Staffing Challenges and Strategies for Organizations Serving Individuals who have Experienced Chronic Homelessness

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Abstract

Hiring and retaining appropriate staff is essential for programs serving those who have experienced chronic homelessness. This paper describes specific staffing challenges and strategies from the Collaborative Initiative to Help End Chronic Homelessness (CICH), an 11-site, multi-agency Federal program designed to serve people experiencing chronic homelessness who also have a disabling condition such as substance use or mental health problems. This paper addresses approaches to staffing including team structures, staff supervision, and training. Challenges identified include low pay, high rates of burnout and turnover, limited time for supervision, and multiple staff training needs. This paper also explores specific staffing strategies based on the experience of the CICH sites, and concludes with implications for practice, research, and policy, including recommendations for ongoing staff training, suggestions for future mixed-methods research, and a call for an enhanced focus on strengthening the homeless services workforce.

Introduction

An estimated 150,000 to 200,000 individuals experience chronic homelessness in the USA each year, some living on the streets or in shelters for months, years, or even decades.[1,2] The Federal

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government defines chronic homelessness as being continuously homeless for a year or more or having at least four episodes of homelessness in the past 3 years.[3] An estimated 30% of individuals who experience chronic homelessness have severe mental health issues and 50% have co-occurring substance use problems. Many also suffer from developmental disabilities, physical illnesses, and problems with cognition. In recent years, programs and policies have increasingly targeted individuals with long histories of homelessness who also experience mental illness and substance use problems.[4–6]

A growing body of evidence suggests that individuals who are chronically homeless can be stably housed and can, with supportive services, attain positive medical and behavioral health outcomes, even without restrictive eligibility criteria for entry into programs.[2,5–9,10] Cost studies also suggest that this approach may be cost-neutral or even cost-effective because of offsets such as decreased utilization of shelters, emergency rooms, psychiatric hospitalization, and the criminal justice system.[11]

To respond to the complex needs of chronically homeless individuals, a multi-agency Federal program was initiated in 2003 to provide comprehensive housing and supportive services. The Collaborative Initiative to Help End Chronic Homelessness (CICH), funded by the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Health and Human Services (DHHS; the Substance Abuse and Mental Health Services Administration [SAMHSA], Health Resources and Services Administration [HRSA]), and the U.S. Department of Veterans Affairs (VA) consisted of 11 grantees.[10] The objective was to provide housing and supportive services for individuals meeting the Federal definition of "chronically homeless."

CICH grantees developed housing linked to services, drawing on various practice models including Housing First, Assertive Community Treatment (ACT), and others.[12] In addition, sites drew on various housing models such as scattered site rentals, SRO housing, and Shelter Plus Care vouchers.[13] Despite the variety of housing and practice models, all sites faced the challenge of providing comprehensive yet flexible services to meet the evolving needs of individuals with multiple needs, and who in many cases had been alienated from traditional systems of care that were unable to respond to their needs. As a result, project staff faced many challenges in providing supportive services to meet complex client needs.

An essential component of serving this population is a knowledgeable, skilled, and committed workforce that can stay engaged with clients over long periods. Workforce issues were therefore critical to the success of the CICH program. The purpose of this paper is to examine the range of staffing issues encountered by CICH projects and how sites worked to overcome them.

Background

Programs serving clients with complex behavioral health, social service, and medical needs—such as individuals who have been chronically homeless—face various staffing challenges. These challenges include hiring an appropriately skilled workforce, training and supervising staff to ensure high-quality care, and supporting staff to prevent burnout and turnover. Further, given the limited funding available to support these programs, they may offer relatively low salaries for work in difficult community settings.[14,15] Hiring staff is difficult, due in part to limitations in the available workforce. For example, three reports sponsored by SAMHSA[16–18] and a report from the Institute of Medicine (IOM)[19] describe the inadequate number of trained mental health and addictions personnel across all disciplines (e.g., psychiatry, social work, psychology, and nursing). These reports note that this aging workforce is limited further by its demographic homogeneity—primarily female, white, and older.

