Routledge
Taylor & Francis Group

Social Work in Mental Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wsmh20

# Homeless, hopeless, and hungry in Central Virginia: a case study on a wrap-around intervention targeting youth homelessness

Jennifer Smith Ramey, Lora Passetti & Adedamola Onafowokan

**To cite this article:** Jennifer Smith Ramey, Lora Passetti & Adedamola Onafowokan (2021) Homeless, hopeless, and hungry in Central Virginia: a case study on a wrap-around intervention targeting youth homelessness, Social Work in Mental Health, 19:3, 203-219, DOI: 10.1080/15332985.2021.1894630

**To link to this article:** https://doi.org/10.1080/15332985.2021.1894630

Published online: 18 Mar 2021.

Submit your article to this journal

Article views: 160

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=wsmh20

SOCIAL WORK IN MENTAL HEALTH
2021, VOL. 19, NO. 3, 203–219
https://doi.org/10.1080/15332985.2021.1894630

# Homeless, hopeless, and hungry in Central Virginia: a case study on a wrap-around intervention targeting youth homelessness

Jennifer Smith Ramey EdS[a], Lora Passetti MS[b], and Adedamola Onafowokan MA[a]

[a]Outpatient Portfolio, Horizon Behavioral Health, Lynchburg, Virginia, USA; [b]Chestnut Health Systems, Lighthouse Institute, Bloomington, Indiana, USA

**ABSTRACT**

Driven by the increasing number of homeless youth and young adults in Central Virginia and a lack of resources for this population, a Community Service Board (CSB) formed Cooperative Agreements to Benefit Homeless Individuals (CABHI), a multidisciplinary program to address these problems, which included mental health and substance use, housing, and employment. The purpose of this article is to present a case study of the development and accomplishmentsand to relate the development and accomplishments of CABHI to the literature on youth and young adult homelessness, which may provide generalized lessons that other agencies may consider when addressing youth homelessness.

**KEYWORDS**

Youth; young adults; homelessness; mental health; substance use; case study

Youth and young adult homelessness is characterized by vulnerability. Notably, a correlation exists between youth homelessness and a lack of a high school diploma or General Education Development (GED). Often behavioral healthcare service access for older adolescents and young adults is challenging because funding streams change as youth turn 18, and services are often not tailored to meet the unique developmental needs of this population. When homelessness is overlaid with these challenges, a crisis in this underserved population may ensue as research indicates 12.5% of young adults between the ages of 18–25 have experienced some form of homelessness in the United States (Morton et al., 2018).

Because the numbers of homeless youth and young adults were increasing in Central Virginia, there was a need for the development of a wrap-around program to address the dearth of resources and to increase access to needed services. Through federal funding, a Community Service Board (CSB), Horizon Behavioral Health, formed Cooperative Agreements to Benefit Homeless Individuals (CABHI), a multi-disciplinary wrap-around program to address mental health and substance use treatment, housing, employment, peer support, and transportation. The purpose of this article is to present

**CONTACT** Jennifer Smith Ramey jennifer.smith.ramey@horizonbh.org Horizon Behavioral Health, 2215 Langhorne Road, Suite 102 B, Lynchburg, VA 24501

© 2021 Taylor & Francis

a case study of the development and accomplishments of CABHI in Central Virginia and to relate the development and accomplishments of CABHI to the literature on youth and young adult homelessness. Lessons learned may provide insight for other agencies addressing youth homelessness.

## Literature review

Research suggests that homeless youth experience challenges accessing health care with barriers including limited clinic hours, transportation, money problems, and access to clinic sites. Furthermore, many homeless youth and young adults reported feeling judged by some professionals and society in general which also likely contributed to underutilization of services (Hudson et al., 2010). The literature points to a promising engagement strategy, including educating primary health care providers of community supports and resources for this population and resourcing interagency collaboration to address the complex needs of homeless youth and young adults (Hudson et al., 2010; Morton et al., 2018).

Some of the aforementioned needs of homeless adolescents and young adults may be a result of a history of problematic and potentially harmful behaviors. Some of the problematic behaviors are called "survival behaviors" and may include prostitution, selling drugs, stealing, selling blood or plasma, and panhandling. These behaviors were found to be correlated with transient young adults who were unemployed and had a substance use disorder, suggesting the importance of a harm reduction approach to reduce transience in the homeless young adult population (Ferguson, Bender, Thompson, Xie, & Pollio, 2011).

Research offers significant predictors of homelessness in young adults including social networks, economic factors, and substance use, pointing to the importance of risk area identification and intervention in this vulnerable population (Gomez, Thompson, & Barczyk, 2010). More specifically, studies have documented alarmingly high rates of child abuse, victimization, and substance use among homeless youth and young adults. Males who experienced parental substance use reported higher rates of a substance use disorder, and individuals who reported more childhood physical and sexual abuse and relationship violence more likely to experience a greater frequency of substance use. Thus, studies point to the need for programs that work with homeless young people to have the necessary tools to address substance use disorders and trauma (Tyler & Melander, 2013). Lastly, patient-related factors (e.g., stigma) were cited as the most common reason for medication noncompliance among homeless youth (Coe et al., 2015).

