were impacted more severely than their White counterparts (Enriquez & Goldstein, 2020).

**Houselessness in the Bay Area**

The Bay Area acts as a microcosm for California as a whole. Houselessness is a frequent topic of discussion within the area due to the high number of displaced individuals. Although the majority of the state’s unhoused are concentrated in Los Angeles, a San Francisco point in time count recorded over 8,000 people living on the street in 2019 (Housing Instability Research Department, 2019). Additionally, only 33% of the unhoused population living in the greater Bay Area is sheltered, meaning the issue is more visible in comparison to locations that have adequate shelter space (Bay Area Council Economic Institute, 2019). Within the population, 26% cite alcohol/drug abuse or mental health issues as a primary cause of houselessness (Housing Instability Research Department, 2019). African Americans are significantly overrepresented. For example, African Americans constitute 37% of those who are unhoused and only 6% of the population in the Bay Area as a whole (Housing Instability Research Department, 2019).

As the Bay Area has evolved into a hub for large tech companies due to the proximity to Silicon Valley, economic dislocation has driven 34% of cases of houselessness (Jackson & Winegarden, 2019). Specifically, between 22% and 26% of cases of houselessness are the result of job loss (Housing Instability Research Department; 2019; Jackson & Winegarden, 2019). Job
loss within the bay area has only been exacerbated by the COVID-19 pandemic, as unemployment rose from 3.6% to 13.1% between March and April of 2020 (Bay Area Council Economic Institute, 2020). While the influx of tech in the area is not the sole contributor to the high number of displaced individuals, housing prices and the cost of living have risen as a result (Housing Instability Research Department, 2019). For a family of 4 in the United States, a yearly income of $26,500 marks the poverty line (U.S. Department of Health and Human Services, 2021). For San Francisco in 2023, however, a family of 4 with an annual income of $148,650 was considered “low-income” (City and County of San Francisco, 2023). The residents who are unable to match the average individual tech employee salary of $155,000 per year are at higher risk for entering into unstable living conditions (McCarthy, 2020).

Where there is a high population of unhoused individuals, organizations providing resources will inevitably follow. Many of these organizations have a mental health focus, as a high percentage of those experiencing houselessness struggle with psychiatric conditions. In the counties that make up the Bay Area it is estimated that between 50 and 66% of unhoused individuals experience a mental illness (Bay Area Council Economic Institute, 2019). Although community health resources are often underfunded, they are tasked with providing services to a population with unique and diverse needs.

**Houselessness and Mental Health Sequela**

The histories of houselessness and mental health are intricately connected via the process of deinstitutionalization. The Kennedy administration passed the Community Mental Health Act of 1963 in an attempt to overhaul the notoriously inhumane psychiatric hospitals operating in the asylum era of the 1940s and 50s (Kupers, 2018). The Community Mental Health Act also promised to fund community mental health centers to support those recently discharged (Kupers,
As institutions were systematically shut down after criticism over inhuman treatment and poor living conditions, individuals with serious mental illness were released into the community (Kupers, 2018). Around the same time, the first antipsychotics were introduced, instilling hope that previously debilitating symptoms of mental illness could be managed outside of an institutional setting (Pow et al., 2015). President Kennedy’s stated goal was to decrease the number of people living within psychiatric hospitals by half within the next decade and transition care to community-based clinics (Erickson, 2021). The intention of the Community Mental Health Act was to dismantle institutional psychiatric care by providing higher quality mental health services in an outpatient setting while employing community resources to structure rehabilitation (Sullivan & Starnino, 2018).

However, in many places across the country, including California, the promised funding never came to complete fruition (Kupers, 2018). As individuals were released into the community, there was little infrastructure in place to provide adequate care. Even today, many people living with mental illness are deemed unemployable or are restricted in employment opportunities due to untreated symptoms (Brouwers, 2020). This left many of those who were released unable to support themselves financially. Additionally, no structured living environments or community housing was established in tandem with deinstitutionalization leaving many without a stable living environment to return to (Kupers, 2018). This lack of housing coupled with underfunded care organizations resulted in individuals with mental illness on the street or the criminal justice system (Lamb, 1984). In the years after deinstitutionalization, it was estimated that 1/3rd to 1⁄2 of unhoused adults in the United States had a major mental illness (Lamb & Bachrach, 2001). The lack of infrastructure and resources limited access to
treatment meaning that many cases of mental illness on the street went untreated. Thus, the association of houselessness and mental illness was reinforced.

**Bidirectional Relationship Between Homelessness and Mental Health**

The complex relationship between mental illness and houselessness follows many potential trajectories (Folsom et al., 2005). Symptoms of psychiatric illnesses can significantly impact one’s ability to maintain employment or housing (Sullivan et al., 2000). Conversely, the experience of being unhoused can exacerbate symptoms of mental illness, creating a cycle of aggravation for individuals involved. As a result, those with a psychiatric illness tend to remain unhoused for longer periods of time (Novasky & Rosales, 2020). This bidirectional influence highlights the importance of mental health care in the population to disrupt the cyclical interaction (Padgett, 2020).

Psychiatric diagnoses have long been recognized as a risk factor for houselessness (Aubry et al., 2021). The onset of mental illness precedes houselessness in two-thirds of cases (Balasuriya et al., 2020; Sullivan et al., 2000). Sullivan and colleagues (2000) compared the residential trajectories of groups of unhoused individuals with and without psychiatric diagnoses. Participants who entered into houselessness after the onset of their mental illness were more likely to report symptoms of psychotic disorders, bipolar disorders, or substance use problems (Sullivan et al., 2000). These diagnoses produce symptomology with the potential to significantly interfere with activities of daily living, making it difficult to maintain employment if left untreated. In contrast, those whose illness manifested after their transition to living unhoused reported higher levels of depression, potentially as a result of disadvantageous changes in life circumstances (Sullivan et al., 2000). By identifying and understanding the relationships between diagnoses and the trajectories of houselessness, mental health professionals and
organizations can interrupt this cycle. To do so, areas of improvement for mental health care in this population must be identified and addressed.

**Mental Health Profile of Houseless Individuals**

Research suggests that between 63 and 76.5 percent of unhoused individuals report a mental illness (Stergiopoulous et al., 2008; Strehlau et al., 2012). However, determining the prevalence rates of psychiatric illnesses within the unhoused population is difficult for various reasons. To begin, due to the variation in the experience of being unhoused, participants in studies are often pulled from different places along the continuum of houselessness (Strehlau et al., 2012). Participants characterized as unhoused may vary based on length of time spent unhoused, degree of literal houselessness, and access to resources such as temporary shelter, vehicles, and public facilities. Discrepancies in the experiences of homelessness have different outcomes on physical and mental health (Murphy & Tobin, 2011). Additionally, many researchers only look for the presence of a single, diagnosable mental illness, rather than comorbidities or behaviors that span diagnoses and can be detrimental to functioning (Strehlau et al., 2012). Despite these challenges, the high rates of mental illness within the unhoused population are well-documented (Fazel et al., 2008; Folsom et al., 2005; Stergiopoulous et al., 2008; Sullivan et al., 2000).

Unhoused individuals endorse alcohol dependence at twice the rate of those who are housed, and problematic drug use at six times the rate of their domiciled counterparts (Folsom et al., 2005). Between 48 and 58% endorse comorbid mental health and substance related problems (Stergiopoulous et al., 2008; Strehlau et al., 2012). Unhoused individuals also have a much higher prevalence of psychotic disorders, ranging from 7 to 21% (Ayano et al., 2019; Fazel et al., 2008; Strehlau et al., 2012). Major Depressive Disorder (MDD), Generalized Anxiety Disorder
(GAD), and Post-Traumatic Stress Disorder (PTSD) are of particular interest for this study. A 2021 review found that 1 in 8 unhoused individuals experience MDD, which can impact negative outcomes for this population (Gutwinski et al., 2021). In a study of unhoused veterans in the U.S., nearly 27% endorsed a diagnosis of an anxiety disorder (Norbeck et al., 2020). Lastly, researchers reported PTSD prevalence rates of 27% among unhoused individuals, a rate significantly higher than that of the housed (Ayano et al., 2020). For organizations providing mental health services to this population, proper identification of diagnoses through assessment or screening tools is an important part of ensuring adequate care is received.

**Subgroup Differences in Mental Health Needs.** Given the complex interactions between the individual and social factors contributing to houselessness, there is an immense amount of heterogeneity among the experiences of being unhoused. Within the population of unhoused persons, mental illness and the associated needs manifest differently between subgroups.

**Gender.** Research indicates that the mental health needs of unhoused individuals can vary based on gender (Milaney et al., 2020). In general, women endorse psychopathology more frequently than their male counterparts (North & Smith, 1994; Winetrobe et al., 2017). One potential contributing factor to this difference within the unhoused population is that women report more abuse and trauma than their male counterparts (Phipps et al., 2019; Schmidt et al., 2015). Additionally, the relationship between trauma and the development of psychiatric conditions is stronger for women than for men (Phipps et al., 2019; Schmidt et al., 2015). While living unhoused is associated with more experienced violence for individuals of all gender identities, women are particularly vulnerable (Murray, 2011). Oftentimes, female trajectories into houselessness include cycles of leaving and returning to abusive relationships due to a lack of
resources or a need for housing (Phipps et al., 2019). Increased violence and victimization are possible contributors to the higher likelihood of women to report PTSD and depressive symptoms than males (de Vet et al., 2019). This is often associated with higher rates of depression, suicidality, and diagnoses of PTSD in unhoused women (Phipps et al., 2019; Tinland et al., 2018). The high levels of trauma associated with women’s experiences of being unhoused suggest a need for gender specific and trauma informed services (Duke & Searby, 2019; de Vet et al., 2019; Milaney et al., 2020).

**Household Size.** In addition to increased exposure to violence, many women find themselves caring for young children or other relatives while experiencing houselessness (Phipps et al., 2019). Caregiving duties may impact their ability to connect with crucial resources needed to achieve housing and economic stability (Phipps et al., 2019). Research has been inconsistent in the comparison of mental health outcomes of women both with and without children. While some studies suggest that those without children endorse higher levels of mental health conditions and substance use, others indicate that those with children experience more mental health conditions, substance use problems, and overall stress (Austin et al., 2008; Chambers et al., 2014; Duke & Searby, 2019; Zabkiewicz et al., 2014). Regardless of the conclusions of the literature, it is important to take into account social factors when treating unhoused women and their families.

**Race and Ethnicity.** The overrepresentation of individuals of color within the unhoused population is well documented (Fusaro et al., 2018; Jones, 2016; Olivet et al., 2021). In a nationally representative survey of adults in the Baby Boom cohort, Fusaro and colleagues (2018) found significant differences between non-Hispanic whites and both non-Hispanic black and Hispanic individuals of any race. Rates of houselessness for white identifying individuals
were 4.8%, while rates for black individuals were 16.8% and 8.1% for the Hispanic population (Fusaro et al., 2018). The overrepresentation is particularly salient in African American and Native American communities. One study found that the number of African American individuals in the unhoused population is 1.7 to 7 times greater than in the general population and 2 to 17 times greater for the American Indian or Alaska Native population (Olivet et al., 2021). This disproportionality for African Americans is mirrored in the unhoused population in the San Francisco Bay Area in that they constitute 37% of those who are unhoused and only 6% of the general population (Coalition on Homelessness, 2019).

Research examining the relationship of houselessness, race, and mental health is imperfect, as many of the studies compare single ethnic groups with cohorts of white participants. Not only does this design disproportionately center the white experience, but it also disregards the realities of many other racial and ethnic groups that comprise a growing proportion of the unhoused population (Austin et al., 2008). While the U.S. Surgeon General reported that rates of mental health disorders are comparable across racial and ethnic groups, research suggests that mental health conditions manifest differently within the unhoused population (U.S Department of Health and Human Services, 2001). Studies comparing white identifying individuals with people of color have found that white populations endorse higher levels of mental illness (Austin et al., 2008; North & Smith, 1994). For individuals of color, cases of homelessness are more often associated with external factors such as inequitable access to societal resources or socioeconomic stress (Carter, 2011; North & Smith, 1994). Both white men and women are more likely to meet criteria for a psychiatric or substance use disorder than people of color (Austin et al., 2008; North & Smith, 1994). This pattern suggests that
impairments in functioning due to symptomology contribute to homelessness for white identifying individuals at a higher rate.

**Stable Housing and Mental Health**

Residing in stable housing has been empirically associated with improvements in many areas of overall well-being, including mental health (Iaquinta, 2016). Access to housing can serve as a way to provide structure in the life of a previously unhoused individual. In turn, this can counter some of the external stressors that accompany living unhoused (Harris et al., 2009). Individuals report that obtaining stable housing fosters a sense of pride, security, and self-esteem (Iaquinta, 2016; Patterson et al., 2015). Stable housing promotes an environment generally more conducive to focusing on health-related issues (Kaltsidis et al., 2020). Those who are housed are more likely to access services for presenting problems to manage both mental and physical illness, resulting in a higher quality of life (Gordon et al., 2019; Pollio et al., 1997).

Some research suggests that mental health symptoms can impede one’s ability to be placed in stable housing (Bowen et al., 2015; Gabriellan et al., 2020; Iaquinta, 2016; Orwin et al. 2005; Pollio et al., 1997; Zlotnick et al., 1999). In a study of unhoused women discharging from a residential, sex-work exiting program, those who reported higher levels of mental health issues and problematic substance use were less likely to obtain stable housing upon their exit via any housing program (Bowen et al., 2015). Additionally, a 2020 study found that unhoused individuals who had seen a psychologist within the last 12 months were more likely to achieve better housing outcomes than those who did not, suggesting that mental health treatment strengthens the positive effects of improvement in housing status (Kaltsidis et al., 2020). Not only does this emphasize the connection between service utilization and housing stability, but also the importance of symptom management in improving outcomes.
The influence of stable housing on mental health is demonstrated in the success of Housing First Programs. The Housing First initiative was adopted nationally under President George W. Bush in 2004 with the goal of ending chronic homelessness (U.S. Department of Housing & Urban Development, 2007). Programs structured on the Housing First model operate under the assumption that once an individual can meet their basic needs for survival, which includes stable housing, they are better able to focus their attention on achieving other goals, such as tending to mental health symptoms (Patterson et al., 2015). People are considered to be inherently “housing ready” and are provided housing regardless of their mental health or substance use status (Tsai & Rosenheck, 2012). Programs modeled after Housing First tend to produce a high level of consumer satisfaction while decreasing the number of days spent homeless by 36% and decreasing the number of days spent hospitalized for physical and mental illness by nearly 80% (Culhane et al., 2002; Rog et al., 2014; Rosenheck et al., 2003; Stanhope & Dunn, 2011). Since adopted by the government, Housing First has been considered to be the gold standard approach for solving chronic homelessness (Tsai & Rosenheck, 2012).