Lack of professional training is most acute among direct care staff such as case workers.[16,17] Many individuals in these positions do not have graduate level professional training, and pre-professional training is often either inconsistent or non-existent.[16,17] Additionally, professionally

trained or licensed staff (e.g., medical professionals, social workers, or substance abuse counselors) may lack training on issues specific to homelessness. As a result, programs must train employees through formal (organized educational programs) or informal ("on-the-job training") mechanisms —if and when the resources are available to do so. This places an additional burden on programs beyond routine staff supervision. Training is key to ensuring that staff have the skills necessary to serve clients with complex mental health, substance use, and medical problems.[8,20] A qualitative study of mental health staff described their desire for training on topics ranging from clinical to management skills.[21] Burke [8] found that training shelter staff on mental health issues is helpful in improving treatment outcomes.

Lack of training is complicated by an increasing emphasis on adopting evidence-based practices in behavioral health service settings.[22] Training staff to understand the rationale for evidence-based practices may facilitate the adoption of such practices.[23] In addition, training staff on specific skills required to properly implement evidence-based practices is essential. In a study evaluating the training of mental health clinicians on an ACT team, Graham[24] suggests that on-site group training of teams, with role modeling, supervision, and ongoing training sessions, can improve the clinical skills and self-efficacy of team members.

Service providers encounter other daily challenges in working with clients who have experienced chronic homelessness and behavioral health problems. For example, Fisk et al.[15] note that staff must engage clients while maintaining appropriate boundaries, monitor the safety of clients and themselves, and cope with the stress of "witnessing" the traumatic life experiences of the people they serve. Direct service workers, particularly those who see clients outside of a program office or clinical setting, frequently find themselves operating away from direct supervision. The combined challenges of the inherently difficult nature of their work, the need to work independently, and the lack of professional training can create a stressful work environment and potentially diminish the quality of care. Staff burnout often ensues.[25–30] Staff training and supervision can reduce burnout by ensuring that the staff has the skills necessary to cope with the daily challenges of their work and maintain high-quality care for their clients.

Effective supervision and leadership can also play a positive role in reducing staff burnout and turnover, as well as the adoption of evidence-based practices.[21,31–33] Evidence suggests that strong performance is associated with service teams that have well-defined goals, regular feedback on performance, administrative support for their work, guidelines for coordinating team work, and leadership willing to take responsibility for making difficult decisions.[25,27,29,31,32,34]

Practice models such as ACT offer structures that can improve staff support. Boyer and Bond[35] compared burnout and job satisfaction among case managers on ACT teams to case managers working in other programs. Their findings suggest that because of smaller caseloads, shared caseloads, team support, and improved client outcomes, "the ACT model may be especially suited to protect against burnout in case managers serving clients with the most severe disabilities and who are most prone to psychiatric readmissions" (p. 31). ACT, in contrast to other case management models, allows staff the time to engage and build relationships with clients, make and follow up on referrals, and more fully address a range of clinical issues.[16,23,36]

While the broad range of issues pertinent to staffing behavioral health programs is described in the literature, the nature of these issues within the context of programs designed to address the housing and service needs of individuals who have experienced chronic homelessness is not well understood. The CICH program offered an opportunity to explore staffing in the context of a Federally supported, multi-site effort. Other issues related to the homelessness workforce are also being explored in other workforce efforts. For example, SAMHSA's Homelessness Resource Center recently initiated a project to understand and respond to workforce needs among homeless services by focusing on pressing workforce training as well as long-term strategies for expanding capacity.[20] Results, conclusions, and implications discussed in this article can be best understood in the context of these workforce activities and the emerging body of research designed to examine chronic homelessness.