The research on resiliency and homeless young adults suggests external social supports, individual strengths, positive life perspective, and individual coping strategies as key factors associated with positive future outcomes

(Miller & Bowen, 2019; Rew, Taylor-Seehafer, Thomas, & Yockey, 2001; Thompson et al., 2016). Homeless youth and young adults cited increased satisfaction in agencies that provided youth-specific services and interactions with adults with shared lived experience, such as Peer Recovery Specialists (Hudson et al., 2010; Morton et al., 2018). Furthermore, the use of drop-in centers to engage homeless youth has shown demonstrated results in reducing hard drug usage and improved treatment outcomes versus youth living in shelters (Guo & Slesnick, 2017; Pedersen, Tucker, & Kovalchik, 2016; Slesnick et al., 2016; Slesnick, Prestopnik, Meyers, & Glassman, 2007). This research suggests that drop-in centers may assist homeless young people with accessing external social supports and developing coping strategies. Inasmuch as programs can be tailored to address these factors through provision of client-centered, strength-based interventions that include development of pro-social peers, the unique developmental needs of this population may be addressed.

## Problems that led to the development of CABHI

According to the Central Virginia Continuum of Care (CVCoC), there was a 50% increase in youth homelessness during the annual Point-in-Time (PIT) count in 2018. This represents an average of 81 youth per year accessing emergency shelters in Central Virginia. This population posed both challenges and opportunities for agencies to serve youth with the appropriate interventions and services. First, the youth population tended to be more transient than the adult one and harder to track in the homeless response system. Of the 668 people who accessed the homeless response system in 2018, 19% were children or adolescents, 40% reported a physical or mental health condition at entry into the homeless response system, and 23% reported a mental health or substance use problem as reported through the CVCoC's Homeless Data Information Management System (HMIS). In the Centra Health 2018 Lynchburg Area Community Needs Assessment, the top service identified as "hard to get in the community" was safe and affordable housing.

Driven by these alarming data, the Community Service Board (CSB), Horizon Behavioral Health, received federal funding in September 2017 to implement a wrap-around, multi-disciplinary approach to reduce homelessness in youth and young adults through linkage to permanent stable housing. In order to achieve this ambitious goal, the CSB proposed a multi-disciplinary wrap-around approach that incorporated community partnerships.

The CSB developed CABHI for three purposes: 1) to reduce the number of homeless youth and young adults in the Central Virginia catchment area, 2) to develop and improve services targeted to meet the specific and unique developmental needs of homeless youth and young adults (e.g., vocational support, transportation, behavioral health services), and 3) to enable agencies to work on a common agenda of addressing pressing needs for homeless young people

in Central Virginia, as research indicates that agency relationship development can lead to a greater understanding of how to leverage systematic change (Leonard, 2011).

## How CABHI operated and grew

The CSB leadership developed a staffing plan consisting of a director to oversee daily operations of the team, referral management, and community engagement and outreach. Two therapists were added, both trained in evidence-based substance use and mental health treatment models. The team included two case managers who focused on service coordination and linkage to needed resources (e.g., primary care, food banks, etc.) A housing specialist assisted clients with linkage to both short-term housing and ultimately permanent stable housing. An employment specialist focused on job readiness, skills training, and linkage to employment. Finally, two peer recovery specialists completed the team. The peers were individuals with lived substance use and/or mental health history who were in recovery and able to serve as role models and support for the clients.

One main task of the director was to form a steering committee comprised of community stakeholders to guide and direct the program's goals and strategic planning. The steering committee consisted of individuals from local housing agencies, schools, social services, court services, veterans, private citizens, and the faith-based community. The director developed meeting agendas (see Table 1) and provided updates on project goals at these quarterly meetings because research suggests that structure coupled with accountability supports the long-term sustainability of a collaborative group, such as the steering committee (Walzer, Weaver, & Mcguire, 2018).

The director developed relationships with community partners in order to leverage shared resources, consistent with the research on community collaboration (Provan & Lemaire, 2012; Smith Ramey & Randall, 2020). These relationships simplified referrals and service coordination among the CSB and its community partners (e.g., Salvation Army, Hand Up Lodge, Goodwill). In turn, homeless youth and young adults were able to access services quicker leading to a reduction in days of homelessness, as 97% of CABHI clients referred by community partners were linked to needed services within 7 days by case managers according to program data.