Mental Health as a Barrier to Stable Housing. Once stable housing has been obtained, untreated mental health symptoms can negatively impact housing tenure. The typical trajectory for people with high levels of symptom severity is to gain housing rather quickly but soon experience a sharp decline in housing stability (Adair et al., 2017). People may find themselves alone for the first time or with more free time than while living unhoused. For individuals with mental illness, this can bring up underlying psychological distress previously suppressed by the chaos of living on the streets (Patternson et al., 2015). Additionally, when an individual exits a program into homelessness or loses stable housing, their ability to access vital resources can be cut off. Becoming unhoused after residing in a housing program means that clients can no longer
utilize case management or mental health services (Balasuriya et al., 2020; Gordon et al., 2019). In turn, this can lead to an exacerbation of mental health symptoms. By identifying mental health related characteristics that are connected with returns to unstable housing, mental health professionals can intervene in an attempt to prevent a return to houselessness.

**Stable Housing and COVID-19: Project Roomkey**

The data used for this project was collected during the COVID-19 pandemic, necessitating an examination of how access to stable housing was impacted by social and political efforts put forth during that time. When shelter in place was established in March of 2020, individuals who were living on the street or in a congregate shelter could not physically maintain the recommended 6 feet of distance due to their living conditions. In response to this issue, the California government established Project Roomkey in order to “provide non-congregate shelter options for people experiencing homelessness” (California Department of Social Services, 2021). The California government dedicated $100 million to go directly to local governments to establish emergency housing options, which typically took the form of rooms in a hotel or motel (California Department of Social Services, 2021). Individuals considered high-risk due to health conditions or those who had been exposed to COVID-19 and needed to quarantine were prioritized for placement into rooms.

As of November of 2020, 23,000 people had been successfully housed through Project Roomkey (State of California, 2020). Soon after, $62 million was set aside to continue the initiative and help consumers transition to stable housing after their stay (State of California, 2020). However, preliminary data indicates that only 20% of individuals who have exited from emergency shelters have been placed in stable housing while the rest have returned to various locations along the spectrum of homelessness (State of California, 2021).
Barriers to Mental Health Treatment

Unhoused individuals face significant barriers in accessing quality mental health care. While limited access is not unique to the population, mental health symptoms such as active substance use, psychosis, trauma from systemic racism, and anhedonia can interfere with one’s ability to access mental health services (Balasuriya et al., 2020; O’Carroll & Wainwright, 2019). Additionally, many barriers to access are directly related to the experience of being unhoused. For example, in places like the United States where insurance is deeply involved in the process of receiving health care of all kinds, lack of insurance, the infrequent coverage for behavioral health, and high cost of care even with insurance, obstructs low-income individuals from accessing services (Sauer-Zavala et al., 2019). However, in a study conducted in Canada where the population has access to provincially funded health insurance, significant practical barriers were still identified (Bonin et al., 2007). Obstacles such as transportation access, smaller support networks, and lack of a fixed address are all associated with lower levels of service utilization (Bonin et al., 2007). Additionally, for individuals who are unhoused, ensuring basic needs are met such as food, shelter and income often take priority over mental health care (Balasuriya et al., 2020; O’Carroll & Wainwright, 2019; Schmidt et al., 2015).

Similar to those in the general population, cultural stigma surrounding psychiatric services can stand in the way of an unhoused person’s willingness to seek mental health care (Sauer-Zavala et al., 2019). Research indicates that racial and ethnic groups utilize services at different rates (Horvitz-Lennon et al., 2009). Additionally, there is a documented gap between the attitudes of mental health providers and unhoused clients (O’Carroll & Wainwright, 2019; Stahler et al., 1993). Internalized stigma regarding an unhoused person’s circumstances can result in an urge to conceal their background in order to avoid discrimination and contribute to a
general lack of confidence in the mental health system (O’Carroll & Wainwright, 2019).
Conversely, health care providers tend to blame unhoused clients for their lifestyle and
subsequent health issues and report feelings of frustration with patterns of service use among
unhoused clients (O’Carroll & Wainwright, 2019). Unfortunately, these attitudes may preclude
care providers from better understanding the unique motivations and needs of this population.

Most importantly for this study, unhoused individuals are rarely consulted when
structuring mental health treatment (Kiser & Hulton, 2018). Many interventions or assessments
utilized with this population are normed or validated for use with individuals with higher levels
of functioning and resources (Bates & Toro, 1999; Keogh et al., 2015; Mastropieri et al., 2015;
Mazur, 2018; Richards et al., 2015; Zanis et al., 1994). Unvalidated measures may include
language or constructs that are irrelevant to the population (Gordon et al., 2019). It is possible
that by using assessment measures not tailored or normed to the population, organizations are
misusing resources or inadequately screening for psychiatric diagnoses.

**Patterns of Service Use**

Due to the barriers previously outlined, this population has unique patterns of service use.
Despite the high rates of psychiatric diagnoses, there are relatively low rates of mental health
service utilization within the unhoused population (Horvitz-Lennon et al., 2009; Strehlau et al.,
2012). However, a 2020 study found that unhoused individuals who had seen a psychologist
within the last 12 months were more likely to achieve better housing outcomes than those who
did not, suggesting that mental health treatment strengthens the positive effects of improvement
in housing status (Kalsidis et al., 2020). Not only does this emphasize the connection between
service utilization and housing stability, but also the importance of symptom management in
improving outcomes. Nevertheless, unhoused individuals tend to postpone treatment for both
physical and mental health conditions (O’Carroll & Wainwright, 2019). When coupled with poor medication compliance and low treatment completion rates, the delay results in a higher level of severity when they eventually present to treatment and a higher need for emergency services (Folsom et al., 2005). Unhoused individuals are 10 times more likely to use crisis residential services and 4 times more likely to use inpatient psychiatric services than their housed counterparts (Folsom et al., 2005). Not only do emergency services match the acute needs of the population, but they also provide temporary shelter (O’Carroll & Wainwright, 2019). Once released from emergency treatment facilities, clients are less likely to be connected with resources offering continued care, resulting in an eventual return to crisis services (Sadowski et al., 2009). The repeated use of emergency services indicates a “cycling through the system” pattern of service use in which individuals frequently jump between providers. This sequence of usage provides ample opportunity for clients to become disconnected with resources, only to enter the cycle again.

**Unique Needs of the Population**

The barriers to accessing mental health services and patterns of service utilization combine to create a set of unique needs. Treatment retention is a significant issue for the unhoused population in mental health care (Center for Substance Abuse Treatment, 2013). One of the reasons for early termination of treatment is lack of fit or accessibility for the population (Orwin et al., 1999). Early termination can be indicative of a failure of the clinician or the service provider to adapt treatment to the needs of the population (Kirmayer, 2001; Orwin et al., 1999). Many clients struggle to see the value in interventions and processes not directly related to obtaining housing (Orwin et al., 1999). Research has indicated that brief and pointed interventions or assessments are needed so that the majority of treatment can shift to topics that
the client deems relevant (Winiarski et al., 2020). Additionally, traditional clinic based mental
health care can be difficult to access without reliable transportation, requiring innovative ways to
provide care and reach the unhoused population. Alternative modalities of providing care such as
mobile clinics, technology-based services, and embedding mental health treatment within shelter
networks can serve as ways to bring behavioral health care directly to clients (Koh, 2020;
Zlotnick et al., 2013).

**Importance of Brief Screening Tools**

For community mental health organizations lacking the resources and time to conduct full
length diagnostic interviews, screening tools can serve as a viable alternative (Ali et al., 2016).
Brief screeners can aid in accurate identification of psychiatric disorders and subsequently
inform treatment decisions (Mughal et al., 2020). Since many screening tools were developed for
use in primary care settings, they can also be used to train professionals who are unfamiliar with
diagnostic criteria to identify symptoms (Ali et al., 2016).

It is important to note that screeners developed for use in one population may overlook
the presentation of disorders in another because of differing cultural contexts (Mughal et al.,
2020). The manifestation of psychiatric diagnoses can vary based on cultural norms of emotional
expression, sources of distress, and interpretation of symptoms (Kirmayer, 2001). A review of
screeners found that the tools performed best when utilized in the originally normed population
(Ali et al., 2016). Despite the frameworks available to guide adaptation of mental health
screeners, most assessments are validated on high functioning and high resourced populations
(Bates & Toro, 1999; van Ommeren, 1999). Clinicians utilizing screening tools ill-fit for their
client population may be misusing resources or failing to provide accurate diagnoses.
Available Assessment and Treatment Options for Adults Experiencing Houselessness

There is an established lack of research on mental health interventions for the unhoused population (Bates & Toro, 1999; Hyun et al., 2020). Historically, these individuals have been viewed as undeserving of specialized treatment due to the public opinion that their suffering is the result of personal choices (Hamid et al., 1993). Most assessment tools used have been validated on resource rich populations exhibiting higher levels of functioning (Bates & Toro, 1999). It is especially important to investigate constructs relevant to individuals experiencing homelessness due to their complex set of needs.

In a systematic review of psychosocial interventions for use with unhoused adults, only 11 randomized controlled trials were identified (Hyun et al., 2020). Many of them are specifically for anxiety and fail to take into account the wide range of mental health conditions this population experiences. In a review of 24 screening tools for substance use, psychiatric diagnoses, and cognitive functioning that are potentially relevant to unhoused individuals, only two had been validated on a population of people experiencing houselessness (Gordon et al., 2019). The identified screeners were the Beck Depression Inventory (Beck et al., 1961) and the Addiction Severity Index (McLellan et al., 1992), which are both widely used but do not capture the full scope of problems present within the population such as psychosis, PTSD, and anxiety (Gordon et al., 2019; Zanis et al., 1994).

LifeMoves

LifeMoves is a 501(c)(3) non-profit organization headquartered in Menlo Park, California aimed at providing services to the unhoused population of the South Bay Area. They operate 26 shelter sites from Daly City to San Jose. The LifeMoves client base includes both entire households and single adults with a special focus on unhoused Veterans, LGBTQ+
individuals, and families. LifeMoves operates via three main programs all with the goal of helping clients return to stable housing: residential services, supportive services, and community outreach. The community outreach department focuses on providing services such as healthcare, drop-in centers, and secure parking sites to individuals who are not residents in one of the 26 shelter sites. In the residential services department, LifeMoves offers a variety of temporary housing options ranging from emergency shelters to permanent supportive housing units along with on-site holistic case management services. Through case management, clients can access additional support such as free mental health services, education, and housing and employment assistance within the supportive services department. The Behavioral Health Program at LifeMoves will be the focus of this program evaluation.

**LifeMoves Behavioral Health Program**

The LifeMoves Behavioral Health Program is a supportive service offered to clients at no cost. It doubles as a training program for doctoral-level graduate students in Clinical Psychology as well as master-level graduate students in Social Work. The training takes on a trauma-focused, culturally sensitive, evidence- and strengths-based approach in order to meet the diverse needs of the client base. Students have the opportunity to train in neuropsychological assessment, group, family, couples, and individual therapy while supervised by licensed psychologists. Clients are referred to the behavioral health program via their case manager if they express an interest in or need for mental health services.
Method

This was a two-phase mixed-methods program evaluation combining a quantitative secondary data analysis component and a qualitative component employing individual interviews. The goal of this program evaluation was to increase understanding of the client base as well as the client experience of accessing mental health services at the community organization LifeMoves, with the goal of evaluating the fit of program procedures and informing training decisions. A memorandum of understanding (MOU) between LifeMoves and the researcher was established to specify roles and responsibilities of each of the involved parties (Appendix A).

Phase 1: Quantitative Phase

Participants

Data was collected for 440 clients accessing individual or family therapy through LifeMoves. The only inclusion criteria for the quantitative phase of the study was that participants must be 18 or older.

Quantitative Data Collection

Data collection was conducted using retrospective chart review of the LifeMoves electronic health records database, Voyager by Salesforce®. The data collected included information from the initial intake assessment completed by student clinicians as well as non-identifying, demographic and case information inputted by case managers.

Measures

Demographic Characteristics. Demographic information was assessed using the following variables extracted from the chart review.
**Age.** Age was recorded as a continuous variable and represents the age of the client at the time the data was extracted.

**Gender Identity.** Gender identity was recorded as a categorical variable upon the client’s intake to their shelter site. Clients are identified as either male, female, or gender non-conforming.

**Race and Ethnicity.** Race was collected as a categorical variable. Clients are identified as Black/African American/African, Asian/Asian American, White, American Indian/Native/Indigenous, Native Hawaiian/Pacific Islander.

Ethnicity was recorded as a dichotomous variable, either Hispanic/Latin(o)(a)(x) or Non-Hispanic/Non-Latin(o)(a)(x).

**Relationship to Head of Household.** Relationship to head of household was recorded as a categorical variable. Clients are categorized as self, spouse/partner, or child.

**Household Size.** The number of people residing in the household with the client receiving mental health services was recorded as a continuous variable.

**Case Information.** Information about the specific services each client has accessed was assessed using the following variables extracted from the chart review.

**Case Status.** Case status was measured as a dichotomous variable, “open” or “closed”. Open cases indicate that the client is still receiving mental health services from LifeMoves. Closed cases are those that have terminated care.

**County.** LifeMoves provides services across two counties in the Bay Area: San Mateo County and Santa Clara County. The county indicates the location the client received services from.
**Length of Stay.** Length of stay was recorded as a continuous variable and represents the days since the client entered the shelter.

**Number of Provided Services.** Provided services was recorded as a continuous variable and refers to the number of individual or family therapy sessions the client has received.

**Number of Provided Service Hours.** Provided service hours was recorded as a continuous variable and represents the number of hours the client has spent in individual or family therapy.

**Exit to Stable Housing.** This program evaluation also investigated whether there was an association between the number of therapy sessions and the likelihood of exiting the LifeMoves program into stable housing. Because placing clients into stable living situations is a primary goal of the organization, this data could provide insights as to factors contributing to successful exits from the program.

Within research, there is little agreement upon what constitutes an official end to houselessness. There is no clear definition on what represents stable housing (van Straaten et al., 2017). Definitions of stable housing vary within research studies and organizations as to the type of shelters considered to be stable as well as time an individual needs to live there for the placement to be deemed stable. Because houselessness is conceptualized as rapidly changing and occurring along a continuum, it is difficult to determine when an individual enters a stable housing situation that can be maintained (Zlotnick et al., 1999). It is important to note that successfully exiting houselessness into stable housing is conceptually different than maintaining stable housing (Zlotnick et al., 1999). Once stable housing has been obtained, the housing tenure can follow different trajectories resulting in varied outcomes (Adair et al., 2017). Due to the
limitations of the data set, this project could measure housing tenure from individuals who have exited the LifeMoves program into stable housing.

Whether a client exits the LifeMoves program into a stable housing situation was measured as a dichotomous variable. For this study, an exit to stable housing was identified by the definition used by LifeMoves (Table 1).

Mental Health Screening Tools. This program evaluation examined the use of the Patient Health Questionnaire-9 (PHQ-9; (Kroenke et al., 2001), the Generalized Anxiety Disorder Scale-7 (GAD-7; Spitzer et al., 2006), the Primary Care-PTSD Screen for the DSM-5 (PC-PTSD-5; Prins et al., 2016), and the Adverse Childhood Experiences Scale (ACEs; Felitti et al., 1998) within a population of unhoused adults seeking mental health treatment. Therapists administer these measures at the outset of treatment, then use results from the screener to inform diagnosis or identify symptoms for intervention. Total scores on some of the brief assessments were used as outcome variables of symptom severity. Item level data was used to assess inter-item reliability of the measures within this population.