Methods

Study design

The purpose of this paper is to explore and describe the experiences of the 11 CICH grantees specifically related to staffing issues. In particular, the review sought to understand key challenges and lessons learned related to hiring, training, supervising, and minimizing staff turnover. Using 150 CICH documents written between 2003 and 2007, the authors identified and analyzed key themes that resulted from the 3-ear program. Documents came from two primary sources. The first source of data was the group of project proposals from the 11 CICH grantees. Grantees applied to HUD for funds for permanent housing and SAMHSA for integrated support services. Additionally, they submitted optional proposals to the VA and HRSA requesting support for veterans and primary health care. Continuation applications were submitted to SAMHSA at the end of funding years 1 and 2 to continue supportive service teams. The second set of documents came from site visits and technical assistance functions related to the CICH program. These documents included: (1) notes on staff interviews and group discussions with clients completed for two site visits to each site; (2) site visit reports; (3) notes from conference calls established to provide program-wide technical assistance; (4) reports written by consultants following technical assistance offered to individual project sites; and (5) project notes and summary reports of annual grantee meetings. Documents were available in electronic form, with the exception of the initial and continuation funding applications, which were available only in hard copy. Atlas.ti software[37] facilitated text search and coding procedures.[10]

Analysis

Coding and analysis followed an iterative process. [38,39] In the first step, the authors listed and defined a series of relevant terms including hiring, recruitment, staff turnover, caseload, composition of teams, boundaries, team functions/operations, supervision, schedule, staff roles, team communication, stress, safety, self-care, vicarious trauma, training and orientation, cross-training, and technical assistance. Using the initial coding list, research assistants coded all documents and selected text matching the definitions for the domain of interest. To ensure consistency in the coding process, the research team wrote definitions of each code illustrated with sample text. The lead analyst met regularly with coders to review coding and reconcile any discrepancies in the application of codes. Documentation of the coding structure and definitions (codebook) was recorded and stored in the Atlas.ti project file accessible to the coders for immediate reference used for the ongoing comparisons.[40] The authors then read the selected text and listed themes and core ideas within each domain. These themes were compared across coder/co-author. In the final step, themes emerging from this level of analysis were clustered into higher order themes to reflect explanatory concepts and relationships among the codes. Results of the analyses are presented thematically rather than organized by frequency.

Results

While the 11 CICH projects used diverse approaches to providing housing and services, all sites used multidisciplinary teams to provide services. Teams included housing staff, such as housing specialists and resident or property managers, as well as supportive services staff, including case managers, mental health and substance use professionals, health care providers, employment specialists, and others. Teams faced challenges such as recruiting and hiring skilled staff, managing tensions about various treatment philosophies, recognizing and addressing staff preconceptions, and collaborating across multiple agencies. As a result, the sites developed a range of strategies to support project staff that yielded mixed results in addressing these challenges. The nature of the

challenges and team responses are grouped into three categories: (1) creating diverse, multi-disciplinary teams, (2) supervising and supporting staff, and (3) training.

Multi-disciplinary teams

The 11 projects formed teams to identify and organize suitable permanent housing and provide the range of services necessary to support clients in their homes. Although all of the sites formed multidisciplinary teams, the teams' size, nature of staff roles, supervisory structures, and staff training varied across sites. Reasons for variations included difficulty recruiting and hiring appropriate staff, staff turnover, degree of experience of the program managers and team leaders, and philosophical approaches to staffing.