Some of CABHI's benefits include leveraging limited resources in agencies to address homelessness in young people and improving quality of services (Hudson et al., 2010; Morton et al., 2018; Provan & Lemaire, 2012; Smith Ramey & Randall, 2020). CABHI partners have stated that CABHI enables them to accomplish more collectively to address the homeless youth problem than what they could accomplish as a single agency. CABHI partner agencies have cited improvements in their quality and quantity of services with an

**Table 1.** Intake demographic and clinical characteristics (n = 177).

| | n | % |
|---|---|---|
| **Age** | | |
| Under 18 | 17 | 10 |
| 18–19 | 40 | 23 |
| 20–21 | 45 | 25 |
| 22–23 | 38 | 21 |
| 24–25 | 34 | 19 |
| 26 | 2 | 1 |
| 34 | 1 | 1 |
| **Gender** | | |
| Male | 75 | 42 |
| Female | 99 | 56 |
| Transgender | 2 | 1 |
| Non-binary | 1 | 1 |
| **Hispanic** | 15 | 8 |
| **Race** | | |
| Black or African American | 66 | 37 |
| Asian | 3 | 2 |
| Native American | 7 | 4 |
| Native Hawaiian or Pacific Islander | 1 | 1 |
| Alaska Native | 0 | 0 |
| White | 100 | 56 |
| **LGBTQ** | 44 | 25 |
| **Substance Use Past 30 Days** | | |
| Alcohol | 63 | 36 |
| Cocaine/Crack | 13 | 7 |
| Marijuana/Hashish | 61 | 34 |
| Opiates | 13 | 7 |
| Non-prescription Methadone | 2 | 1 |
| Hallucinogens/Psychedelics, PCP, MDMA, LSD, Mushrooms, or Mescaline | 2 | 1 |
| Methamphetamine or Other Amphetamines | 10 | 6 |
| Benzodiazepines | 7 | 4 |
| Barbiturates | 1 | 1 |
| Non-prescription GHB | 0 | 0 |
| Ketamine | 0 | 0 |
| Other Tranquilizers | 2 | 1 |
| Inhalants | 1 | 1 |
| Other Substances | 0 | 0 |
| **IV Drug Use Past 30 Days** | 11 | 6 |
| **Living Arrangements Past 30 Days** | | |
| Shelter | 23 | 13 |
| Street/Outdoors | 13 | 7 |
| Institution | 7 | 4 |
| Own/Rent Apartment, Room, or House | 17 | 10 |
| Someone Else's Apartment, Room, or House | 105 | 59 |
| Hotel/Motel | 5 | 3 |
| Halfway House | 1 | 1 |
| Residential Treatment | 1 | 1 |
| Dorm/College Residence | 2 | 1 |
| Job Corps | 1 | 1 |
| Rent Free Housing | 1 | 1 |
| Assisted Living | 1 | 1 |
| **Currently Pregnant** | 8 | 5 |
| **Currently Enrolled in School or Job Training Program** | 29 | 16 |
| **Currently Employed** | 59 | 33 |
| **On Parole/Probation** | 21 | 12 |
| **Unprotected Sex Past 30 Days** | 53 | 30 |
| **Mental Health Problems Past 30 Days** | | |
| Serious Depression | 138 | 78 |
| Serious Anxiety or Tension | 153 | 86 |
| Hallucinations | 20 | 11 |
| Trouble Understanding, Concentrating, or Remembering | 124 | 70 |
| Trouble Controlling Violent Behavior | 54 | 31 |

(*Continued*)

Table 1. (Continued).

| | n | % |
|---|---|---|
| Attempted Suicide | 13 | 7 |
| Been Prescribed Medication for Psychological/Emotional Problem | 106 | 60 |
| **Lifetime History of Violence or Trauma** | 136 | **77** |

increased range of services and quicker access to services for homeless youth and young adults. Through the development of a wrap-around program focused on the developmental needs of youth and young adults, CABHI has been able to successfully engage and retain clients in services (Miller & Bowen, 2019; Thompson et al., 2016).

Over the course of the three-year project, 177 unduplicated youth and young adults were enrolled in the project evaluation.

## CABHI services

CABHI utilized a wrap-around approach, including housing services, case management, peer support, evidence-based therapy, a drop-in center, and an entitlement specialist. These services are described in more detail below.

### *Housing services*

A housing specialist assisted CABHI clients with linkage to short-term and permanent housing, as the ultimate goal of the program was linkage of homeless youth and young adults to permanent and stable housing. To this end, the housing specialist approached each client by first confirming if they were in a safe environment. At times, clients resided temporarily with a friend or family member who had granted them short-term residence. The housing specialist would then give the clients a brief synopsis of the CABHI program which would include its benefits and its limitations, the most pertinent being that the grant did not allow for the direct payment of rent, late fees, past due rent, or security deposits. The housing specialist could however assist the client in navigating the shelter system and finding the option that would best accommodate their need for temporary shelter. By the time the clients were referred to the program, they were often feeling overwhelmed. The housing specialist was able to facilitate local shelter placement, including checking for bed availability, seeing if there were any criteria the client needed to meet, or placing the clients on a wait-list for a bed, at which point they would be notified once one became available.