Patient Health Questionnaire (PHQ-9). The Patient Health Questionnaire-9 (PHQ 9) is a 9-item self-report questionnaire extracted from the depression subscale of the larger Patient Health Questionnaire (Kroenke et al., 2001). It was initially developed in a primary care sample of 3000 predominantly Caucasian (79%) patients to detect symptoms of depression and determine level of severity (Kroenke et al., 2001). The PHQ-9 demonstrated excellent internal consistency within the primary care, normed population with a Cronbach’s alpha = .89. Each of the items on the questionnaire corresponds with the DSM-IV criteria for Major Depressive Disorder (MDD). Using a 4-point Likert scale ranging from 0 or “not at all” to 3 or “nearly every day” participants rate the frequency with which they are impacted by each of the symptoms. At
the end of the scale, participants are asked to report how difficult these symptoms have made it for them to complete their day-to-day tasks using a similar scale with altered wording. The final question is not included in the total score. The number associated with a participant’s answers are summed to receive a total score of depressive symptom severity which can be rated as minimal (0-4), mild (5-9), moderate (10-14), moderately severe (15-19), or severe (20-27) (Kroenke et al., 2001). Eighty-eight percent of participants who scored ≥ 10 also received a diagnosis of MDD, indicating this to be an acceptable cutoff score. See Appendix B for this measure (Kroenke et al., 2001).

**Generalized Anxiety Disorder Scale (GAD-7).** The Generalized Anxiety Disorder Scale-7 (GAD-7) was developed to identify cases of Generalized Anxiety Disorder and determine the severity of symptoms (Spitzer et al., 2006). It is a 7-item self-report measure, created using a sample of 2740 predominantly Caucasian primary care patients across the U.S. (Spitzer et al., 2006). Within this sample, the GAD-7 demonstrated excellent internal consistency with Cronbach's alpha = .92 (Spitzer et al., 2006). Participants are asked to rate how often they have experienced the listed symptoms over the past two weeks on a 4-point Likert scale. Similar to the PHQ-9, the GAD-7 presents participants with options ranging from 0 “not at all” to 3 “nearly every day.” Participants are also asked to report the level of difficulty these symptoms pose to their daily lives. Once the total score has been calculated, participants fall into categories similar to those outlined for the PHQ-9; minimal (0-4), mild (5-9), moderate (10-14), or severe (15-21) (Spitzer et al., 2006). Eighty-nine percent of participants who scored ≥ 10 met criteria for Generalized Anxiety Disorder, representing an adequate cutoff score for the screener. See Appendix C for this measure.

**Primary Care Post-Traumatic Stress Disorder Screen for the DSM-5 (PC-PTSD-5).
The Primary Care PTSD Screen for the DSM-5 was adapted from the DSM-IV version of the screener to fit the DSM-5 diagnostic criteria for Post-Traumatic Stress Disorder (Prins et al., 2016). It was developed on a sample of 398 Veterans who were primarily male, white, and over the age of 60 (Prins et al., 2016). The PC-PTSD-5 begins with a statement asking participants whether they have experienced an event that is “unusually frightening, horrible, or traumatic” (Prins et al., 2016). If participants answer “yes”, they proceed on to five, dichotomously formatted questions about hallmark PTSD symptoms. The total number of questions the respondent marks “Yes” comprises the total score, ranging from 0 to 5. Using a cutoff score of 3, the authors of the measure were able to identify 94.8% of cases of PTSD (Prins et al., 2016). See Appendix D for this measure.

**Adverse Childhood Experiences Survey (ACEs).** Although the Adverse Childhood Experiences survey (ACEs) is not used for diagnostic purposes, all clients at LifeMoves are administered this screener at intake, regardless of symptom presentation. Additionally, the ACEs survey has demonstrated predictive validity of houselessness and housing status within samples of unhoused adults (Barnes et al., 2021; Roos et al., 2013). It was originally developed by researchers at Kaiser to explore the connection between childhood trauma and risk factors for physical disease in adulthood, using a sample of 9,508 predominantly White patients (Felitti et al., 1998). The ACEs survey is a self-report questionnaire consisting of 10 “yes” or “no” questions regarding a participant’s experience before the age of 18. The assessment covers seven areas of potential childhood trauma: psychological, sexual, physical, violence against mother, exposure to substance use, mental illness or suicidality, and imprisonment of a household member (Felitti et al., 1998). The number of questions answered “yes” are added to calculate an
individual’s ACEs Score, which ranges from 0-10. Higher scores indicate a client has experienced a wider range of types of adverse experiences. See Appendix E for this measure.

Quantitative Data Analysis Plan

The data collected from the electronic health records database was organized in an Excel spreadsheet. The data was then inputted into Jamovi (Version 2.2.5) for analysis. Missing data was addressed using pairwise deletion to increase the data available for each analysis. As a result, each analysis had a different sample size.

Research Question 1. What are the demographic characteristics of the clients receiving mental health services through LifeMoves? Demographic and case information for the entire sample of 398 was analyzed using descriptive statistics. Categorical variables (case status, county, placement in stable housing, gender identity, relationship to head of household, and race/ethnicity) were presented as frequencies. Continuous variables (length of stay, age, household size, number of provided services, and number of provided service hours) were presented using means and standard deviations.

Research Question 2. What is the reported prevalence of symptoms of depression, anxiety, and post-traumatic stress disorder among LifeMoves clients receiving mental health services? Using the total scores on the PHQ-9, GAD-7, and the Primary Care-PTSD-5 Screen, frequency distributions were created in order to determine the severity of depression, anxiety, or PTSD symptoms endorsed by clients.

Research Question 3. Do total scores on the chosen screeners vary by gender identity, race/ethnicity, or relationship to head of household? A series of multiple regression analyses was used to understand subgroup differences in symptom severity. Separate analyses were conducted to distinguish participants based on gender identity and whether or not they are a single adult or
have others in their household. Race and ethnicity were excluded from this analysis due to inconsistencies in data recording and concerns of oversimplification of client experience. Because all independent variables are categorical, they were dummy coded to be included into the multiple regression model. Gender identity was coded as female “1”, male “0”, and household size was coded as single adult “1”, others in household “0”.

**Research Question 4.** What are the inter-item reliabilities of the Patient Health Questionnaire-9, Generalized Anxiety Disorder Scale-7, Primary Care PTSD Screen-5, and the Adverse Childhood Experiences Scale within a sample of unhoused adults? Inter-item reliability was calculated using item level scores from the GAD-7, PC-PTSD Screen 5, and the ACEs. Cronbach’s $\alpha$ above 0.70 will be considered acceptable (Tavakol & Dennick, 2011).

**Research Question 5.** Is there a relationship between the number of sessions a client attends and whether or not they exit to stable housing? The relationship between number of therapy sessions and exiting to stable housing was analyzed through a binary logistic regression. Gender identity and household size were screened as potential covariates using a Phi coefficient. Any covariates significant at the .05 level will be included in the analysis.

**Phase 2: Qualitative Phase**

**Participants**

Inclusion criteria for the qualitative component included adults residing in a LifeMoves shelter who were fluent in English and have participated in at least two sessions of therapy at LifeMoves. The second session marks the end of the intake portion of mental health services in the Behavioral Health Program.

**Recruitment.** Participants were recruited through a convenient purposive method via student trainees currently at the LifeMoves practicum placement. Practicum trainees were also
informed about the purpose of the study and asked to assist with recruitment. Student therapists spoke with clients who they believe fit criteria and gauge interest. If a client indicated interest in participating in the qualitative portion of the study, they were asked to fill out a contact form that will then be sent to the researcher (Appendix F).

**Qualitative Data Collection**

**Participant Contact.** Once the researcher had received contact forms from the student therapists, reached out to the individuals via phone to schedule a 30 to 45-minute interview. During the initial phone call, the researcher screened participants to ensure they met inclusion criteria. If the client was eligible for participation, the researcher scheduled an interview either in-person or via Zoom. Zoom for Healthcare, the HIPPA compliant version of Zoom, was chosen as the platform as it allows participants to call into the meeting from their personal phones, as well as for the ease of recording and transcription. Once the interview had been scheduled, they were asked to complete a consent form provided to them by the researcher via email or their case manager (Appendix G). Consent for this study included information regarding the privacy parameters, the voluntary nature of the study, time requirements, and potential harm and benefit.

**Interview.** A semi-structured interview was scheduled and conducted over Zoom for Healthcare or in-person. Each interview had a unique access code to ensure the privacy of the participants. Additionally, participants were given the option to use pseudonyms throughout the interview. Interviews were scheduled for 30 to 45-minutes and included time to review informed consent and answer any participant questions. The researcher utilized an interview schedule to ensure standardization across participants (Appendix H). The general goal of the interview was to understand client experience accessing mental health resources through LifeMoves. After the interview, participants received a $20 Visa gift card as compensation.
Qualitative Data Analysis Plan

Thematic analysis was used as the qualitative method of data analysis because of the relative flexibility allowed in the data collection process (Braun & Clarke, 2012). Because the qualitative portion of this dissertation is exploratory in nature, the researcher adopted an inductive lens (Braun & Clarke, 2006, 2012). The researcher ensured the themes extracted from the data were closely related to the information gathered during the interviews rather than drawing upon existing theories to analyze the data. This allowed for the prioritization of participant experience over attempts to fit data into pre-existing frameworks (Sundler et al., 2018).

Analysis followed the six-step model developed by Braun and Clarke (2006, 2012). After data from the interviews has been transcribed, the researcher worked to familiarize themselves with the data through re-reading written transcripts and listening to audio recordings. Process and observational annotations were made during this phase. Step two included the creation of codes linked to portions of the transcript. Step three consisted of locating themes within the identified codes in order to extract broader threads within the interview data. In step four, the themes were evaluated to determine whether they should be expanded to include more codes or collapsed to increase specificity. The final iterative step consisted of defining and analytically developing themes so that participant experience is cohesively represented. After the themes had been finalized and properly defined, the results of the qualitative analysis were integrated with those of the quantitative piece to determine their relevance to the program evaluation as a whole.

Completion and Dissemination

Once the research process was completed, the researcher discussed with LifeMoves contacts as to how the organization would like the findings to be communicated and to whom.
The full manuscript has been made available to the organization as well. The researcher will also make attempts to share findings with the larger academic community through publication.
Results

Phase 1: Quantitative Results

Participants

The demographic characteristics of previous and current clients receiving mental health services through LifeMoves was examined through descriptive statistics. The sample included all therapy clients over the age of 18 who had received mental health services through the LifeMoves Behavioral Health Program since the initiation (N = 398). Demographic and case information is summarized in Tables 2 and 3. At the time of data collection, 58.4% of cases were closed, meaning the majority of clients in the sample had been discharged from the LifeMoves program to either stable or unstable housing conditions. Most of the sample was female identifying (62.7%) and only 0.8% identified as gender non-conforming. Of the entire sample, 63.7% identified as White, 14.9% identified as Black, African American, or African, 6.4% identified with more than one racial category, 4.3% identified as Native Hawaiian or Pacific Islander, and 3.2% identified as Asian or Asian American. Fifty-six percent of the sample identified as Non-Hispanic/Non-Latin(a)(o)(x)(e). The mean age of the sample was 43.8 years, ranging from 18 to 77 years (SD = 12.9). The majority of the sample was considered to be the head of their household (95.7%), with 3% of the sample listed as the partner or spouse and 1.3% as the adult child of the head of household. The mean number of people in each case was 2.33 (SD = 1.85), suggesting that the average LifeMoves therapy client is not a single unhoused adult but has at least one other person in their household. The average length of stay or time in the program at data collection was 277 days (SD = 282), ranging from 2 to 2,434 days. The average provided mental health service count was 7 sessions (SD = 8.25) of either individual, family, or group therapy and the average number of provided service hours was 6.5 (SD = 8.23).
Prevalence of Psychiatric Symptoms

The reported prevalence of symptoms of depression, anxiety, post-traumatic stress disorder, and adverse childhood experiences was explored through total scores on the PHQ-9 (Kroenke et al., 2001), GAD-7 (Spitzer et al., 2006), PC-PTSD-5 (Prins et al., 2016), and ACES Questionnaire (Felitti et al., 1998) (Table 4). The mean score on the GAD-7 for the sample was 10.73 (SD = 5.7), which falls into the “moderate” range. Thirty percent of the sample endorsed symptoms of anxiety in the “severe” range. On the PHQ-9 the mean score for the overall sample was 11.91 (SD = 7.49), which falls into the “moderate” range of depressive symptoms. Twenty four percent also reported depressive symptoms in the “moderate” level. The mean score on the Primary Care PTSD Screen for DSM 5 was 2.79 (SD = 1.92) indicating the average LifeMoves client endorsed roughly 3 PTSD symptoms and 25.8% endorsed all five PTSD symptoms on the screener, while 24.2% endorsed none. The mean number of adverse childhood experiences reported on the Adverse Childhood Experiences Scale was 4.46 (SD = 2.83) indicating the average LifeMoves client has experienced around 4 adverse experiences before the age of 18. The highest proportion of the sample (25.8%) reported 4 to 5 adverse childhood experiences out of 10.

Internal Consistency of Screening Tools

The internal consistency of the Patient Health Questionnaire-9, Generalized Anxiety Disorder Scale-7, and Adverse Childhood Experiences Scale was assessed using Cronbach’s alpha (Table 5). The Primary Care PTSD Screen for DSM 5 was omitted from this analysis due to the small number of items on the scale and dichotomous structure. The internal consistency of the PHQ-9 indicated a Cronbach’s alpha of .86, indicating good inter-item reliability (Tavakol & Dennick, 2011). The GAD-7 also showed good inter-item reliability within the sample with a
Cronbach’s alpha of .83. Lastly, the internal consistency of the ACES produced a Cronbach’s alpha of .80, also in the “good” range.

**Associations Between Symptom Severity and Demographic Factors**

A series of four multiple regression analyses identified associations between symptom severity and participant demographics and case information. Separate models were completed for each screening tool; PHQ-9, GAD-7, PC-PTSD-5, and ACES. Gender identity (male/female) and household size (single adult/adult with family members) were included as predictor variables, based on previous literature suggesting mental health profiles of unhoused individuals varied based on gender and social support (Milaney et al., 2020; Phipps et al., 2019; Schmidt et al., 2015). Race and ethnicity were excluded due to limitations in how the variables were recorded. Prior to constructing the regression models, necessary assumptions were checked. The mean Cook’s distance for each of the models was below 1, suggesting the absence of outliers impacting the results. The Variance Inflation Factor (VIF) and Tolerance for each independent variable in each of the four regressions were also tested to assess for multicollinearity. The VIF for gender and household size remained below 10 across all three models suggesting acceptable levels of collinearity. Additionally, the tolerance for both independent variables remained above .2. Both collinearity statistics suggest the absence of multicollinearity within the models.