Staff Composition Table 1 shows the average levels of staffing expressed as full-time equivalent (FTE). The staffing patterns proposed originally are compared to the actual staffing levels during the third year of the project. The number of staff for each of the 11 projects ranged from as few as three FTEs to as many as 17 FTEs. Also, as shown on Table 1, staff included program managers, housing staff, medical professionals, case managers, behavioral health specialists, and other support staff. Specific staffing patterns varied across projects. Five of the 11 sites had at least two FTEs in leadership roles and four had only one or fewer (part-time). In some projects, the director

Table 1
CICH team staff composition: average FTEs by position

	Proposed in original application	Actual staff in year 3
Management	0.50	0.50
Program director		
Project coordinator		
Team leader		
Behavioral health		
Case managers	2.73	3.67
Social worker	0.36	0.31
Substance use specialist	1.93	1.60
CASA/CADAC		
Co-occurring disorders specialist		
Recovery specialist		
Psychologist/therapist	0.18	0.09
Psychiatrist	0.48	0.52
Peer counselor/case worker	1.75	1.53
Medical care		
Nurse/PA	0.80	1.43
Physician	0.13	0.40
Housing coordinator	0.18	0.36
Other staff	1.1	1.1
Community health worker		
Supportive employment specialist		
Benefits specialist		
Money manager		
Administrative assistant/Aide		

or coordinator doubled as a team leader and performed clinical functions as well as managerial functions, while in other cases the director or manager functioned primarily in a managerial or administrative capacity. The majority of staff positions among the 11 projects were drawn from the behavioral health fields. Other supportive service positions included supportive employment specialists, benefits specialists, money managers or representative payees, housing coordinators, and administrative assistants. At some sites, individuals in these positions were members of the team, while at others they were not formal team members, but worked closely with the team. At least seven of the sites had nurses on their team; other sites did not have a nurse who was a regular member of the team. Medical needs were addressed by part-time physicians, physician assistants, nurses, and community health workers.

An important component of service teams for four projects was the VA social worker. In these cases, the VA social worker became a central clinician, providing not only services to veterans, but also consultation, support, and training to other staff on clinical issues affecting their clients. VA social workers also provided access to and assistance in navigating the VA system.

All sites worked closely with property managers, resident managers, and real estate agents to ensure stability of clients in housing. At least two sites included property managers as part of the service team. Team members stated that this close communication with property managers helped to support clients in retaining their housing. It should be noted that for at least one site, clients and staff expressed concern about resident managers who were formerly homeless or near homeless. Concerns focused on lack of clinical skills and issues of confidentiality. According to one program resident, some resident managers "forgot where they came from;" for example, at one site, complaints were filed against resident managers for standing in the doorway yelling threats of eviction. In response to these complaints, the project provided additional training and supervision to one manager and replaced another. Another site used a real estate agent who specialized in working with low-income people. The agent met regularly with the team and learned the housing needs and wishes of individual clients who required apartments.

Eight of the 11 sites employed consumers in various key roles, such as peer advocate, peer mentor, peer caseworker, peer counselor, peer outreach worker, consumer case manager, and community living specialist. This level of consumer involvement was designed to improve teams' ability to build rapport, better understand client needs, and assist clients in the transition from the streets into housing. One site emphasized the importance of including people in recovery on the team, as well as diversity of culture and clinical backgrounds. According to staff, this proved crucial to engaging "particularly difficult populations that may be mistrustful of traditional service systems and providers."

Challenges to Building Teams Limited resources, high turnover, and the multi-agency nature of the collaborative created challenges to building strong teams. First, low pay challenged the ability of at least three teams to remain fully staffed or to attract skilled applicants. A staff member at one site said, "the low salary offered tended to limit the type of case management applicants we could attract." Another stated, "With the resources we have available, it is hard to get experienced or licensed staff." Other projects acknowledged that original budget assumptions about staff salaries unintentionally restricted the possibility of hiring experienced clinical staff. Additionally, three sites reported that they found a limited pool of qualified job applicants—particularly applicants comfortable working in a program based on a "low-demand" rather than "abstinence only" approach. A low-demand approach generally involves making services available but allowing client choice in accessing those services. For example, there would likely be no sobriety requirement or mandatory psychiatric treatment in a low-demand housing program.