Permanent housing provided its own set of unique challenges. The housing specialist would first evaluate the situation that the client was departing from. Since the best possible outcome would be for the client to remain housed, barring a domicile unfit for human habitation, the housing specialist would

inquire as to back rent owed, circumstances for the eviction, and if there was anything that could be done so that housing could be maintained. With an eye toward securing stable permanent housing, the specialist would then inquire about current streams of income, benefits, special or unique needs, desired location, proximity to employment, treatment, and public transportation. Using a combination of scouring the local rental listing websites and using relationships that had been cultivated over the course of the program with landlords and renters, the housing specialist would review various potential apartments, often visiting them with clients to make sure they fit their needs and could be maintained for the long term. The housing specialist also worked with Lynchburg's Rapid Rehousing, which would assist with the first few month's rent payments and provide housing assistance to clients who met the necessary criteria.

The housing specialist, in conjunction with the peer support specialist, would also assist the client in going out to local businesses and charities to secure donations and pledges to help further offset the costs of the initial security deposits or upfront rent fees, as well as connecting clients to local businesses that offered either free or discounted furnishings to help outfit the secured housing. The housing specialist also remained engaged in local community groups and think-tanks consisting of local renters, charities, and social work organizations that maintained current knowledge of the housing/rental market in Lynchburg. This was done to quickly identify and engage with any opportunity to advocate for the expansion of safe and affordable housing in our locality.

Finally, linkage to permanent stable housing posed a challenge throughout the duration of the project. For example, it was markedly more difficult to provide the needed homeless response outreach to county-based clients versus urban clients. The reasons for this challenge ranged from a lack of public transportation to a lack of local resources. Though community partners and peer support specialists were very helpful in closing the gap, it was far easier for county or rural clients to fall through the cracks. As with many elements of homeless outreach, community partners were key in the development of a safety net of resources and services to keep clients engaged and more importantly, keep updated on their whereabouts to be able to check in on their safety and well-being.

### *Case management*

The CABHI case managers performed a variety of functions as part of the wrap-around program. Case managers monitored, assessed, and linked CABHI clients to necessary resources to meet their identified needs. For example, a case manager might link the client to a food pantry to address food insecurity. If a client needed dental treatment, the case manager may

provide linkage to a dentist. Advocacy was a mainstay in the role of a case manager. A case manager may assist a client in advocating for his or her needs through the use of teaching and modeling communication and problem-solving skills. One pertinent example was using positive communication with shelter staff, peers, and landlords. Some challenges encountered by case managers were that homeless clients were far more transient making some of the clients more difficult to locate and evaluate their bevy of needs. The case managers attempted to locate and engage clients and partner with the peer support specialist to ensure the client was connected to the needed support services and treatment options. Case managers' participation in weekly team meetings provided valuable input when it came to identifying client whereabouts, new contact information, and needed services. The case managers provided the clinically focused structure, planning, and guidance needed by CABHI clients and were an excellent counterpart to the informal, more relational approach of peer supports.

### Peer support

Research indicates that peer recovery specialists are associated with improved recovery outcomes (Bassuk, Hanson, Greene, Richard, & Laudet, 2016). The role of the Peer Recovery Specialists (PRS) provided valuable engagement and an entry point for homeless youth and young adults into the wrap-around program. Peers were often a primary point of contact for CABHI clients and the link by which clients engaged with other services such as therapy, case management, and linkage to community partners. The duties of a peer could often run somewhat parallel to the duties of a case manager, with the marked difference that PRS were encouraged to bring their lived experience into the equation as a catalyst and an example to encourage clients to believe that a turnaround was indeed possible. While a case manager might have been perceived by a client as yet another member of their treatment team, the PRS role was perceived by the client as more informal. To this end, maintaining appropriate boundaries was critical. The training and certification process for a Peer Recovery Specialist included a focus on setting and maintaining appropriate boundaries. While engagement with clients was more informal than other treatment team members, the relationship was a professional relationship, not a friendship or social relationship.

Transportation was one barrier that prevented homeless young adults from accessing needed services, including medical and behavioral health care The majority of CABHI clients lacked reliable transportation, with one client remarking: *"Transportation should always be provided."* To address this challenge, peers assisted with transportation needs and case managers worked with the young adults to identify more permanent solutions to their transportation needs (e.g., find housing and employment on a bus line).

Lastly, consistent with research suggesting the importance of social network development and peer support (Bassuk et al., 2016; Gomez et al., 2010), CABHI clients reported satisfaction with Peer Recovery Specialists who model pro-social behaviors and encourage the development of healthy social networks and activities, as indicated in program satisfaction surveys. A CABHI client succinctly summarized her relationship with a Peer Recovery Specialist, underscoring the value that peers added to CABHI: *"Karen is the best PRS. She is always patient and kind*", highlighting research that suggests increased satisfaction in agencies that provided opportunities to connect with adults with shared lived experience, such as Peer Recovery Specialists (Hudson et al., 2010; Morton et al., 2018).