The first regression model examined associations between gender and number of people in a household and the severity of depression symptoms (Tables 7 & 8). The predictors accounted for 3% of the variance ($R^2 = .03, F(2,50) = .78, p > .05$). Neither gender nor number of people in the household were significantly associated with scores on the PHQ-9. In the second linear regression model examining the relationship between gender, household size, and symptoms of anxiety, the predictors again accounted for 3% of the variance ($R^2 = .03, F(2,70) = $
1.18, \( p = .31 \)). Similarly, neither of the predictor variables showed significant associations with scores on the GAD-7. The third model tested whether gender or number of people in the household explained variance in PC-PTSD 5 Screener scores. The predictors explained less than .1% of the variability in scores on the screener \( (R^2 = .001, F(2,62) = .03, p = .97) \). The scores on the PC-PTSD Screen-5 did not vary significantly based on either of the predictor variables. The final model tested whether total scores on the ACEs scale varied by gender or number of people in the household. While the model was statistically significant \( (R^2 = .06, F(2, 146) = 4.83, p < .01) \), neither predictor was statistically significant suggesting there were no differences in the number of adverse childhood experiences by gender or number of people in the household.

Independent samples \( t \) tests were performed comparing mean scores on the four screening tools between males and females as well as single adults and those residing at LifeMoves with others (Tables 7 & 8). The differences in the mean number of adverse childhood experiences for both men and women as well as single adults and those with others in their household were statistically significant. Women \( (M = 4.94, SD = 2.9, N = 95) \) reported experiencing more adverse childhood experiences than men \( (M = 3.63, SD = 2.52, N = 54), t(147) = 2.77, p < .01 \) and individual adults \( (M = 3.92, SD = 2.73, N = 75) \) experienced fewer adverse childhood experiences than those accompanied by loved ones \( (M = 5.01, SD = 2.84, N = 74), t(147) = -2.39, p < .05. \)

**Associations Between Exiting to Stable Housing and Provided Therapy Services**

A binary logistic regression was conducted to determine whether exiting to stable housing after discharge from the general LifeMoves’ program could be predicted by either provided therapy services count or number of hours of therapy services received. Age and number of individuals in the household were found to be significantly correlated with stable
A second binary logistic regression was conducted to examine two additional predictors of exiting to stable housing, including two mental health screeners and gender. Scores on all the mental health screeners were significantly correlated with one another ($p < .05$). As a result, only the GAD-7 and PC-PTSD Screen-5 were included as potential predictors based on the prevalence in the community (Table 10). Overall, the model was not significant, ($\chi^2 (3) = 1.37, p = 0.71$). Roughly 6% of the variance was explained by the chosen predictors. The model indicated that scores on mental health screeners and gender were not significantly associated with exits to stable housing ($p > .05$) (Table 11).

**Phase 2: Qualitative Results**

Phase 2 of this project consisted of semi-structured interviews with 6 current LifeMoves clients (Table 13) to understand their perspectives on access to mental health care and provide context for the quantitative analyses. Participants were majority male identifying (66%) and single adults (83%). Participant ages ranged from 19 to 64 and the number of sessions of therapy ranged from 3 to 21. Data from the interviews were analyzed using Braun and Clarke’s (2006, 2012) thematic analysis approach given the flexibility and compatibility with mixed methods research. Individual interviews focused on 4 topics: (1) logistics of client’s initial connection with their therapist, (2) client perspectives on their initial contact and first session with their
therapist, (3) client perspectives on subsequent sessions with their therapist, and (4) client perspectives on the overall mental health therapy experience. The interview schedule can be found in Appendix A. Six themes and several subthemes (Table 13) emerged from the interviews: (1) “journey” to Life Moves, (1a) iterations of success and loss, (1b) begging for access, (2) seamless connections, (3) importance of trust, (3a) communicating trust, (4) dynamic needs of the unhoused, (4a) on-going trauma of living unhoused, (4b) flexible in-person modality, (5) benefits of therapy at LifeMoves, and (6) areas for growth.

“Journey” to LifeMoves

Participants often detailed events that had occurred before connecting with mental health services with LifeMoves. LifeMoves was often not the first organization they had been involved with after becoming unhoused. Typically, participants had been referred to LifeMoves through a different social services organization and had experienced many iterations of success and failure through their tenure of houselessness. Cole, a 56-year-old White male, shared he was in a “different shelter, and the shelter that I was in was only a temporary shelter until they placed me in a long-term shelter,” which was LifeMoves, while Andres, a 52-year-old Latinx male, noted a hospital “gave us a referral to the sobering center…and then from there we had no idea where to go to get to the next referral.” The non-linear nature of this “journey”, as described by multiple participants, was often attributed to a lack of knowledge of and difficulty accessing the resources available to them. Additionally, many participants were confident in their needs but unsure of how to ask for the resources to get them met. This led clients to rely on existing social relationships to connect them with community organizations. Multiple participants shared they needed to “go stay at friends or family” or “call up an old friend” prior to being connected with
the program, suggesting they utilized both formal (e.g., community centers, health care organizations, other shelters) and informal networks to reach LifeMoves.

**Iterations of Success and Loss.** When asked about their initial connection with LifeMoves, participants reflected on the immense amounts of loss experienced prior to coming to the organization. The physical loss described was often related to housing situations, connection with family, or incarceration. In describing their experience, Andres recounted that he “lost everything and ended up in prison until I lost really everything.” In moving between different societal systems, clients’ losses compounded, ultimately resulting in houselessness. However, participants also communicated a loss of integral parts of their identity that occurred with their transition into houselessness. Ada, a 28-year-old African female, described the initial shock she experienced as she “came from the mainstream…and then went into a shelter” after having to give up a career due to declining mental health. Andres voiced his sadness by stating “I had a cool life and losing it was a disaster, just total failure, everything…I lose all that shit and then back at the bottom.” This led to significant amounts of emotional distress as expressed by describing his reaction: “I was totally crushed, man. I was pissed off, mad, angry, and just I didn’t give a fuck anymore, and so I knew I needed help after a week and a half.”

In addition to expressing grief over losing their previous identities as parents, employees, siblings, and friends, many participants utilized the interview to reflect on periods of success as well. They shared stories of previous relationships with family members as well as jobs and hobbies they used to enjoy. One participant proudly shared “I was on my comeback tour, man, I found purpose again and drive…it just got screwed up”. For some LifeMoves clients, they were in their first episode of houselessness and adjusting to the shock of being unhoused. Ada reflected on acclimating to being unhoused, stating “I didn’t, you know, know what to expect
from LifeMoves, because I came from the mainstream…and then went into a shelter and that was like culture shock” after giving up a successful career in healthcare due to the onset of mental health symptoms. For others, they had been through many iterations of success and loss throughout their lifetime, which sometimes included previous episodes of houselessness. John, a 64-year-old White male, stated, “I’ve actually been here [LifeMoves] a few times, but this is, I didn’t expect to ever come back again after a certain time”, highlighting the difficulty of returning to houselessness after periods of stability. However, with each round of loss, LifeMoves clients remained focused on returning to success and stability, as evidenced by one participant’s statement: “You know this isn’t part of the plan, but you know no, we have to redo the plan again and again and again.”

**Begging for Access.** Prior to being connected with LifeMoves, participants were keenly aware of the mental health resources they needed but were often unsure of how to access them. Several clients shared they knew “I need to connect with the healthcare system because I have all these symptoms I want to manage” and “I had known I needed help with resources, but never was really shown how to access them.” The myriad of poorly connected and highly impacted community resources in the Bay Area led to confusion and overwhelm for many, typically prolonging the time before clients were able to get help. Several participants described finding themselves in desperate positions in which they were “begging for help”. When trying to schedule an appointment with a potential medical provider, Andres recalls saying:

> I can’t wait that long, really. I really need help, you know… I’m begging for help. I’m telling you I need it…I need to use this. Get a pen and pad, you know, and start to write this down because I’ve been mugged twice when I was sleeping out in the park at night, and that’s just no fun.
After unsuccessful connections with many different organizations and eventual returns to houselessness, this client was left with emergent needs they were unsure how to get met. He went on to share that even when they had connected with short-term, crisis focused resources, it was difficult to find the help they needed: “I was begging them. I mean, I was at the Behavioral Health and Alcohol Center, and you know I need help, and nobody would help me.” These stories of desperation while navigating the system of resources for unhoused individuals compounded with the prior loss many had faced, resulting in an overwhelming level of suffering that permeated the interviews.

**Seamless Connections**

Participants were asked and shared directly about their experience of service initiation with therapy at LifeMoves. Participants recounted connections with mental health clinicians that were “seamless and uncomplicated and unpressured,” standing in stark contrast to their previous experiences seeking services through external community mental health services. One participant described the relief they felt when connected with their therapist after a pattern of cycling through and navigating resources: “I felt relief, you know. I wanted someone to talk to so I could like, explain myself.” Many clients came in knowing what they needed and felt comfortable asking directly for mental health services while others were linked with therapy at the suggestion of case managers. Either method resulted in hassle-free service initiation, as noted by Daniel, a 19-year-old African American male: “I think…it’s like the easiest thing ever, I guess. Yeah, like one day, I was like living my life. The next day, boom, you got a therapist.” Participants also became engaged in services after meeting their therapist during milieu hours, in which a therapist would be present in common spaces in shelters. These milieu encounters offered a low-pressure avenue to initiate mental health services. John recalled their introduction to their therapist during
milieu stating, “It was very casual. It doesn’t feel like ‘Oh, you have to, you must’, you know. It’s just gently, you know, offer first…I think it is a really good approach”. Other participants echoed this, sharing how casual conversations in the milieu or in the dining hall seamlessly led to more formal therapeutic relationships.

**Importance of Trust**

Participants discussed their experience of coming to trust their therapists and how trust was communicated within the dyad. Predictably, participants described a range of emotions during their initial sessions with their LifeMoves therapists. Some reported feeling “nervous”, while others noted they were “excited” to have finally been connected with someone. One participant stated, “there was a ton of feelings…there was anger, stress, boredom, just fed up with the screwed-up system,” referring to the obstacles they overcame in order to reach the initial meeting with their clinician. Despite any initial apprehension, participants also described a gradual increase in comfort throughout the first sessions as they began to develop relationships with their therapists. Because of their existing knowledge of the mental health system, many clients recognized the initial sessions as not only a time to complete formalities such as informed consent and history gathering, but also a time to “help you therapist get to know you, where you’re at, with your experiences…whether it be happy or traumatic.”

**Communicating Trust.** In order for participants to feel increasingly more comfortable, they indicated they first needed to feel they could trust both the therapist and LifeMoves as an institution. When discussing initial sessions with their therapists, participants frequently mentioned the importance of trust within the therapeutic relationship. Andres stated, “I told myself, if I could trust them…and if they’re good, then I’ll continue to see him”, suggesting that trust was an important factor in this client’s retention in mental health services. He continued to
describe using the initial sessions as a way to “size [them] up” to determine whether the therapist can be trusted:

It’s kind of a feeling out type of thing, you know. You’re givin’ juicy dirt, you know, and see if you can really rely on them in future meetings and [be] trusted. Trust is a huge issue when it comes to that.

As described throughout the interviews, clients knew they were in need of services and even described “begging” to be seen in order to address their concerns, but this quote illustrates that in order to do so, they need to ensure their therapist is reliable and trustworthy. While many participants explicitly named trust as an important component of their experience during initial sessions, others communicated the ways in which their therapist conveyed a sense of trustworthiness. In describing their first session, Ada recalled their therapist as “very like warm and welcoming, and [they] were very respectful. And the room was nice, calm. They have like a good…aura in there.” Through creating a calm and inviting environment, the therapist communicated a sense of safety to their client. For this particular participant, it stood in contrast to the environments of the shelter and on the street, which often brought an increased sense of vulnerability and chaos. Another participant explained that their trust and comfort with their therapist increased “once you get that…you could say like personal connection with somebody, like oh, this is a person” and “this is a person who’s like here to help you.” Clients came into therapy expecting clinicians to be judgmental, as many providers can be of individuals who are unhoused. However, when LifeMoves therapists were willing to demonstrate their humanity, it helped to increase trust within the therapeutic relationship.
Dynamic Needs of the Unhoused

Throughout the interviews, participants shared information that was not directly related to the therapeutic process but that was indicated as important to the clients. Because the environment accompanying houselessness is dynamic and at times chaotic, clients described their needs as changing frequently. While participants typically had an intimate knowledge of what they needed in terms of resources, services, and goals, the reality of getting those needs met shifted once they were faced with the reality of living in a shelter. Ada recalled “the goals I had in mind at the shelter, and even beyond, like they’re not [feasible], you know. They changed because things changed.” She initially expected their stay with LifeMoves to be short but the stress and confusion of navigating the system of obtaining benefits through various social services agencies forced her to modify their goals. Due to the unpredictability in the shelter environment, participants shared they needed to adjust the structure of therapy. Cole recalled asking to modify the length and intensity of their session on a particularly difficult day by explaining to his therapist “Look, today’s not a good day…and so we’d shorten up our session” or “Look, I need to just take, you know, or have less of a session.” The act of modifying services to meet the dynamic needs of clients served as a way for therapists to allow clients to be “heard”.

On-Going Trauma of Living Unhoused. One of the factors making living unhoused or staying in a shelter so unpredictable and dynamic is that it constitutes a traumatic experience for many clients. Multiple participants described having parts of their past brought up when entering into the shelter system. Andres recalled arriving at his shelter and finding “it brings up all kinds of shit about county”, referring to time spent in the criminal justice system and a previous traumatic environment. Ada shared:
I didn’t expect all the PTSD triggers, and like all the harassment, or whatever, like a lot of the drama that would, you know, be like I’d have to deal with it on a daily, multiple times and all that.

The same client went on to describe the difficulty of navigating the “sexual harassment stuff” as well as the “power and dominance…dynamics” within the shelter that they did not anticipate encountering when initially becoming unhoused. This quote and the experience of this participant illustrates the potential for a shelter environment to amplify the trauma many clients have experienced prior to coming to LifeMoves.

**Flexible In-Person Modality.** Due to the recency of the COVID-19 pandemic and the larger shift to providing services via telehealth, interview questions focused on the modality in which clients had been receiving services as well as their preference for either in-person or telehealth. Largely, clients shared a preference for in-person services for a variety of reasons. One participant described in-person services as feeling “more like, you know, homemade pie rather than imitation.” Others shared feeling like they “can’t get a sense of who someone is through Zoom” because “they’re like present, they’re like real you know” or wanting in-person services due to vulnerability to distractions. Overall, clients felt they were able to get a more authentic experience of their clinician when receiving services in-person, which in turn helped to communicate a sense of trust and reliability.

Despite these preferences, most clients had been utilizing a mixture of both in-person and telehealth because of the unpredictable nature of their schedules and circumstances. Knowing their therapist was willing to be flexible with scheduling and modality of care gave clients a sense of autonomy while they worked to secure employment or more permanent housing options. One client described the benefit of their therapist “having an open schedule… I didn’t feel like
they were like watchers over me, you know, poking.” Clients are undergoing many adjustments when they enter the shelter system from unstable housing. There is more structure and supervision than on the streets and there often are more frequent changes in the environment. Flexibility in their mental health care allows them to attend to other needs that may take priority while maintaining consistency in support. One participant summed up the importance of a reliable yet flexible therapy schedule by sharing the benefit of “the consistency in meetings, you know, and like and like communication. It’s been good interactions, like you know, when we’re meeting…if we need to reschedule it’s you know, it’s just flexible.” With these accommodations, clients were able to address their immediate needs such as finding employment, obtaining identification documents, or childcare while knowing they have on-going therapeutic support, ultimately resulting in higher rates of treatment attendance.