Another challenge for projects was higher-than-expected staff turnover or an inability to fill certain team positions. Six sites specifically mentioned facing high rates of staff turnover, with two experiencing 60% team turnover over the course of the 3 years. Further, the challenges of working

with chronically homeless clients compounded these recruiting difficulties. As team members at one site noted, "Not all individuals are well-suited to this work." Likewise, another project had difficulty finding health professionals "willing to work outside their comfort zone." The most difficult positions to fill and retain were the nurse, psychiatrist, and addictions specialist.

Strategies used to recruit and hire staff varied by site. Several sites chose to recruit highly experienced staff from partner agencies and from the broader community, believing that hiring experienced staff was essential for providing high-quality care. Others deliberately targeted recruitment to younger, less experienced workers based on the premise that they come with fewer personal and professional judgments about the people they serve and fewer preconceptions about low-demand housing models. Regardless of these variations, grantees agreed about the characteristics necessary for working on a CICH team. Team members, leaders, and consumers identified the following characteristics: openness; empathy; clear boundaries; knowledge of homelessness, mental health, and substance use; culturally competent; and a desire and willingness to learn. As one grantee stated, "attitude is as important as skills." None of the projects required previous experience working with people who were homeless.

Other challenges faced by teams arose from the multi-agency nature of the CICH projects. Hiring and supervision were affected by the reality that team members were employed by different agencies, and therefore had differences in hiring procedures, working hours, salaries, benefits, holidays, and even end-of-year bonuses. At one site, each team member, regardless of agency affiliation, was given a day off and a yearly bonus. Another team attempted to ensure quality of hiring across multiple agencies by developing a list of core competencies for team members, which was used by all partner agencies in hiring for the CICH team. In some cases, these cross-agency issues created problems due to employment policy differences among partner agencies. For example, at one site, a single agency provided all evening and weekend coverage because the partner agencies would not allow their staff to work after-hours.

Although the teams included staff from multiple disciplines, the daily realities of working with clients who have multiple needs meant that each staff member often performed a variety of functions outside of their own practice domain. The staff at one site explicitly noted that staff expected to be flexible about the nature of the work they might perform on any given day. A staff member explained that they expect everyone on the service team to perform services not traditionally within their realm—nothing should be "beneath" them. Managers at this site make it explicit that all team members are expected to deal with "mental and physical health issues." In addition, understaffing because of turnover and difficulties filling positions placed additional demands on the staff, particularly the team leader. For example, staff at several sites noted that the team leader was often required to do more than that role required to ensure that "we're getting the job done."

Supervision and staff support

While teams were clearly aware of the importance of strong supervision and support to ensure performance, prevent burnout, and promote staff development, projects varied in the abilities of team leaders to provide this supervision and support. Only four sites reported weekly individual supervision. Others found this time-consuming and opted for group supervision through team meetings. Further, some but not all projects held daily team meetings, as prescribed in the ACT model, while others limited these meetings to once or twice a week. Yet other supervisory plans included in vivo supervision, with supervisors accompanying case managers on home visits or outreach workers into the field. At most sites, staff members also used peer-to-peer support through team meetings, as well as more informal discussions or consultations about clients.

Team members at two sites expressed a desire for additional supervision, noting that they were "free floating." At three sites, staff noted that learning to work in a client-centered and low-demand approach was one of the most challenging aspects of their job—an approach that felt foreign to

their prior experience or training. These individuals required additional support and training to adapt to a new approach. For example, one project faced challenges moving people into housing because of what the team leader viewed as "an inbred prejudice among staff members who require clients to maintain their sobriety for six months." Some staff at this site felt that clients were "just playing games" and that the program was "coddling the clients." Staff on another project stated her belief that "Folks don't want to go through changes." A team leader at another site stated, "substance abusers posed the greatest challenge" for staff, and as a result, initiated a process to "weed out those who were not severely and persistently mentally ill (i.e., substance users)," accounting for about 40% of program participants. Overall, negative staff preconceptions about substance use were the exception rather than the norm. A more common approach was summed up in the words of a team member: "A lot of assumptions I had I threw away." Some staff commented on the need for more supervision on how to maintain boundaries with their clients. At one site for example, the team leader noted that staff needed help learning to avoid "giving in to client demands such as requests for cigarettes or money to purchase food."