### *Evidence-based therapy*

Some of CABHI's challenges of have included serving homeless young people with both a mental health and substance use disorder (Ferguson et al., 2011; Tyler & Melander, 2013). To address this challenge, CABHI therapists were trained in evidence-based models to address both mental health and substance use. Prior to initiating outpatient therapy, clients received a bio-psycho-social-cultural assessment to identify their strengths, needs, history, preferences, and goals for services. The CABHI outpatient therapists used evidence-based treatments, including Adolescent Community Reinforcement Approach (A-CRA) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). CSB leadership chose A-CRA because it has been shown to decrease substance using behavior and increase healthy and positive non-using behaviors and activities (Hunt & Azrin, 1973;). A-CRA has demonstrated efficacy in reducing substance use and increasing healthy and positive non-using behaviors and activities (i.e., pro-social activities) through interventions such as the functional analysis of substance using behavior (Hunt & Azrin, 1973; McGarvey et al., 2012; Meyers & Godley, 2001). Adolescent Reinforcement Community Approach (A-CRA) has been found to be more effective than treatment as usual for homeless and street-living youth and young adults (Slesnick et al., 2007). Moreover, A-CRA has demonstrated efficacy in addressing both substance use and externalizing and internalizing mental disorders, as studies demonstrated that not only did young adults experience benefits from A-CRA, those clients with a history of abuse or neglect demonstrated even greater improvement (Godley, Smith, Passetti, & Subramaniam, 2014).

In this intervention, the counselor assists the client in outlining the antecedents and consequences of their substance use. This procedure underscores both the positive and negative consequences of the substance using behavior, with a goal of assisting the client in finding healthier ways to access the positive consequences associated with substance use. A-CRA focuses on client reinforcers, or motivators, to change their behavior and uses these motivators to

set goals that are important to the client. For example, if the client wants to get a job, the counselor may introduce job-seeking skills in an A-CRA session. The overall goal is to eliminate or reduce substance use and to increase the client's level of functioning so that he or she can attain goals that are important to him or her. A-CRA has been shown to be efficacious with homeless young adults through a randomized controlled trial (Slesnick et al., 2007).

TF-CBT is introduced when a client needs therapy to address a trauma that is causing problems in his or her functioning, as TF-CBT has been shown to be effective in reducing trauma symptoms and responses (Cohen & Mannarino, 2004; Happer, Brown, & Sharma-Patel, 2017). Through gradual exposure to the trauma, components of TF-CBT are provided to CABHI clients. Components include psycho-education and parenting skills; relaxation techniques (e.g., focused breathing, progressive muscle relaxation, and teaching the client to control his or her thoughts); affective expression and regulation (e.g., enhancing their skills in identification and expression of emotions, and encouraging self-soothing activities); cognitive coping (i.e., through this component, the client learns to understand the relationships between thoughts, feelings, and behaviors and think in new and healthier ways). Following the aforementioned components, the trauma narrative and processing is completed (e.g., gradual exposure exercises including verbal, written, and/or symbolic recounting of the traumatic event(s) so the client learns to be able to discuss the events when they choose in ways that do not make the client feel overwhelmed. Following the completion of the narrative, clients are supported in identifying, challenging, and correcting cognitive distortions and dysfunctional beliefs. The remaining components include gradual exposure to harmless trauma reminders in client's environment (e.g., basement, darkness, school, etc.) so the client learns they can control their emotional reactions to things that remind them of the trauma to enhance personal safety and future growth (Cohen & Mannarino, 2004).

### *Drop-in center*

Consistent with research demonstrating the importance of youth-specific services to engage homeless young people (Hudson et al., 2010) and the preference of homeless young adults for a "one-stop" shop that drop-in services offer where they can access mental health, substance use, and medical services (Pedersen et al., 2016), CABHI collaborated with community partners from the Salvation Army and Central Virginia Continuum of Care to develop a youth drop-in day. The drop-in day catered services specific to the needs of young adults, including outreach to behavioral health services, transportation, vocational and education resources, and peer recovery support. Since homeless young adults are more likely to engage with and reported greater satisfaction in working with adults with shared lived experience (Hudson et al., 2010;

Morton et al., 2018), CABHI staffed the drop-in day with Peer Recovery Specialists to increase engagement with homeless young adults.

### *Entitlement specialist*

Consistent with research, a lack of health insurance coverage is the main variable associated with utilization of health care services for homeless young adults (Winetrobe, Rice, Rhoades, & Milburn, 2015). According to CABHI program reports, 99% of CABHI clients were linked to an entitlement specialist to assist with applications for health insurance and other entitlements. CABHI embedded an entitlement specialist from the Lynchburg Department of Social Services in the intake unit to expedite access to health care insurance and reduce the barriers of transportation to another agency to apply for benefits. With an embedded entitlement specialist, clients were able to apply for benefits at the same location where they received therapy, medication management, and case management, as research suggests that homeless young people expressed a preference for a "one-stop shop" (Pedersen et al., 2016).