**Benefits of Therapy at LifeMoves**

In addition to nuanced ways in which participants benefited from the mental health services, they also shared positive experiences directly related to therapy at LifeMoves. While some mentioned specific therapeutic interventions such as “mindfulness,” “meditations,” and learning general coping strategies, overwhelmingly participants felt most reinforced by therapist qualities and the treatment environment. Multiple clients referred to the balance between “the human connection” and professional opinion as a particularly useful part of their treatment. Daniel described:

I think that has been really beneficial to our sessions. I guess, and her just not being like, how do I say it, like dead inside, you know like reserved, like, like cold, I guess you could say, like we’re able to like, you know, laugh and talk about things.
This quote illustrates how the therapist was able to increase the level of comfort and therapeutic effectiveness through sharing parts of their humanity with their client, demonstrating that it is acceptable for clients to present authentic versions of themselves in treatment. Shoshana, a 29-year-old African American female, shared how helpful it was to “actually connect with them [therapists] as a person, you know them being able to actually give a professional and unbiased opinion, and also being willing to share their personal opinion.” Clients were able to find comfort within the therapeutic relationship while clinicians served as guides for participants to explore different parts of themselves with an outside, professional point of view as described by Daniel:

If I have an issue or a problem whether that’s emotional or physical or anything like that, I’m able to come up with the solution on my own [with] something like that’s been discussed between me and Therapist X…you know, like therapy is like a way to hold a mirror…you need someone to like, you know, have as, you know that guide who knows more

Therapists were also described as being “open”, “understanding”, and “approachable” which helped to foster a safe therapeutic environment clients found to be important to their care. Through these qualities, therapists created environments in which participants described feeling “heard” and were able to actively shape how their mental health services were delivered. Cole shared instances in which he “asked ‘Let’s push a little harder here and there’” or “said, ‘Look, this amount of discomfort is too much for me’, and we would take a break from the session and try and come back to it.” Clients were provided an environment in which they could exercise autonomy over their own care, which was distinctly different from their experiences within the
social services system that were described as “a rollercoaster”. At LifeMoves, therapists served as a guide as participants are able to “come to a resolution for myself.”

**Areas for Improvement**

Participants were also asked to speak to ways they felt their mental health services could have been improved in order to formulate specific recommendations for the LifeMoves Behavioral Health Program. Overall, clients shared a desire for a targeted, solution and future oriented approach in therapy to match the immediacy of their needs, as well as more education on the services available to them. To alleviate the confusion that comes with navigating the social services system participants described prior to coming to LifeMoves, clients indicated more information about the services available to them through LifeMoves and other organizations would be helpful. Ada described not knowing what services they were able to access until being told by a LifeMoves employee:

I just like learning the system, you know. But I see that this is not an available thing. It’s not easy for people to get unless someone comes in, sets up a thing and says, ‘We’re here’…it’s not going to be something that’s easy for people to access.

The lack of transparency regarding resources can lead clients to feel disempowered when trying to make significant changes in their circumstances. By providing them with more information about services offered, organizations can give clients the tools to get their needs more adequately met.

Participants also expressed a desire for a future-oriented and solution-focused approach to therapy, to compliment the dynamic and immediate needs of living unhoused. John, who had spent multiple years living unhoused indicated it would be most help to focus on where he was in his present circumstances:
I mean they may ask me a question from some time back…you might say something like do you have any issues to bring up about something that hurts you…so that kind of thing. But it’s not something that’s gonna affect housing.

As evidenced by this quote, many unhoused individuals view their immediate needs such as housing, financial stability, and employment as more pressing to address over topics traditionally covered in therapy. Participants acknowledged “each person’s got a different story” and they “may have issues that are different than your issues,” but given that circumstances can change quickly, and many people are working to get basic needs met, clients shared it is most helpful when the providers stay “present in and positive with the person’s abilities there.” The same participant poignantly stated they wanted to focus on “a path moving forward because we don’t move backwards, do we?” They felt it was unnecessary to dwell on their past losses or periods of living unhoused and wanted to utilize therapy to cultivate resilience for the future.
Discussion

This project was a mixed-methods program evaluation aimed at better understanding the client demographics, mental health profiles, and perceptions of access to mental health care of unhoused adults receiving mental health services at a community-based organization serving unhoused individuals and families in the South Bay Area/Peninsula of Northern California. This project employed a mixed-methods approach, consisting of quantitative secondary data analysis of electronic health record data and a qualitative component of semi-structured interviews utilizing a thematic analysis framework as outlined by Bruan and Clarke (2006). Data from 398 clients who had received or were actively receiving mental health services was analyzed for the quantitative portion of the study, while a subset of current LifeMoves clients (n = 6) participated in individual interviews on their view of access to mental health services. The results of the study will be communicated to the organization’s leadership to improve understanding of client needs related to mental health, as the unhoused population’s complex circumstances are often overlooked.

Phase 1: Quantitative Discussion

A primary aim of the quantitative component of the study was to understand the demographic profile of the individuals receiving mental health services through LifeMoves. The majority of the sample analyzed identified as female (62.7%) which is slightly incongruent with the gender breakdown of the population of unhoused individuals in California as a whole (Homeless Policy Research Institute, 2020). In 2020, the Homeless Policy Research Institute reported that 65% of those living unhoused were male, 33.4% were female, 1.2% identified as transgender, and 0.4% were gender non-conforming. While the proportion of gender non-conforming and transgender identified individuals seeking mental health services through
LifeMoves is roughly comparable to the larger unhoused population in California, these comparisons may suggest that women involved with the LifeMoves organization are seeking mental health services at higher rates than males.

Being at the center of interlocking systems of oppression (e.g., unequal pay, caregiving, domestic violence) (Bullock et al., 2020; Phipps et al., 2019), unhoused women tend to report higher levels of psychopathology than males, particularly symptoms of PTSD and depression, leading them to seek mental health services at higher rates than men (de Vet et al., 2019; North & Smith, 1994; Phipps et al., 2019; Tinland et al., 2018; Winetrobe et al., 2017). In addition, previous empirical findings indicate that men typically hold more negative attitudes towards mental health services due to significant self-stigma and socialization of traditional gender norms impacting help seeking behaviors, which can be compounded by the increased vulnerability of living unhoused (Vogel et al., 2011). Both the disproportionality between the number of men living unhoused and those engaged in mental health services as well as the high number of women seeking services at LifeMoves suggests the need for gender specific outreach.

The majority of clients seeking mental health services through LifeMoves identified as White, while smaller proportions identified as Black\(^2\), bi-racial, Native Hawaiian or Pacific Islander, or Asian or Asian or Asian American (Table 2). Despite the overrepresentation, Black, African American, or African identifying individuals in the unhoused population in California, are not seeking mental health treatment through LifeMoves at a comparable rate (Table 2).

\(^2\) The term “Black” refers to individuals who self-identified as Black, African, or African American in the LifeMoves system and encompasses those who trace their ancestry to many places, including but not limited to, continental Africa as well as Caribbean and South American nations.
Conversely, Native Hawaiian or Pacific Islander and Latinx, individuals are utilizing LifeMoves mental health services at higher rates than they are represented in the unhoused population in California as a whole (Davolos & Kimberlin, 2022). African Americans tend to be overrepresented in this population both nationally and locally, constituting 37% of those living unhoused in the Bay Area and only 6% of the general population (Coalition on Homelessness, 2019; Davalos & Kimberlin, 2022; Olivet et al., 2021). This pattern is reflective of the mental health service utilization rates of Black Americans as a whole, hypothesized to be the product of general distrust in the mental system due to historical and current racism (Alang, 2019). Unhoused Black Americans are subjected to different stereotypes at the intersection of both race and class that may preclude them from accessing services (Edwards, 2021).

**Prevalence of Psychiatric Symptoms**

The severity and prevalence of symptoms of depression, anxiety, PTSD, and adverse childhood experiences was measured through total scores on screening tools collected for portions of the sample. The inter-item reliabilities of the PHQ-9, GAD-7, and ACES scale were calculated as part of this study in an effort to determine the appropriateness of the tools for use within the unhoused population and all demonstrated good internal consistency within an unhoused population of adults. The majority of the sample endorsed moderate symptoms of depression, moderate symptoms of anxiety, all five trauma-related symptoms, and 4 or more adverse childhood experiences (ACES) (Table 4). The proportion of individuals endorsing 4 or more ACES and all symptoms associated with PTSD is congruent with the robust literature

3 The term “Latinx” refers to individuals who identified themselves as Hispanic/Latin(a)(o)(x)(e) in the LifeMoves system and encompasses those that trace their ancestry to many places, including but not limited to Central and South America, as well as Caribbean nations.
documenting trauma within the unhoused community (Ayano et al., 2020; Campbell et al., 2016; Liu et al., 2021; Montgomery et al., 2013; Office of the California Surgeon General, 2020; Roos et al., 2013). The number of clients in the sample reporting significant levels of depression and anxiety were higher than those found in previous meta-analyses of anxiety and depression in unhoused individuals (Ayano et al., 2021; Gutwinski et al., 2021; Hossain et al., 2020). It is difficult to determine factors contributing to higher levels of anxiety and depressive symptoms in this sample. However, some of the data was collected during the COVID-19 pandemic, which disproportionately impacted unhoused individuals (Tsai & Wilson, 2020). Additionally, the socio-political climate surrounding houselessness in the San Francisco Bay Area is unique in that the number of unhoused individuals has been increasing, constituting a “crisis” in the area, while notable gaps in service and funding have led to a shortage of affordable housing, potentially creating higher levels of stress within the community (Krivkovich et al., 2023). It is important to note that the results from this analysis are likely not representative of the LifeMoves client base, as clinicians decide the screening tools to administer based on client presentation and reason for referral.

**Associations Between Symptom Severity and Demographic Factors**

There were no significant associations between gender identity and household size and total scores on the PHQ-9, GAD-7, and PC-PTSD-5. All of the models demonstrated poor fit, ranging from explaining less than 0.1% to 3% of variability in symptom severity, suggesting that factors outside of gender identity and household size contribute to symptoms of depression, anxiety, and PTSD. One explanation for the lack of significance could be the extreme levels of social disadvantage that accompany houselessness may be diluting and overriding the impact of identity factors by generating a shared level of distress across subgroups of people (Horvitz-
Lennon et al., 2009). More comprehensive research, addressing a wider range of potential predictors race and ethnicity, time spent unhoused, and pathways to housing instability is needed to better understand the relationship between symptom severity and demographic factors among unhoused individuals.

In this study, women had significantly higher scores on the ACE scale than men which is consistent with empirical literature suggesting women, both housed and unhoused, report higher rates of adverse childhood experiences than men (Haahr-Pedersen et al., 2020; Hurley et al., 2022; Liu et al., 2021). Previous studies suggest that women with ACE scores higher than four are more likely to develop anxiety, depression, and PTSD (Ijeaku et al., 2021). However, this was not reflected in the current sample as there were no significant differences between men and women’s scores on the GAD-7, PHQ-9, or PC-PTSD-5 regardless of the differences in ACEs scores. While there were no gender differences in symptom prevalence, the significant difference in ACE scores in this sample reiterates the need for gender specific, trauma-informed care suggested by previous literature, as increased levels of victimization for women often contribute to their pathways to houselessness (Duke & Searby, 2019; de Vet et al., 2019; Milaney et al., 2020).

The difference in mean ACE scores between single adults and those living with family members was also significant, indicating that those who have loved ones living with them typically experienced more adverse childhood experiences. This is the first study to compare mean ACE scores of these groups; however, there are several possible explanations for this finding. The mean number of household members for women in this sample was 2.77, suggesting the average female participant was not classified as a single unhoused adult but typically had loved ones with them at the LifeMoves shelter site, such as children or partners.
This is consistent with national data showing most unhoused families are led by single mothers bearing both the burden of caregiving and houselessness (Slesnick et al., 2012). In both this study and existing literature, women have higher rates of adverse childhood experiences, potentially explaining the link between ACEs and non-single adults in this sample.

**Associations Between Exiting to Stable Housing and Provided Therapy Services**

A binary logistic regression was conducted to understand the relationship between exiting to stable housing and both the number of therapy sessions and the time spent in therapy. In this model, neither variable significantly predicted exiting to stable housing. This finding contrasts available literature suggesting a positive relationship between units of service use as well as length of treatment and housing outcomes, suggesting that connection with a mental health professional is linked to greater chances of achieving stable housing (Lo et al., 2022; McGuire et al., 2010; Pollio et al., 1997; Stergiopoulos et al., 2008). While not included in this analysis, shorter lengths of stay and difficulty with client retention may have impacted the results. It is possible clients are ending mental health treatment before receiving enough services for housing outcomes to be positively impacted which may explain the lack of significance in this analysis. Early termination of mental health services is a significant area of concern for the unhoused population receiving mental health treatment due to lack of fit and accessibility of traditional therapy models for this population (Center for Substance Abuse Treatment, 2013; Orwin et al., 1999).

**Phase 2: Qualitative Discussion**

The primary aim of the qualitative portion of this study was to better understand client perspectives on accessing mental health care while living unhoused. The themes extracted from the six semi-structured interviews highlight the difficulties experienced by this community when
navigating systems that rely on trust and perceived safety. Additionally, the mental health needs of people living unhoused appear to vary based on their environment and the accompanying social disadvantage, requiring additional considerations for organizations and clinicians serving this population.

Access to Resources Prior to LifeMoves

Before being connected with LifeMoves, participants described a “journey” which included navigating a confusing system of resources, iterations of loss and success in maintaining housing stability, and a reliance on informal networks. The importance of informal networks within the unhoused community is well documented (Babayan et al., 2021; Buck-McFayden, 2022; Cook-Craig & Koehly, 2011). These relationships offer a stable form of advocacy when the environment associated with houselessness changes frequently. These informal support systems were often an integral part of the iterations of loss and success experienced by participants. This cyclic pattern described by clients is reflective of patterns of service use highlighted in existing literature (Folsom et al., 2005; O’Carroll & Wainwright, 2019; Sadowski et al., 2009). Those who are unhoused tend to postpone engagement with services until their needs become emergent and require crisis intervention (Folsom et al., 2005). However, when utilizing emergency services there is a lower likelihood of being connected with longer-term care resulting in an eventual return to houselessness and the cyclic pattern of loss and success (Folsom et al., 2005; O’Carroll & Wainwright, 2019; Sadowski et al., 2009).

Participants also described having to “beg” for services prior to connection with LifeMoves, which is likely reflective of the lack of literature on the needs of those living unhoused and stigma from health care providers. In a meta-analysis of studies examining stigma, houselessness, and health care conducted by Reilly and colleagues (2022), of the 21
studies reviewed, all 21 confirmed the stigma experienced by unhoused individuals from providers when accessing health care. The negative attitudes related to care seeking behaviors towards this community based on housing status and lower social class led to feelings of dehumanization, increased internalized stigma, and care avoidance, ultimately contributing to the cycle described above (Folsom et al., 2005; O’Carroll & Wainwright, 2019; Reilly et al., 2022; Sadowski et al., 2009). The experience of invalidation and stigma from providers in healthcare encounters was communicated by participants in this study as they described having an intimate knowledge of their needs but being unable to get them met after being dismissed by the healthcare system, an experience not unique to the unhoused population and shared with other stigmatized groups in the health care system (Valencia-Garcia et al., 2017).