Concern about staff burnout was a recurring theme expressed by grantees during site visits, technical assistance calls, and grantee meetings. One team member described how "serving chronically homeless people is an emotionally, mentally, and physically strenuous endeavor." Staff at another site observed that "for clients who have long-term addictions, improvements come very slowly," a reality that can be demoralizing for both staff and clients. Staff at another project reported feeling pressured by the amount of work they faced and said they "needed a break. We never get a lunch." Teams experienced other stressors such as concern for their own safety and client deaths, often due to untreated chronic medical conditions.

Sites implemented several specific strategies to address self-care and burnout prevention. One team leader described her efforts to support staff by "putting boundaries on the job hours, telling them they don't need to be down here at midnight doing outreach." Another strategy was the use of regular staff retreats designed to "celebrate accomplishments, build commitment, blow off steam, and sharpen skills." Retreats, which for some sites were a quarterly occurrence, met with mixed reviews among staff. One team noted that retreats "reduce burnout and improve their capacity to provide respectful services," while staff from another site stated, "We were burnt out, and retreats gave us a spark but we didn't see the change." Another plan to prevent burnout was to hold critical incident debriefings after difficult events such as client deaths, a strategy embraced by at least two sites. Not only did this approach address burnout by providing staff support in the wake of a difficult event, it also created an opportunity for learning and improving clinical practice. Less formal approaches were also used, such as celebrating team birthdays and sobriety anniversaries for staff and clients, team social outings, as well as "a lot of levity and encouraging people to take time off." It is notable that the team leader cited here supervised a team with less turnover compared to the other sites. A team member at one site stated that "the ACT model facilitates using everyone's voice. Ultimately, everyone has an opportunity to express themselves. ACT decreases burnout because people feel vested in the decisions."

Training

Not surprisingly, another strategy for supporting staff employed across all of CICH sites was training. Initial and ongoing training both proved essential. High turnover rates complicated training efforts. Program leaders found that training the entire team was preferable to sending individuals to receive training. First, teams stated that initial and ongoing training was essential for acquiring new knowledge and skills to serve clients effectively. As one staff member said, "Working with these clients is different from anything I've ever done." A team leader commented that staff needed "months of training before [they] really understood what they are doing." A team leader at another site observed that after working for a year or two, members of her team had

arrived at a point where they realized they needed to "upgrade their skills." She felt her team was at a point at which they would benefit from a "very intensive boot camp for team building."

During the course of the site visit interviews, staff at a number of sites mentioned the need for education about basic topics such as mental health and substance use disorders, medications, conducting client assessments, homelessness, and the criminal justice system. Team leaders at three sites commented on the need to train staff to record information in client charts. One team leader noted that he did not expect "literally to have to start from day one and teach people how to chart." He also observed that some staff had limited writing skills, rendering charting even more challenging for these individuals. For several sites, State or insurance provider requirements for documentation exacerbated the difficulty of this task.

Formal training by outside consultants was organized by the sites themselves and by the National Technical Assistance Center on Chronic Homelessness (NTACH). These trainings covered topics such as Motivational Interviewing (MI), ACT, Housing First, SOAR (SSI/SSI Outreach, Access, and Recovery), and others. Staff from seven projects had training on MI. Four sites received training on implementing the ACT model. Other staff training conducted at multiple sites included Housing First, SOAR cultural competence, and harm reduction. In addition, one or more sites trained staff on treatment planning, documentation, stages of change, traumatic stress, vicarious traumatization, mental health, co-occurring disorders, post-traumatic stress disorder, crisis management, first aid, HIV, supportive employment, and entitlements/benefits. Team members identified several specific areas that were helpful and merited additional training, including MI, trauma-informed care, and SOAR.