## Accomplishments of CABHI with linkage to the literature

CABHI has produced accomplishments in several areas, including linkage to permanent stable housing, reduction in behavioral health symptoms, and linkage to health insurance among the population of homeless youth and young adults in Central Virginia. CABHI's development and accomplishments are based on several aspects of the aforementioned literature on homeless youth and young adults. How CABHI's development and accomplishments relate to the literature and potential generalized lessons for other agencies that may consider developing a multi-disciplinary program to address youth homelessness will be discussed in the next sections.

### *Linkage to permanent stable housing*

One of CABHI's important accomplishments and simultaneously one of CABHI's greatest challenges has been linkage of youth and young adults to permanent stable housing. Of CABHI's 177 clients served, 38% were linked to permanent stable housing according to program data. This percentage does not include those linked to emergency shelter or other temporary housing. Qualitative feedback from clients underscored challenges and successes: *"CABHI even helped me get a bed when I had bedbugs! Rosemary is the best case manager! She and Regina got me a new place to live with my mom.*" Client satisfaction remained high overall among CABHI clients, with 91% of respondents completing the client satisfaction survey reporting that CABHI "did

a good job", "gave you enough help for now", "helped you do something about your other problems."

### *Reduction in mental health symptoms*

In order to address the need for mental health and substance use treatment in the homeless youth and young adult population (Tyler & Melander, 2013), CABHI recognized the importance of rapid service initiation. As a result, 90% of CABHI clients were offered a same-day assessment to identify needed services through a drop-in intake consistent with research suggesting drop-in centers are effective to engage homeless young people (Slesnick et al., 2016). Program data collected highlights that 94% of CABHI clients with a need for trauma treatment were assessed and linked to an evidence-based treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), as research suggests that TF-CBT promotes increased resilience and reduced symptoms of trauma (Happer et al., 2017). Youth who perceived themselves as resilient were less likely to engage in life-threatening behaviors and reported less feelings of loneliness and hopelessness (Rew et al., 2001). CABHI management reports highlighted that CABHI clients experienced significant reductions in their mental health symptoms which will be discussed in an outcome manuscript.

## Potentially generalizable lessons from CABHI

The development, implementation, and outcomes of CABHI in Central Virginia offer several potential lessons for agencies that may be considering collaborating to address youth and young adult homelessness. In the next section, potentially generalizable lessons from CABHI will be presented.

### *The trauma of housing instability*

Consistent with research, the causes for unstable housing or homelessness can be myriad, and with CABHI clients, precipitating factors were varied from loss of employment to substance use and other related mental health issues (Gomez et al., 2010). These variables can be exacerbated by family abandonment or discord, recently experienced traumas, physical or emotional breakdowns, and other co-occurring disorders. In the most severe cases, staff observed a general sense of hopelessness and helplessness from the program participants, including a feeling that the obstacle seemed insurmountable with the mounting stress of being unsure where they could seek shelter. This feeling was further intensified when children were involved. Facilitating participant's transition into the shelter system when they were willing allowed them the stability and relative peace of mind to cope with the trauma of their situation. Meeting the immediate need of shelter with the cooperation and aid of

community partners was the catalyst toward meaningful and lasting recovery for CABHI clients, as described by one CABHI participant: *"Tom and Karen and the rest of the team did so much to help me make the right but really difficult decisions about making amends and going back to jail"* and another participant added: *"Miss Regina helped me get a new place and I still have it. Life has gotten so much better."*

### *Client expectation versus reality*

Despite the best efforts of the housing specialist to lay out the ways in which the program could help move homeless or unstably housed clients toward shelter stability, CABHI staff often found that clients came to the program with outsized expectations of what could be done to help them. They were also oftentimes not aware of the different requirements and stipulations of the various shelter programs in the area which could lead to them getting removed from those shelters for noncompliance. Clients would often provide a list of housing needs and expectations that did not align with their current financial situation or past rental history. Clients would often not be aware of down payments and security deposits that were needed as a precursor to renting an apartment or they would not be aware of needing two months' rent in advance or security deposits. Some clients would expect to afford a large multi-bedroom apartment in a nicer part of town while working a minimum wage job or being completely unemployed. The lack of financial awareness or education on the part of some clients could be a significant stumbling block to understanding the housing they could afford based on their current income and benefits. Some clients found the local shelter system too rigorous or punitive. They were often not mentally or emotionally prepared for shelter requirements such as the transition from staying on temporary cots to evaluate one's readiness and willingness to engage in a job search and wellness programs before transitioning to more private rooms. The number of red flags, road blocks, and barriers faced by clients could be rather daunting. The CABHI team had to work with clients to set reasonable and attainable goals as to shelter and housing and collaborate with community partners and various external resources and programs to find the best possible housing and shelter fit for any given client situation.