**Service Initiation**

Due to an overall lack of trust in healthcare services, participants described their initial encounters with therapists as integral to successful engagement in mental health treatment. LifeMoves utilizes a milieu therapy model, in which therapists are present in shelter common areas, as one way to engage clients in mental health services. Participants shared that this allowed for casual and unpressured introductions which resulted in seamless connections with mental health services. Non-traditional approaches to service introduction such as utilizing consumers as outreach workers or going into the community to meet potential clients are common throughout care for individuals who are unhoused (Olivet et al., 2010).

Several studies have highlighted trust and personal connection as integral to the process of treatment engagement with the unhoused community (Barker et al., 2018; Cormack, 2009; Magwood et al., 2019; Olivet et al., 2010). Participants indicated they were not able to fully engage in services until they felt they could trust their therapist and went through periods during
which they were “sizing them up” to gauge trustworthiness. Clients also explicitly named factors such as respect, safe environments, and authentic human connection as ways their therapist communicated trust, ultimately leading to treatment engagement. All of these factors were also identified by Magwood and colleagues (2019) as facilitators of effective social health care interventions for people who are unhoused, suggesting that trust, safety, and personal connection are important qualities for mental health providers to demonstrate when working with unhoused populations beyond LifeMoves.

**Houselessness as a Traumatic Experience**

In addition to expressing mental health needs that often change with the dynamic environment, participants communicated that the unpredictability and compounded stress associated with living unhoused, even once sheltered, constituted a traumatic experience. For the small number of LifeMoves clients interviewed, the shelter setting mirrored previous traumatic environments or experiences within the LifeMoves shelter itself were traumatic. Some equated being in the shelter with incarceration, while others noted gender and power dynamics that threatened their sense of safety. These responses reflect a growing body of literature recognizing the experience of living unhoused as an index trauma event (Deck & Platt, 2015; Hopper et al., 2010; Lewinson et al., 2014; Tsai et al., 2020). While housing is an important step in achieving long-term stability and safety, it does not guarantee an end to the on-going trauma of houselessness. The transition to stable housing is often accompanied by changes in support networks, loss of community and identity, and adjustment to new environments that can exacerbate mental health symptoms and require the development of additional coping mechanisms (Balasuriya et al., 2020; Carnemolla & Skinner, 2021; Gordon et al., 2019; Mercado et al., 2021; Patternson et al., 2015). It is important for providers to expand their view
of what constitutes trauma when working with this population in order to provide services that are adequately trauma informed, while attending to aspects of client’s identities that influence their experience of living unhoused.

**Modality of Services**

LifeMoves had transitioned to offering telehealth services to therapy clients in 2020 to adhere to social distancing guidelines, however interviews occurred in 2023. Participants largely preferred in-person services due to the level of connection they were able to establish with their therapist, again reflecting the importance of trust within the therapeutic relationship. However, clients also emphasized the need for flexibility in the modality of services to accommodate the unpredictable nature of their schedules and environments. These perspectives are reflective of research findings on the use of telehealth services for individuals who were unhoused during the COVID-19 pandemic (Zahir et al., 2023). This population was disproportionately impacted by the pandemic due to communal living situations and overall lack of access to resources (Tsai & Wilson, 2020). Research has shown that in addition to limiting the risk to both clinicians and clients, offering telehealth services increases access to care and decreases the utilization of emergency resources which is a key component in service utilization patterns within the unhoused community (Adams et al., 2021). Despite these benefits, research has highlighted some skepticism towards telehealth services and a preference for in-person meetings which was also communicated by the participants in this study (Zahir et al., 2023). When offering telehealth services to individuals, organizations must account for these attitudes as well as additional considerations which will be discussed in the following Clinical Implications section.
Clinical Implications

Given that this project is a program evaluation, a section dedicated to clinical implications and actionable recommendations is warranted in order for proper dissemination of the data and for the voices and perspectives of those who are unhoused to be upheld.

Mental Health Profiles and Symptoms

The lack of significant differences between subgroups in symptom profiles and high levels of symptom endorsement that emerged through the quantitative phase of the project suggests a baseline level of suffering that overrides demographic and case differences within the unhoused population. This can be attributed to the compounding stressors, not limited to difficulty successfully connecting with resources and on-going trauma that can occur once involved in a shelter system. Research has shown this experience results in a loss of identity, feelings of powerlessness, and an inability to get basic needs met—all experiences not typically captured on typical measures of trauma symptoms, but that can contribute to significant emotional distress (Hopper et al., 2010). In order to account for this unique set of circumstances, clinicians need to move beyond the typical approach to trauma informed care that focuses on screening for and assessing previous trauma and acknowledge the experience of houselessness as active and an on-going traumatic experience. While some individuals may not present with symptoms typically associated with PTSD in the DSM-5, clinicians can anticipate their clients have experienced immense amounts of loss, as evidenced by the descriptions of iterations of loss and success from participants in this study. Current literature examining evidence-based interventions to treat PTSD in those who are vulnerably housed guides practitioners to utilize treatments such as Eye Movement Desensitization and Reprocessing (EMDR) and Cognitive Behavioral Therapy (CBT) for PTSD (Bennett et al., 2022). While these interventions may have
Empirical support, they focus on trauma-specific symptoms within the individual and fail to take into account the systems perpetuating the experience (Goodman, 2015). Clinicians can expand their view and treatment of trauma by helping clients locate their experience within a network of current and past oppressive systems to decenter the problem from within the individual while focusing on cultivating future resilience as they navigate houselessness (Goodman, 2015).

While the experience of trauma may be somewhat universal within the unhoused population, research demonstrates that pathways into houselessness vary significantly, which results in differing presentations and mental health needs (Bullock et al., 2020; Carter, 2011; de Vet et al., 2019; North & Smith, 1994; Phipps et al., 2019). This requires mental health care providers to balance acknowledging the shared level of trauma across the population, while working to identify each client’s unique needs and story through asking questions such as “What was your experience prior to coming to LifeMoves?” or “Who were you prior to being connected with this organization?” to understand and appreciate what parts of themselves clients may be grieving.

Additionally, utilizing all available mental health screening tools such as the PHQ-9, GAD-7, PC-PTSD-5, and ACEs during initial assessments of all clients will ensure important clinical data is not overlooked and care can be tailored specifically to individual needs. Screening based strictly on clinical judgment or symptom presentation may result in a delay in necessary treatment, which is an existing concern for this community (Bommersbach et al., 2020; O’Carroll & Wainwright, 2019).

**Approach to Care**

While some participants specifically mentioned therapeutic interventions they found to be helpful such as mindfulness and coping, most highlighted the importance of their relationship
with their clinician and the therapeutic environment. This highlights the need for therapists providing services to individuals who are unhoused to carefully attend to the environment they create and their overall approach to care. Participants noted the comfort offered by clinicians who were able to balance both their professional and personal identities within therapy. While developing and maintaining a professional identity is a core competency in professional psychology (APA, 2012), literature demonstrates that therapist authenticity and a strong therapeutic relationship has a positive impact on client outcomes (Gelso et al., 2018; Schnellbacher & Leijssen, 2009). This is particularly important for the unhoused population due to the high level of skepticism and difficulty with trust communicated both by participants in this study and previous research (Barker et al., 2018; Cormack, 2009; Magwood et al., 2019; Olivet et al., 2010). Based both on participant feedback and existing literature, clinicians are encouraged to focus on client-specific adaptations to therapy focusing on their present needs, attend to patient satisfaction and feedback, and cultivate an environment of empathy and collaboration (Norcross & Lambert, 2018).

**Flexibility.** Across multiple aspects of treatment, participants communicated the importance of flexibility in their care. Adaptable and unconventional approaches to therapy have shown to be important components of both retention and recruitment of unhoused individuals experiencing mental illness (Strehlau et al., 2017). Based on feedback from participants in this study, clinicians must be prepared to provide services across different modalities such as in-person, video conferencing, or over the phone. While many participants prefer in-person therapy, the constantly changing nature of unhoused clients’ environments and the additional demands of living unhoused may make it difficult for individuals to engage with a more traditional and consistent service delivery model. By offering flexible and adaptive services, such as dedicating
space in clinicians’ schedules to allow for reschedules or being prepared to shift the focus of therapy to address concerns as they arise, clinicians are not only tailoring services to meet the dynamic needs of this population, but also honoring the fact that clients’ priorities may fluctuate when navigating houselessness (e.g., having a job interview scheduled during typical therapy hour or needing to spend the day at the DMV to obtain identity documents) (Balasuriya et al., 2020; O’Carroll & Wainwright, 2019; Schmidt et al., 2015). As with any population, implementing telehealth services requires additional considerations. In their 2023 article, DeLaCruz-Jiron and colleagues outline questions clinicians may ask themselves prior to initiating tele-mental health services with clients who are unhoused: What is the level of digital literacy in the client population? What kind of access does this population have to electronic devices, data, and internet connection? Are they able to find a location that feels safe and upholds client confidentiality? By combining intentional consideration of access and offering flexibility in modality and scheduling, clinicians can eliminate some of the many barriers to mental health care for the unhoused population (Bonin et al., 2007).

Flexibility also becomes an important component of service initiation. Throughout the interviews, it was clear participants utilized various avenues to initiate mental health services at LifeMoves. Some relied heavily on their case managers to suggest therapy and schedule initial appointments while others came in asking specifically to meet with a clinician, suggesting varying levels of comfort with seeking help. Additionally, some participants shared they appreciated the casual nature of the interactions with their therapist during milieu hours, a unique service provided by LifeMoves. Through milieu hours, clients were able to develop a relationship with a clinician and establish a sense of trust, an essential aspect of care for people living unhoused, prior to committing to a more formal therapeutic relationship (Barker et al.,
EVALUATION OF CBO SERVING UNHOUSED ADULTS

2018; Cormack, 2009; Magwood et al., 2019; Olivet et al., 2010). Allowing for flexibility in the referral and service initiation process creates opportunity for individuals with varying levels of comfort with mental health services or internalized stigma regarding their needs to be connected with therapy services on their own terms.

Limitations

Several limitations were present in this study. First, the high proportion of White identifying individuals in the quantitative phase of this study limits the generalizability of the results to people of color, who are overrepresented in the unhoused population (Fusaro et al., 2018; Jones, 2016; Olivet et al., 2021). Race and ethnicity could not be included in the analysis due to the complexity and inconsistency with which the variables were measured. Houselessness inevitably intersects with other forms of social disadvantage, resulting in more obstacles for people of color and other marginalized communities and previous literature has shown that the experience of living unhoused with mental illness varies substantially based on race; however, that could not be demonstrated in this study (Austin et al., 2008; Bullock et al., 2020; Carter, 2011; Fusaro et al., 2018; North & Smith, 1994). Pathways to houselessness for individuals of color are more likely to include barriers to housing resources, discrimination within service provision, and multisystemic involvement whereas White identifying individuals are more likely to report substance use and mental health conditions that contribute to housing instability (Austin et al., 2008; North & Smith, 1994; Olivet et al., 2021). This level of nuance could not be captured in this study due to limitations in recording demographic information.

Second, bias may have been introduced to the measurement of the prevalence of psychiatric symptoms with the PHQ-9, GAD-7, and PC-PTSD 5 Screen when the data was collected, as clinicians were able to choose which screeners based on client presentation and
reason for referral. Thus, the results from the analysis are likely not representative of the entire LifeMoves client base but provide important information regarding the distribution of symptom severity in a subset of the group. Moving forward, clinicians are encouraged to administer all screening tools available to understand the entirety of the clinical picture for all individuals seeking treatment.

Based on the limited data set, common in a secondary data analysis, the number of variables available for predictors was limited. Both gender and number of people in the household, used as predictors, may have better served as covariates. Future research and program evaluations should consider alternative predictors that may be more related to variation in both symptom profiles and exits to stable housing. Previous literature suggests individual factors such as relationship status, psychiatric diagnosis, and drug use can predict exits to stable and unstable housing, and therefore should be considered in future analyses (Nilsson et al., 2019).

Any study examining length of treatment with unhoused individuals may be impacted by difficulty in treatment retention rates within this population. This study did not find any significant association between units of mental health service provided and exiting the LifeMoves program to stable housing, despite existing literature suggesting a positive relationship between the two (Lo et al., 2022; McGuire et al., 2010; Pollio et al., 1997; Stergiopoulos et al., 2008). As mentioned previously, it is possible this data set was limited by clients dropping out of therapy before their housing outcomes could be impacted positively and are therefore not captured in these data.

The generalizability of the qualitative phase of the study was limited by a small sample size of 6. Additionally, the convenience purposive method of recruitment likely introduced bias
in perspectives in that individuals willing to participate in interviews may have had generally positive experiences with therapy at LifeMoves and thus felt more comfortable sharing their thoughts and experiences. While saturation was achieved with the data collected (Saunders et al., 2017), each experience of living unhoused is unique and multifaceted. Six interviews could not capture the totality of LifeMoves clients’ experiences, nor is it sufficient to represent the experience of living unhoused as a whole. This phenomenon varies significantly based on geographic location and socio-political environment. However, the inclusion of personal perspectives is imperative in order to provide context for quantitative data and promote research that is grounded in stakeholder experience.