Given high staff turnover and the intensive process of developing new clinical skills, all teams found that one-time training was not adequate. One site found that "it may be more useful to administer training in an ongoing manner, rather than in a concentrated period of time." Managers at another site established a list of core competencies and developed a systematic approach to ongoing training throughout the project. To address the problem of staff turnover, one project videotaped trainings so that new staff could view sessions that were offered prior to joining the team. However, the team leader commented that simply viewing a videotape was a much less compelling experience than participating in a live training. Another training approach, staff shadowing, was used by one project (where a new staff member followed a more experienced staff member) as one method of training new employees.

Team leaders and case managers from several sites noted the value of group trainings for the full team as opposed to individual training. However, they also pointed out the practical realities that limited their ability to enable training for the full team. One project member noted that managers should "not get trapped into thinking that taking a day for training is a loss of revenue…you lose money with turnover."

Another major challenge facing CICH teams was balancing the tension between a "low-demand" approach and an approach that required clients to participate in various services. Low-demand housing has been defined by the Corporation for Supportive Housing as "housing provided in a low-demand environment [that] emphasizes ease of entry and ongoing access to services with minimal requirements."[9] This approach stands in contrast to traditional approaches to supportive housing that require services in order to access housing. The transition to a low-demand model that is based on client choice often proved difficult, especially for staff in recovery themselves. One staff member stated, "It took me a while to adapt to the harm reduction philosophy and learn how to establish a relationship with a client. It took me three or four months to become comfortable with the program philosophy." In one community, "the Housing First and Harm Reduction models are viewed with skepticism by some in the substance abuse treatment community," creating tension among team members who came from different treatment backgrounds and perspectives. Team members noted that "staff coming to the team who had abstinence-based training had to 'buy in'" to the low-demand approach to care.[41] Table 2 synthesizes various staffing approaches and

practices utilized by CICH sites through the course of this project. These may offer guidance for other projects designed to serve people experiencing long-term homelessness.

Discussion

While much has been written about staffing issues faced by social service agencies generally,[8,14,15,21,28,32] this paper is the first to describe staffing issues based on the experiences of multiple organizations across the country working toward a common goal of serving individuals experiencing chronic homelessness. The findings in this study build on previous work on burnout and other staffing challenges in the behavioral health literature, while grounding these findings in the experience of homeless programs. One of the most significant sets of findings relates to the use of multidisciplinary teams. While these teams were common across each of the CICH projects, these teams were not always easy to build and sustain. Projects faced challenges in hiring and retaining appropriately skilled staff, and in developing efficient and effective means of supervising and

Table 2

Summary of best practices related to staffing programs to serve people experiencing chronic homelessness

Practice from CICH	Description
Diverse multidisciplinary teams	Expertise in mental health, substance use, primary health care, social work, housing, employment, money management. Formerly homeless individuals as peer counselors or peer support specialists. Close working relationships with landlords or property managers, and may even include these individuals as formal members of the service team.
Strong supervision	Sites utilize various combinations of: Weekly individual supervision Group supervision In vivo supervision on home visits or work in the community
Formal staff supports	Staff retreats Peer support in team meetings Critical incident debriefing
Informal staff supports	Informal case consultation Celebrating birthdays and sobriety anniversaries Social outings for staff Humor
Focus on training	Initial and ongoing training may include: Mental health Substance abuse Motivational interviewing Trauma-informed care HIV Crisis management Basic first aid Supportive employment Accessing benefits

training their staff. These challenges are a function not only of the caliber of the pool of potential employees, but more importantly, of the complexity of the tasks required of staff working in these projects.