### *The evolving role of peer support*

The two peer support specialists played an indispensable role in ensuring program success (Bassuk et al., 2016), but it was not without growing pains. It takes time, effort, and communication within any agency to work toward integrating non-clinical peers into the service structure. Oftentimes, their roles can be seen as nebulous and their crossing over in the various zones of client

care which can sometimes lead to internal conflict. Staff learned that it is crucial to make sure that the peers are seen as assets and valuable partners and not as competition or a hindrance to other services. The informal approach to client involvement that peers can take often makes them adept at forming connections and stabilizing bonds with what can otherwise be a very transient group (Morton et al., 2018). As research suggests, many clients would first reach out to an informal, non-clinical peer for support which, in turn, allowed for peers to connect them to clinical and therapeutic services (Hudson et al., 2010; Morton et al., 2018)

### *Do not assume "if you build it, they will come"*

The genesis for the youth drop-in day was sparked at an early CABHI steering committee meeting. To the community providers and CABHI team, the idea was grounded in the literature on targeting specific outreach to the youth population and offering a drop-in day at a location (i.e., Salvation Army) central to several areas in the community where youth frequent (e.g., the park, the library). However, organizers soon realized that the lack of youth utilizing these resources was likely due to the lack of communication and information sharing to the homeless youth population. To remedy this area, CABHI used clients to provide "word of mouth" and serve as ambassadors to link their peers to the drop-in day. As information spread from the grassroots level, the drop-in day staff began to see an increase in utilization. Other adjustments made to the youth drop-in day included ensuring that the drop-in center was central to areas where transient youth frequent, thereby making access easier for homeless young people. Lastly, the drop-in day was staffed with Peer Recovery Specialists, as research suggests homeless young people reported greater satisfaction with interactions with adults with shared lived experience, such as Peer Recovery Specialists (Hudson et al., 2010; Morton et al., 2018).

### *Temporary storage needs*

One of the toughest challenges with CABHI clients who found themselves suddenly homeless was looking for a safe space to store their belongings until they were able to find replacement housing. Most clients resorted to friends, family, or their vehicles, but these were not always options and the belongings ended on the side of a curb or disposed of by a landlord. Despite pursuing several different options for temporary storage (e.g., local churches, storage businesses), a suitable solution never really presented itself with the most major objections being the length of time needed to store these items and the potential for the transfer of bedbugs and other pests. Further exploring and finding an affordable solution to this temporary storage problem may alleviate some of the pressure clients face as they deal with an eviction or other loss of housing.

## Conclusion

This case study outlined the inception, development, and growth of CABHI in Central Virginia that began out of a need to address the increase in youth and young adult homelessness and the lack of access to needed services and resources. Overall, community collaboration and development of wrap-around services to address the unique developmental needs of young adults were key factors in establishing a program to provide needed outreach and services to link young adults to permanent stable housing.

A limitation of this case study is its generalizability as every community may not experience similar needs as the Central Virginia community experienced in addressing the rising numbers of homeless youth and young adults. Other communities may not have a similar resource pool as reflective of the Central Virginia community. Overall, other agencies considering addressing homelessness in youth and young adults may learn from CABHI's successes and challenges in order to implement similar programs to address youth and young adult homelessness.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## Funding

This work was supported by Cooperative Agreements to Benefit Homeless Individuals. Substance Abuse Mental Health Services Administration funding (1H79SM063313-01).

## References

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment*, *63*, 1–9. doi:10.1016/j.jsat.2016.01.003

Coe, A. B., Moczygemba, L. R., Gatewood, S. B. S., Osborn, R. D., Matzke, G. R., & Goode, J.-V. R. (2015). Medication adherence challenges among patients experiencing homelessness in a behavioral health clinic. *Research in Social and Administrative Pharmacy*, *11*(3), e110–e120. doi:10.1016/j.sapharm.2012.11.004

Cohen, J. A., & Mannarino, A. P. (2004). Treating childhood traumatic grief. *Journal of Clinical Child and Adolescent Psychology*, *33*(4), 819–831. doi:10.1097/01.chi.0000135620.15522.38

Ferguson, K. M., Bender, K., Thompson, S., Xie, B., & Pollio, D. (2011). Correlates of street-survival behaviors in homeless young adults in four U.S. Cities. *American Journal of Orthopsychiatry*, *81*(3), 401–409. doi:10.1111/j.1939-0025.2011.01108.x

Godley, S. H., Smith, J. E., Passetti, L. L., & Subramaniam, G. (2014). The Adolescent Community Reinforcement Approach (A-CRA) as a model paradigm for the management of adolescents with substance use disorders and co-occurring psychiatric disorders. *Substance Abuse*, *35*(4), 352–363. doi:10.1080/08897077.2014.936993

Gomez, R., Thompson, S. J., & Barczyk, A. N. (2010). Factors associated with substance use among homeless young adults. *Substance Abuse*, *31*(1), 24–34. doi:10.1080/08897070903442566