**Researcher’s Positionality**

This researcher is a White, cisgender woman pursuing a career in clinical psychology. While she does not have the experience of living unhoused or housing instability, she has an extensive history of providing mental health services to people experiencing houselessness throughout training. She served as a therapist with LifeMoves from 2020-2021 as part of her practicum experience and became familiar with the organization throughout that time. This was particularly important in developing relationships with LifeMoves leadership to identify needs of the organization to be addressed in a program evaluation. Additionally, her affiliation with LifeMoves may have increased clients’ comfort level during the qualitative phase of the research, as many participants communicated general distrust of the system. Lastly, the researcher’s knowledge of the experience of a clinician and the structures in place at LifeMoves were integrated throughout the Clinical Implications section, in order to increase the feasibility of implementation of recommendations.
Future Directions and Conclusion

The experience of living unhoused must continue to be explored from the viewpoint of those who are living it first-hand, with consideration of how it varies on the individual, subgroup, and geographic level. This is particularly important for researchers conducting program evaluations with the intention of implementing systemic and organizational change, as often the voices of stakeholders are left out of the conversation (Padwa et al., 2023). Quantitative data alone is not sufficient to accurately capture the complexity and nuances of living unhoused, requiring researchers to explore parts of the experience that may not fit neatly into a quantitative analysis in order to enact meaningful change. Through including this community’s personal perspectives in future research, the field of clinical psychology can ensure interventions and resources are tailored, relevant, and impactful.
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## Tables

**Table 1**  
*Definitions of Exits to Stable and Unstable Housing*

<table>
<thead>
<tr>
<th>Exit to Stable Housing</th>
<th>Exit to Unstable Housing</th>
</tr>
</thead>
</table>
| **Stable Institutional Setting**  
  Substance abuse treatment facility or detox center |  
  **Unstable Institutional Setting**  
  Hospital or other residential non-psychiatric medical facility  
  Jail, prison, or juvenile detention facility |
| **Stable Temporary Housing**  
  Transitional housing for homeless persons.  
  Staying or living with friends, temporary tenure (e.g., room, apartment, or house.  
  Staying or living with family, temporary tenure (e.g., room, apartment, or house. |  
  **Unstable Temporary Housing**  
  Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside |
| **Stable Permanent Housing (90+ days)**  
  Staying or living with family, permanent tenure.  
  Staying or living with friends, permanent tenure.  
  Rental by client, with GDP TIP housing subsidy.  
  Rental by client, with VASH housing subsidy.  
  Rental by client, with RRH or equivalent subsidy  
  Rental by client, no ongoing housing subsidy.  
  Rental by client, with other ongoing housing subsidy.  
  Owned by client, with ongoing housing subsidy.  
  Owned by client, no ongoing housing subsidy. |
Table 2
*Quantitative Phase Demographic Characteristics (N = 398)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Identity (n = 391)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>245</td>
<td>62.7</td>
</tr>
<tr>
<td>Male</td>
<td>143</td>
<td>36.6</td>
</tr>
<tr>
<td>Gender non-conforming</td>
<td>3</td>
<td>.8</td>
</tr>
<tr>
<td>Race (n = 386)</td>
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<td></td>
</tr>
<tr>
<td>White</td>
<td>253</td>
<td>67.3</td>
</tr>
<tr>
<td>American Indian, Alaska Native, or Indigenous</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Asian or Asian American</td>
<td>12</td>
<td>3.2</td>
</tr>
<tr>
<td>Black, African American, or African</td>
<td>56</td>
<td>14.9</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>16</td>
<td>4.3</td>
</tr>
<tr>
<td>Bi-racial</td>
<td>24</td>
<td>6.4</td>
</tr>
<tr>
<td>Ethnicity (n = 392)</td>
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<td></td>
</tr>
<tr>
<td>Hispanic/Latin/a/o/x/e</td>
<td>172</td>
<td>43.9</td>
</tr>
<tr>
<td>Non-Hispanic/Non-Latin/a/o/x/e</td>
<td>220</td>
<td>56.1</td>
</tr>
<tr>
<td>Relationship to Head of Household (n = 398)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>381</td>
<td>95.7</td>
</tr>
<tr>
<td>Child</td>
<td>5</td>
<td>1.3</td>
</tr>
<tr>
<td>Spouse or Partner</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Age (n = 398)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>43.8</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>12.9</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Due to missing data, the sample size for each variable differs. The sample size for each variable is noted beside the variable name.
### Table 3

*Quantitative Sample Case Information (N = 398)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Status (n = 397)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>165</td>
<td>41.6</td>
</tr>
<tr>
<td>Closed</td>
<td>232</td>
<td>58.4</td>
</tr>
<tr>
<td><strong>County (n = 397)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Santa Clara</td>
<td>243</td>
<td>61.2</td>
</tr>
<tr>
<td>San Mateo</td>
<td>154</td>
<td>38.8</td>
</tr>
<tr>
<td><strong>Placed in Stable Housing after Closed Case (n = 232)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>162</td>
<td>69.8</td>
</tr>
<tr>
<td>No</td>
<td>70</td>
<td>30.2</td>
</tr>
<tr>
<td><strong>Length of Stay (Days) (n = 396)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>277</td>
<td>282</td>
</tr>
<tr>
<td># of Household Members (n = 397)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.33</td>
<td>1.85</td>
</tr>
<tr>
<td>Provided Service Count * (n = 398)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>8.25</td>
</tr>
<tr>
<td>Provided Service Hours b (n = 398)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.5</td>
<td>8.23</td>
</tr>
</tbody>
</table>

* Provided service count refers to the number of individual or family therapy sessions a client has had.

b Provided service hours refers to the number of hours the client has spent in individual or family therapy.
Table 4
Symptom Prevalence Measured by GAD-7, PHQ-9, ACES, and PC-PTSD-5 \((N = 398)\)

<table>
<thead>
<tr>
<th>Screener</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAD-7(^a)</td>
<td>73</td>
<td>10.73</td>
<td>5.7</td>
<td></td>
</tr>
<tr>
<td>Minimal</td>
<td>12</td>
<td>16.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>18</td>
<td>24.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>21</td>
<td>28.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>22</td>
<td>30.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9(^b)</td>
<td>54</td>
<td>11.91</td>
<td>7.49</td>
<td></td>
</tr>
<tr>
<td>Minimal</td>
<td>12</td>
<td>22.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>9</td>
<td>16.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>13</td>
<td>24.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately Severe</td>
<td>11</td>
<td>20.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>9</td>
<td>16.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC-PTSD-5(^c)</td>
<td>66</td>
<td>2.79</td>
<td>1.92</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>16</td>
<td>24.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>93</td>
<td>4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>66</td>
<td>9.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>112</td>
<td>18.2</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>12</td>
<td>18.2</td>
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<td></td>
</tr>
<tr>
<td>5</td>
<td>17</td>
<td>25.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACES(^d)</td>
<td>149</td>
<td>4.46</td>
<td>2.83</td>
<td></td>
</tr>
<tr>
<td>Low-Intermediate Risk for Toxic Stress (0-3)</td>
<td>58</td>
<td>38.9</td>
<td></td>
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</tr>
<tr>
<td>High Risk for Toxic Stress (4+)</td>
<td>91</td>
<td>61.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)GAD-7 refers to the Generalized Anxiety Disorder Scale-7 from Spitzer et al., 2006
\(^b\)PHQ-9 refers to the Patient Health Questionnaire-9 from Kroenke et al., 2001
\(^c\)PC-PTSD-5 refers to the Primary Care PTSD Screen for DSM 5 from Prins et al., 2016
\(^d\)ACES refers to the Adverse Childhood Experiences Scale from Felitti et al., 1998; Ranges for ACES Scores based on suggestions from the Office of the California Surgeon General (2020).
Table 5
Reliability Analysis PHQ-9, GAD-7, and ACES

<table>
<thead>
<tr>
<th>Screener</th>
<th>Cronbach’s α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Health Questionnaire-9 (PHQ-9)</td>
<td>.86</td>
</tr>
<tr>
<td>Generalized Anxiety Scale-7 (GAD-7)</td>
<td>.83</td>
</tr>
<tr>
<td>Adverse Childhood Experiences Scale</td>
<td>.8</td>
</tr>
<tr>
<td>Variable</td>
<td>B</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td><strong>PHQ-9</strong></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>2.36</td>
</tr>
<tr>
<td>Single Adult vs. w/ Family</td>
<td>1.81</td>
</tr>
<tr>
<td><strong>GAD-7</strong></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>-0.17</td>
</tr>
<tr>
<td>Single Adult vs. w/ Family</td>
<td>1.99</td>
</tr>
<tr>
<td><strong>PC-PTSD Screen 5</strong></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>-0.12</td>
</tr>
<tr>
<td>Single Adult vs. w/ Family</td>
<td>-0.07</td>
</tr>
<tr>
<td><strong>ACEs</strong></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>-1.01</td>
</tr>
<tr>
<td>Single Adult vs. w/ Family</td>
<td>0.69</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001
Table 7
*t-test Results Comparing Male and Female Mean Scores on Mental Health Measures*

<table>
<thead>
<tr>
<th>Screener</th>
<th>Males</th>
<th>Females</th>
<th>t</th>
<th>p</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>PHQ-9</td>
<td>12.7</td>
<td>7.54</td>
<td>10.9</td>
<td>7.15</td>
<td>-0.910</td>
</tr>
<tr>
<td>GAD-7</td>
<td>10.2</td>
<td>5.27</td>
<td>11</td>
<td>5.95</td>
<td>0.523</td>
</tr>
<tr>
<td>PC-PTSD-5</td>
<td>2.71</td>
<td>1.94</td>
<td>2.81</td>
<td>1.94</td>
<td>0.199</td>
</tr>
<tr>
<td>ACES</td>
<td>3.63</td>
<td>2.52</td>
<td>4.94</td>
<td>2.90</td>
<td>2.769</td>
</tr>
</tbody>
</table>

*p < .05, ** p < .01, *** p < .001*
Table 8

t-test Results Comparing Single Adult and Non-Single Adult Mean Scores on Measures

<table>
<thead>
<tr>
<th>Screener</th>
<th>Single Adults</th>
<th>Non-Single Adults</th>
<th>t</th>
<th>p</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>PHQ-9</td>
<td>11.61</td>
<td>7.77</td>
<td>12.30</td>
<td>7.25</td>
<td>-0.333</td>
</tr>
<tr>
<td>GAD-7</td>
<td>9.69</td>
<td>5.71</td>
<td>11.73</td>
<td>5.59</td>
<td>-1.540</td>
</tr>
<tr>
<td>PC-PTSD-5</td>
<td>2.82</td>
<td>1.99</td>
<td>2.75</td>
<td>1.87</td>
<td>0.155</td>
</tr>
<tr>
<td>ACES</td>
<td>3.92</td>
<td>2.73</td>
<td>5.01</td>
<td>2.84</td>
<td>-2.394</td>
</tr>
</tbody>
</table>

*p < .05, ** p < .01, *** p < .001
Table 9

Regressions of Associations Between Exiting to Stable Housing and Provided Therapy Services

<table>
<thead>
<tr>
<th>Variable</th>
<th>Exp(B)</th>
<th>95% CI for Exp(B)</th>
<th>B</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.982</td>
<td>0.958</td>
<td>1.01</td>
<td>-0.0186</td>
</tr>
<tr>
<td>Single Adult vs. w/ Family</td>
<td>1.134</td>
<td>0.913</td>
<td>1.41</td>
<td>0.1255</td>
</tr>
<tr>
<td>Therapy Count</td>
<td>0.898</td>
<td>0.757</td>
<td>1.07</td>
<td>-0.1072</td>
</tr>
<tr>
<td>Therapy Hours</td>
<td>1.139</td>
<td>0.952</td>
<td>1.36</td>
<td>0.1302</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001
Table 10

*Pearson’s r of Mental Health Screener Scores*

<table>
<thead>
<tr>
<th>Screener</th>
<th>PC-PTSD-5</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>ACES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC-PTSD-5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>0.521*</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>GAD-7</td>
<td>0.480*</td>
<td>0.808***</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ACES</td>
<td>0.418*</td>
<td>0.700***</td>
<td>0.690***</td>
<td>-</td>
</tr>
</tbody>
</table>

* p < .05, ** p < .01, *** p < .001
### Table 11

*Regressions of Associations Between Exiting to Stable Housing and Screener Scores*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Exp(B)</th>
<th>95 % CI for Exp(B)</th>
<th>B</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.02</td>
<td>-4.19</td>
<td>5.47</td>
<td>0.05</td>
</tr>
<tr>
<td>Gender</td>
<td>-1.591</td>
<td>-4.24</td>
<td>1.05</td>
<td>1.35</td>
</tr>
<tr>
<td>Single Adult vs. w/ Family</td>
<td>-0.079</td>
<td>-0.31</td>
<td>0.15</td>
<td>0.11</td>
</tr>
<tr>
<td>GAD-7</td>
<td>0.467</td>
<td>-0.29</td>
<td>1.22</td>
<td>0.38</td>
</tr>
<tr>
<td>PC-PTSD-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, ** p < .01, *** p < .001*
Table 12
Qualitative Sample Demographic Characteristics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender Identity</th>
<th>Race/Ethnicity</th>
<th>Age</th>
<th>Number of People on Caseload</th>
<th>Number of Therapy Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 (Cole)</td>
<td>Male</td>
<td>Caucasian</td>
<td>56</td>
<td>Single Adult</td>
<td>12 Sessions</td>
</tr>
<tr>
<td>P2 (Andres)</td>
<td>Male</td>
<td>Latinx</td>
<td>52</td>
<td>Single Adult</td>
<td>~21 Sessions</td>
</tr>
<tr>
<td>P3 (Ada)</td>
<td>Female</td>
<td>African</td>
<td>28</td>
<td>Single Adult</td>
<td>12 Sessions</td>
</tr>
<tr>
<td>P4 (Daniel)</td>
<td>Male</td>
<td>African American</td>
<td>19</td>
<td>Single Adult</td>
<td>12 Sessions</td>
</tr>
<tr>
<td>P5 (Shoshana)</td>
<td>Female</td>
<td>African American</td>
<td>29</td>
<td>4 Household Members</td>
<td>4 Sessions</td>
</tr>
<tr>
<td>P6 (John)</td>
<td>Male</td>
<td>Caucasian</td>
<td>64</td>
<td>Single Adult</td>
<td>3 Sessions</td>
</tr>
<tr>
<td>Themes</td>
<td>Definition</td>
<td>Subthemes</td>
<td>Codes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Journey” to LifeMoves</td>
<td>Events that occurred or related to before the client connected with mental health services at LifeMoves</td>
<td>General Codes</td>
<td>“journey” to get to LifeMoves Connection through other organization Navigating resources Reliance on informal networks Impacted system Connection with LM after loss or forced movement Looking back on success “begging” for services Confusion of system Lack of knowledge about resources/access</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Iterations of success and loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knowledge of needs, lack of access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seamless Connections</td>
<td>Experience of service initiation with therapy at LifeMoves</td>
<td>No subthemes</td>
<td>Connection through Case Manager Connection through other providers Knowledge of needs prior to service initiation Client given agency over treatment Exposure to therapy through milieu Staff turnover as barrier Connection amidst chaos of houselessness Casual service initiation Asking for services directly Easy, automatic connection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Importance of Trust in Initial Contact</td>
<td>Experience of client trusting therapist and how trust is communicated</td>
<td>General Description</td>
<td>Uneasy, nervous Mixed emotions during first session Excitement Increasing comfort through in-person services “Testing” therapist Transparency Creating a calm environment (vs. chaos of houselessness) Seeing therapist as “real person” Privacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dynamic Needs of the Unhoused</td>
<td>Experiences not directly related to therapy but relevant to client treatment</td>
<td>General Description</td>
<td>Changing needs based on circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits of Therapy at Life Moves</td>
<td>Positive experiences specifically related to therapy</td>
<td>No subthemes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------</td>
<td>---------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-Going Trauma of Living Unhoused</td>
<td>Tailored to client personality/story triggers</td>
<td>Shock of transition from “mainstream” Shelter as traumatic Trauma from the system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible In-Person Modality</td>
<td>Preference for in-person</td>
<td>In-Person making therapist “real” Both in-person and virtual Flexibility, working with schedule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Areas for Growth</td>
<td>Client feedback on areas for improvement</td>
<td>No subthemes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Knowing when to push Good connection with therapist</td>
<td>Therapist regulating chaos Therapist open, engaged, and flexible Therapist as a guide Approachable therapist Therapist as understanding Therapist matching client Feeling heard and having autonomy Therapist presence on-site decreasing barriers Coping tools/mindfulness Casual nature of services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>More broad education/coping Education on available services Increasing safety/privacy</td>
<td>Solution/Future focused approach</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix A

Memorandum of Understanding
Memorandum of Understanding

This Memorandum of Understanding (MOU) is entered into by and between: Emi Caprio of the University of San Francisco, Dr. Kathryn Woicicki of LifeMoves, and Dr. Brian Greenberg of LifeMoves.