Clearly, a team-based approach brings together the range of skills necessary to meet complex needs associated with chronic homelessness, and ensures strong communication among staff and better coordination of care. Teams are also better equipped to provide the 24-h support often needed for people exiting homelessness. These findings support previous research on the positive effects of multi-disciplinary teams on the health of people experiencing homelessness.[42]

This paper also confirms what has long been voiced in the homeless service provider community: working with people who have been homeless and who have multiple mental health, substance use, medical, and social issues is difficult work, emotionally and physically. Burnout is a risk, pay is often low, and staff turnover can be high. Change often happens more slowly than staff would hope, and celebrating small victories is one way that staff finds strength to continue their work. The data in this review suggest that in addition to multi-disciplinary teams, supervision and training may be powerful tools for supporting staff and reducing burnout, as noted in previous studies.[21,29] Other specific strategies utilized in CICH sites included Critical Incident Debriefing, staff retreats, and case consultation—areas not yet fully examined in the current body of research.

The experience of the CICH projects also reflects an emerging national trend towards increased consumer involvement in homeless services. As Prescott and Harris[43] describe, homeless and formerly homeless individuals can be integrated into homeless services to provide outreach, mentoring, and other supportive services, making care more client-centered as well as more culturally and linguistically competent. The decision by eight sites to employ consumers as team members may have improved teams' understanding of challenges faced by their clients as they moved from homelessness to housing. These team members also have the potential to improve the teams' ability to engage and build trust with clients who have been disconnected from relationships and services.

Findings point to the challenges of preparing staff for work on projects using low-demand approaches. It is axiomatic that all individuals bring their own attitudes and beliefs formed through personal experiences and training. However, project leaders were not always prepared to help staff understand how their particular beliefs and attitudes affected their ability to work within a client-centered context. This suggests the need to address these factors early when training staff for this work.

Limitations

The findings of this study are based on archival documents rather than on a systematic survey of staff or clients. As such, findings can reflect only the data recorded in the documents. The findings in this report are limited to the 11 CICH projects and may not generalize to programs serving other populations experiencing homelessness. However, these 11 projects were distributed across geographic regions of the country in towns and cities of varying size and demographic characteristics, suggesting that their experiences may be relevant to a wide range of programs.

Implications for Behavioral Health

The results of this study have various implications for practice, research, and policy in the homelessness field. At the practice level, findings suggest the need for training and technical assistance among service providers, administrators, organizations, and communities. Projects need to budget and plan for staff training in basic competencies, as well as in more sophisticated clinical skills. Trainings should occur early in the life of the program and should continue throughout. Mechanisms should be developed to train new staff members who joined too late to benefit from the initial team training. Another implication for practice is that involving homeless and formerly homeless individuals as team members in concrete roles such as peer case workers, peer outreach

workers, and peer mentors is a promising approach that was explored on a limited basis in the CICH. This practice may help to create a bridge between those experiencing homelessness, mental illness, and addiction, and those providing services for them.

Next steps for research might include a study that includes quantitative and qualitative data to define the key ingredients of a team-based approach to serving chronically homeless individuals and compares the effectiveness of that model with other models of care. Another question for future research involves examining how service and staffing patterns are linked to various housing models to achieve positive outcomes for people experiencing chronic homelessness. More research also needs to be done on staff attitudes and stigma relative to homelessness, mental illness, and substance use. Specifically, what are the effects of staff attitudes on the quality, frequency, duration, and outcome of services provided? Finally, little research has focused on the efficacy of using consumer peer providers in programs serving chronically homeless individuals. Research in this area could have dramatic impacts on how services are staffed in the future.

In the homelessness policy arena, more attention should be focused on developing a strong workforce. Nationwide, workforce development issues are central to successfully providing housing and services for any population, but especially for those experiencing the co-occurring conditions of homelessness, mental illness, and substance use. A well-trained, knowledgeable workforce trained to understand and implement evidence-based practices is an essential component in moving people successfully from homelessness to stable housing and support. Training and technical assistance requires an investment of time, energy, and financial resources at the Federal, State, and local levels. The result, though, will be a workforce that is equipped to provide the highest quality of care possible for those who, in the past, have too often slipped through the cracks.

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