Guo, X., & Slesnick, N. (2017). Reductions in hard drug use among homeless youth receiving a strength-based outreach intervention: Comparing the long-term effects of shelter linkage versus drop-in center linkage. *Substance Use & Misuse*, *52*(7), 905–915. doi:10.1080/10826084.2016.1267219

Happer, K., Brown, E. J., & Sharma-Patel, K. (2017). Children's resilience and trauma-specific cognitive behavioral therapy: Comparing resilience as an outcome, a trait, and a process. *Child Abuse & Neglect*, *73*, 30–41. doi:10.1016/j.chiabu.2017.09.021

Hudson, A. L., Nyamathi, A., Greengold, B., Slagle, A., Koniak-Griffin, D., Khalilifard, F., & Getzoff, D. (2010). Health-seeking challenges among homeless youth. *Nursing Research*, *59*(3), 212–218. doi:10.1097/nnr.0b013e3181d1a8a9

Hunt, G., & Azrin, N. (1973). A community-reinforcement approach to alcoholism. *Behaviour Research and Therapy*, *11*(1), 91–104. doi:10.1016/0005-7967(73)90072-7

Leonard, J. (2011). Using Bronfenbrenner's Ecological theory to understand community partnerships. *Urban Education*, *46*(5), 987–1010. doi:10.1177/0042085911400337

McGarvey, E. L., Leon-Verdin, M., Bloomfield, K., Wood, S., Winters, E., & Smith, J. (2012). Effectiveness of A-CRA/ACC in treating adolescents with Cannabis-use disorders. *Community Mental Health Journal*, *50*(2), 150–157. doi:10.1007/s10597-012-9566-2

Meyers, R. J., & Godley, M. D. (2001). Developing the community reinforcement approach. *A Community Reinforcement Approach to Addiction Treatment*, 1–7. doi:10.1017/cbo9780511570117.002

Miller, B., & Bowen, E. (2019). "I know where the rest of my life is going": Attitudinal and behavioral dimensions of resilience for homeless emerging adults. *Journal of Social Service Research*, *46*(4), 553–570. doi:10.1080/01488376.2019.1607647

Morton, M. H., Dworsky, A., Matjasko, J. L., Curry, S. R., Schlueter, D., Chávez, R., & Farrell, A. F. (2018). Prevalence and correlates of youth homelessness in the United States. *Journal of Adolescent Health*, *62*(1), 14–21. doi:10.1016/j.jadohealth.2017.10.006

Pedersen, E. R., Tucker, J. S., & Kovalchik, S. A. (2016). Facilitators and barriers of drop-in center use among homeless youth. *Journal of Adolescent Health*, *59*(2), 144–153. doi:10.1016/j.jadohealth.2016.03.035

Provan, K. G., & Lemaire, R. H. (2012). Core concepts and key ideas for understanding public sector organizational networks: Using research to inform scholarship and practice. *Public Administration Review*, *72*(5), 638–648. doi:10.1111/j.1540-6210.2012.02595.x

Rew, L., Taylor-Seehafer, M., Thomas, N. Y., & Yockey, R. D. (2001). Correlates of resilience in homeless adolescents. *Journal of Nursing Scholarship*, *33*(1), 33–40. doi:10.1111/j.1547-5069.2001.00033.x

Slesnick, N., Feng, X., Guo, X., Brakenhoff, B., Carmona, J., Murnan, A., … McRee, A.-L. (2016). A test of outreach and drop-in linkage versus shelter linkage for connecting homeless youth to services. *Prevention Science*, *17*(4), 450–460. doi:10.1007/s11121-015-0630-3

Slesnick, N., Prestopnik, J. L., Meyers, R. J., & Glassman, M. (2007). Treatment outcome for street-living, homeless youth. *Addictive Behaviors*, *32*(6), 1237–1251. doi:10.1016/j.addbeh.2006.08.010

Smith Ramey, J., & Randall, J. (2020). A multiple agencies and counties partnership: Improving parental substance use and services delivery outcomes through a network development and collaboration. *The Journal of Rural and Community Development*, *15*(3), 79–xx.

Thompson, S. J., Ryan, T. N., Montgomery, K. L., Lippman, A. D. P., Bender, K., & Ferguson, K. (2016). Perceptions of resiliency and coping: Homeless young adults speak out. *Youth & Society*, *48*(1), 58–76. doi:10.1177/0044118X13477427

Tyler, K. A., & Melander, L. A. (2013). Child abuse, street victimization, and substance use among homeless young adults. *Youth & Society*, *47*(4), 502–519. doi:10.1177/0044118x12471354

Walzer, N., Weaver, L., & Mcguire, C. (2018). Collective impact approaches and community development issues. *Collective Impact and Community Development Issues*, 1–11. doi:10.4324/9781315112916-1

Winetrobe, H., Rice, E., Rhoades, H., & Milburn, N. (2015). Health insurance coverage and healthcare utilization among homeless young adults in Venice, CA. *Journal of Public Health*, *38*(1), 147–155. doi:10.1093/pubmed/fdv001