A. Purpose. The purpose of this MOU is to establish an agreement among the above-mentioned parties and define roles and responsibilities. Emi Caprio (“Researcher”), Dr. Kathryn Woicicki, and Dr. Brian Greenberg have created a partnership to evaluate clients and client experiences within the Behavioral Health Program. The information from this project will be communicated back to LifeMoves and Behavioral Health Program leadership to inform decisions regarding program structure and training. This research project will also serve as Emi Caprio’s clinical dissertation, which is required for successful matriculation from the Doctor of Clinical Psychology (PsyD) program at the University of San Francisco.

B. Roles and Responsibilities.

Emi Caprio agrees to:

● Analyze quantitative data to discern demographic characteristics, symptom prevalence, subgroup variation of symptom prevalence, inter-item reliability of the chosen screeners, and the relationship between number of therapy sessions and exits to stable housing among LifeMoves clients.

● Communicate with student therapists to recruit participants to engage in the qualitative analysis data collection portion.
  ○ Distribute consent forms to student therapists to complete with their clients.
  ○ Provide $10 Visa gift cards to each participant as compensation for participation in the study.

● Analyze qualitative data collected from interviews with clients and locate themes related to accessing mental health services.

● Provide LifeMoves staff with results of the proposed study in a format to be determined through ongoing conversation with the researcher.

LifeMoves agrees to:

● Provide data from LifeMoves’ client management system, including electronic health records, within specific parameters outlined by the researcher.

● Facilitate communication between the researcher and student trainees in order to aid recruitment.

● Continually collaborate with the researcher to communicate program needs as the project progresses.

C. Reporting Requirements. Emi Caprio will be responsible for transmitting consent documents to student clinicians once potential participants have been identified. Emi Caprio will also be responsible for collection, transcribing, storing, and analyzing data collected during the interviews with LifeMoves clients. LifeMoves will be responsible for compiling the requested quantitative data and providing it to the researcher. Emi Caprio will present a summary of findings and recommendations at the conclusion of data collection and analysis.
D. **Funding.** Emi Caprio will provide participants with incentives ($10 Visa gift cards) at the conclusion of their interview, by mailing them to the client’s preferred address.

E. **Timeframe.** This MOU will be in effect from December 1, 2021 to July 1, 2023.

F. **Confidentiality.** In order to safeguard the privacy of clients and participants, all parties to the memorandum will agree to adhere to the confidentiality expectations as outlined by the University of San Francisco Institutional Review Board policies. This Memorandum of Understanding is the complete agreement between Emi Caprio (University of San Francisco), Dr. Kathryn Woicicki (LifeMoves), and Dr. Greenberg (LifeMoves). This document can only be amended through written agreement signed by each of the above parties. The MOU must be signed by all partners.

AGENCY A
Authorized Official:

Signature

Emi Caprio, Principal Investigator

Printed Name and Title

Address: University of San Francisco, 2130 Fulton Street, San Francisco CA, 94117
Telephone: 925-36-3424
E-mail Address: ehcario@dons.usfca.edu

AGENCY B
Authorized Official:

Signature

Kathryn Woicicki, PsyD, Director of Behavioral Health

Printed Name and Title
Appendix B

Patient Health Questionnaire-9 (Kroenke et al., 2001): Quantitative Phase
### Patient Health Questionnaire - 9 (PHQ-9)

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

(Use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**For office coding:** 0 + 0 + 0 + 0 + 0

=Total Score: 0

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
Appendix C

Generalized Anxiety Scale-7 (Spitzer et al., 2006): Quantitative Phase
# Generalized Anxiety Disorder 7-Item (GAD-7) Scale

**Case#: 000  Date: ______________**

**Over the last 2 weeks, how often have you been bothered by the following problems?**

<table>
<thead>
<tr>
<th>Feeling nervous, anxious, or on edge</th>
<th>Not at All</th>
<th>Several Days</th>
<th>Over Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not being able to stop or control worrying</th>
<th>Not at All</th>
<th>Several Days</th>
<th>Over Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Worrying too much about different things</th>
<th>Not at All</th>
<th>Several Days</th>
<th>Over Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trouble relaxing</th>
<th>Not at All</th>
<th>Several Days</th>
<th>Over Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Being so restless that it is hard to sit still</th>
<th>Not at All</th>
<th>Several Days</th>
<th>Over Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Becoming easily annoyed or irritable</th>
<th>Not at All</th>
<th>Several Days</th>
<th>Over Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling afraid as if something awful might happen</th>
<th>Not at All</th>
<th>Several Days</th>
<th>Over Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td></td>
</tr>
</tbody>
</table>

| Add Scores for Each Column: | 0 + 0 + 0 + 0 + 0 |

**Total Score (Sum of Column Scores):** 0

**If any of the above problems were identified, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?**

□ Not Difficult at All  □ Somewhat Difficult  □ Very Difficult  □ Extremely Difficult

---

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Appendix D

Primary Care PTSD Screen for DSM-5 (Prins et al., 2016): Quantitative Phase
### Post-Traumatic Stress Disorder Test - PC-PTSD-5 Screen

<table>
<thead>
<tr>
<th>Have you ever experienced any event(s) that was/were so frightening or upsetting that, in the past month you have…</th>
<th>No (0)</th>
<th>Yes (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Been constantly on guard, watchful, or easily startled?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Felt numb or detached from people, activities, or your surroundings?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Total Score: 0**

---

**Reference**

Appendix E

Adverse Childhood Experiences Scale (Filetti et al., 1998): Quantitative Phase
Adverse Childhood Experiences Scoring

There are 10 types of childhood trauma measured in the ACE Study.
- Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect.
- Five are related to other family members: a parent who’s an alcoholic, a mother who’s a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment.

Each type of trauma counts as one. So a person who’s been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.

There are many other types of childhood trauma — watching a sibling being abused, losing a caregiver (grandmother, mother, grandfather, etc.), homelessness, surviving and recovering from a severe accident, witnessing a father being abused by a mother, witnessing a grandmother abusing a father, etc. The ACE Study includes only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature.

The most important thing to remember is that the ACE score is meant as a guideline: If other types of toxic stress were experienced over months or years, then those would likely increase the risk of health consequences.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   
   No___ If Yes, enter 1

2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   
   No___ If Yes, enter 1

3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   
   No___ If Yes, enter 1

4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other?
   
   No___ If Yes, enter 1.
5. Did you often or very often feel that ... You didn’t have enough to eat, had to wear dirty
clothes, and had no one to protect you? or Your parents were too drunk or high to take
care of you or take you to the doctor if you needed it?

   No   If Yes, enter 1 ___

6. Were your parents ever separated or divorced?

   No___   If Yes, enter 1

7. Was your mother or stepmother:

   Often or very often pushed, grabbed, slapped, or had something thrown at her? or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   No   If Yes, enter 1 ___

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street
drugs?

   No   If Yes, enter 1 ___

9. Was a household member depressed or mentally ill, or did a household member attempt
suicide?

   No___   If Yes, enter 1

10. Did a household member go to prison?

    No   If Yes, enter 1 ___

Total “Yes” answers:

ACEs Score: ________________________
Appendix F

Participant Contact Form: Qualitative Phase
Thank you for your interest in participating in this research study. I am excited to hear more about your experience receiving mental health services at LifeMoves. Our next step is to schedule your 30- to 45- minute interview. Please provide your preferred method of contact at the bottom of this page. I will be reaching out to you within the next week to schedule the interview.

If you would like, you can reach out to me to schedule your interview. You can contact me by phone or email:

Emi Caprio

Phone: 925-360-3424

E-mail: ehcaprio@dons.usfca.edu

Please return the bottom half of this form to the researcher

Participant Name:

Participant Phone Number:

Participant E-mail:

Which is your preferred method of communication?

☐ Phone

☐ E-mail
Appendix G

Consent Form: Qualitative Phase
CONSENT TO PARTICIPATE IN A RESEARCH STUDY
Below is a description of your rights as a participant in this research study and a description of what is being asked of you. You are encouraged to read this information carefully. If at the end of reading this, you would like to participate, please sign on the space provided. Signing indicates that you have read and understand the information on this consent form. You will receive a copy of this form upon your request.
You have been referred to participate in a research study conducted by Emi Caprio, a graduate student in the Doctor of Clinical Psychology Program at the University of San Francisco. The faculty supervisor for this study is Dr. Dellanira Garcia, a professor in the Doctor of Clinical Psychology Program at the University of San Francisco.

WHAT IS THIS STUDY ABOUT:
The goal of the research study is to better understand the clients who are receiving mental health services through LifeMoves. You have been selected for this study because you have attended at least four sessions of individual therapy with the Behavioral Health Program. I have partnered with LifeMoves to measure a wide range of client characteristics and collect information on client experience. The goal is to eventually help the Behavioral Health Program make decisions about how to better train their student therapists.

WHAT WE WILL ASK YOU TO DO:
During this study you will be asked to participate in an audio recorded 30-45 minute interview that will be scheduled with the researcher. During the interview, you will be asked questions about accessing mental health services through LifeMoves. You will not be asked to discuss or disclose details about your work in therapy.

DURATION AND LOCATION:
Participation in this study will require a single interview lasting 30-45 minutes.

POTENTIAL RISKS AND DISCOMFORTS:
Because the questions about mental health treatment are general and do not require the disclose of any details, we do not anticipate any risk or discomfort from participating in this research study. However, there is always potential for emotional discomfort when discussing matters related to therapy. If you begin to feel distress at any point during the study, you have the option to withdrawal your consent to participate. You will not be penalized for choosing to withdrawal consent. You may also reach out to the following resources for additional support:

- CalHOPE Warm Line: (833) 317-4673
- California Peer-Run Warm Line: 1-855-845-7415
- NAMI HelpLine: 1-800-950-6264
  - Hours of operation: Mon-Fri 10am-10pm EST
- Santa Clara County Suicide & Crisis Hotline: 1-855-278-4204
**BENEFITS/COMPENSATION:**
Upon completion of the interview, you will be given a $20 gift Visa gift card. Additionally, you will have the opportunity to process your experience in therapy thus far and enact positive change for LifeMoves clients in the future.

**PRIVACY AND CONFIDENTIALITY:**
Any information collected in this study will be kept confidential, meaning that it cannot be used to identify you or any other participants. The only exception to this is if disclosure of information is required by law.

All paperwork will be stored in a secure and locked file cabinet where only I will have key access. Copies of informed consent forms will be stored in the locked file for three years as prescribed by the University of San Francisco Internal Review Board.

**AUDIO RECORDINGS**
As a part of this study, your participation in the phone-based interview will be audio recorded so that the researcher can accurately track and include your responses. The researcher will be utilizing Zoom to record the audio and export it to transcript format. No identifying information will be included with the recording or the transcript. The recordings will be transcribed by the researcher and deleted immediately after transcription. Portions of the transcript may be used, partially or in whole, in order to communicate results from this study. No identifying information (e.g., name, voice, age) will be included in these reproductions. All audio recordings collected from the interviews will be password protected on the researcher’s computer until they can be transcribed.

**COMPENTATION/PAYMENT FOR PARTICIPATION**
You will receive a $10 Visa gift card for your participation in this study. If you choose to withdraw before completing the study, you will not receive any compensation.

**VOLUNTARY NATURE OF THE STUDY**
Your participation is voluntary and you may refuse to participate without being punished in any way. Additionally, you may skip any questions in the interview that make you uncomfortable and you may discontinue your participation at any time without penalty. If you choose to withdraw, the service you receive from LifeMoves will not be impacted in any way.

**OFFER TO ANSWER QUESTIONS:**
Please ask any questions you have now. If you have questions later, you should contact the researcher: Emi Caprio at 925-360-3424 or ecaprio@dons.usfca.edu. You may also contact Dr. Dellanira Garcia at dgarcia12@usfca.edu. If you have any questions about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu.

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.
EVALUATION OF CBO SERVING UNHOUSED ADULTS

PARTICIPANT'S PRINTED NAME

DATE

PARTICIPANT'S SIGNATURE

DATE
Appendix H

Interview Schedule: Qualitative Phase
Introduction
“Thank you so much for agreeing to speak with me, I really appreciate your input. Before we get started, I wanted to introduce myself and say a little bit about the study. My name is Emi Caprio, and I am a doctoral student at the University of San Francisco. With this project, I am trying to better understand clients’ experiences receiving mental health services at LifeMoves, so that I can help them make decisions on how to improve the program. My plan is to ask you a series of questions over the next 30 to 45 minutes to understand your experiences with receiving behavioral health services at LifeMoves. Do you have any questions for me before we get started?”

Informed Consent
“I will be audio recording our conversation, but I want to assure you that your name or other identifying information will not be associated with the recording or the transcript in any way. This means that anything you say will remain confidential. You can either make up a name to use throughout the interview or we can use your actual name, and I will remove it from the transcripts later. Which would you prefer?”

“While there is minimal risk to your participation in this interview, there could be some questions that may cause mild emotional discomfort. If you do experience any distress or discomfort, you can choose to skip any question. Because this is voluntary, you can also withdrawal your consent to participate at any time. Do you have questions about any of this?”

“If you’re ok with moving forward, I’m going to go ahead and start the recording. (Omit next phrase if participant chooses to use their name) Remember, we are using a fake name for you throughout the interview to protector your privacy”

Researcher begins audio-recording with participant permission

Opening Questions
“So, to start us off, can you tell me a little bit about why you decided to participate in this study?”
- How long have you been with LifeMoves?
- How did you initially get connected with LifeMoves?
- When did you begin receiving mental health services at LifeMoves?

Initial Contact with Mental Health Provider
“With this next set of questions, I want to hear specifically about your experience getting in contact with your therapist”
- How did you learn about the mental health services that LifeMoves offers?
- What was it like getting in contact with your therapist?
  o Probes: Was it easy to get in contact with your therapist? Was it hard? What made it so?
- What was it like to meet with your therapist for the first time?
  o Probe: What kind of emotions did you experience when you first met with your therapist?
  o What did you think about the services you received at this session?”
- Is there anything that you believe could have improved your experience during the first meeting with your therapist?

Therapy Experience
“Thank you for sharing those parts of your experience with me. Next, I’m curious about what it has been like for you while you’ve been receiving mental health services with your therapist?”

- How/where have you been meeting with your therapist?
  - Probe: Have you been meeting in-person or via telehealth? Which do you prefer? Why?
- Do you feel like the various identities you hold have been taken into account throughout your time receiving mental health services?
  - Probe: How has this impacted your experience?

Moving Forward
“Everything you have shared with me so far has been incredibly helpful, so thank you for being willing to speak with me about this. As a final topic of our conversation, looking back, I’m curious to hear in what ways do you feel like your needs have been met by the therapy services provided by LifeMoves?”

- In what ways could your services have been improved?
  - Probe: What do you wish had been available to you that wasn’t?
- What aspects of the mental health services you received did you find most beneficial?
- What aspects of the mental health services you received did you find were not very helpful to you?
- Would you recommend these services to people you know? Why or why not?

Closing
“Is there anything else that you feel like you want to share that we have not discussed today?”

Researcher stops audio recording
Researcher asks if they would like to be connected with any community or LifeMoves resources
Researcher thanks participant and provides a $20 Visa gift card for their participation