Homeless and Pregnant
Welcome Baby Peer-to-Peer Call
11/5/2018
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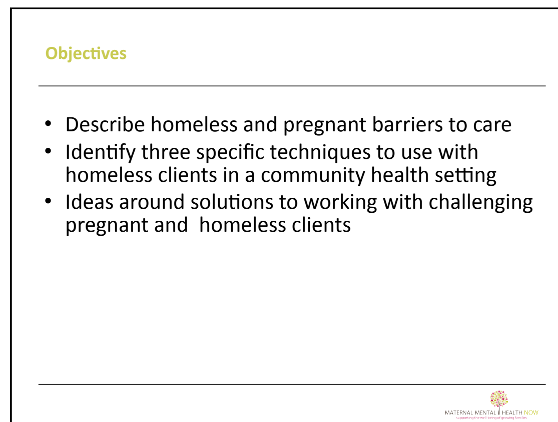
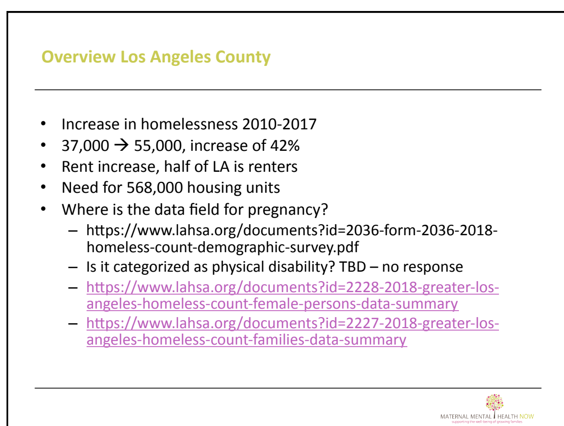
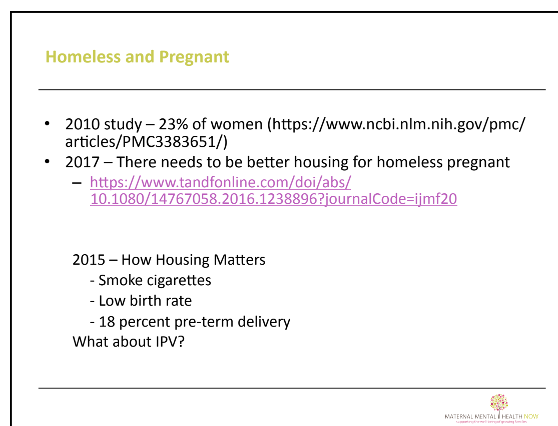
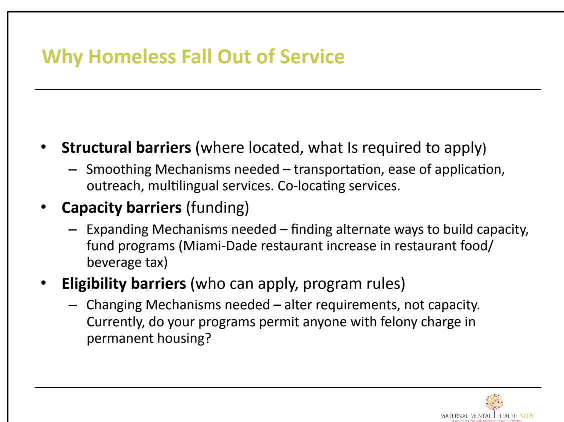
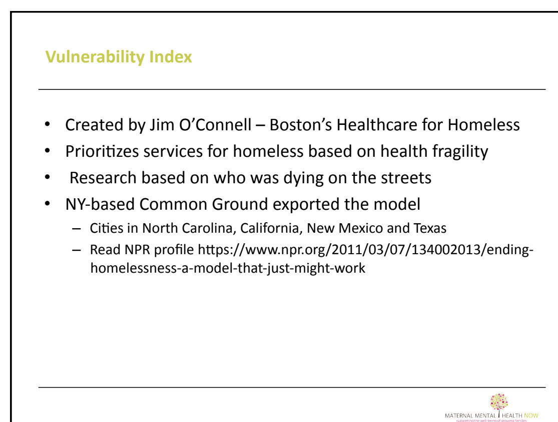
MATERNAL MENTAL HEALTH NOW


Objectives
• Describe homeless and pregnant barriers to care
• Identify three specific techniques to use with homeless clients in a community health setting
• Ideas around solutions to working with challenging pregnant and homeless clients


Overview Los Angeles County
• Increase in homelessness 2010-2017
• 37,000 → 55,000, increase of 42%
• Rent increase, half of LA is renters
• Need for 568,000 housing units
• Where is the data field for pregnancy?
– https://www.lahsa.org/documents?id=2036-form-2036-2018-homeless-count-demographic-survey.pdf
– Is it categorized as physical disability? TBD – no response
– https://www.lahsa.org/documents?id=2228-2018-greater-los-angeles-homeless-count-female-persons-data-summary
– https://www.lahsa.org/documents?id=2227-2018-greater-los-angeles-homeless-count-families-data-summary


Homeless and Pregnant
• 2010 study – 23% of women (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3383651/)
• 2017 – There needs to be better housing for homeless pregnant
– https://www.tandfonline.com/doi/abs/10.1080/14767058.2016.1238896?journalCode=ijmf20
2015 – How Housing Matters
- Smoke cigarettes
- Low birth rate
- 18 percent pre-term delivery
What about IPV?


Why Homeless Fall Out of Service
• Structural barriers (where located, what Is required to apply)
– Smoothing Mechanisms needed – transportation, ease of application, outreach, multilingual services. Co-locating services.
• Capacity barriers (funding)
– Expanding Mechanisms needed – finding alternate ways to build capacity, fund programs (Miami-Dade restaurant increase in restaurant food/beverage tax)
• Eligibility barriers (who can apply, program rules)
– Changing Mechanisms needed – alter requirements, not capacity. Currently, do your programs permit anyone with felony charge in permanent housing?


Vulnerability Index
• Created by Jim O'Connell – Boston's Healthcare for Homeless
• Prioritizes services for homeless based on health fragility
• Research based on who was dying on the streets
• NY-based Common Ground exported the model
– Cities in North Carolina, California, New Mexico and Texas
– Read NPR profile https://www.npr.org/2011/03/07/134002013/ending-homelessness-a-model-that-just-might-work

Criteria Vulnerability Index

- More than three hospitalizations or ER visits in a year
- More than three emergency room visits in the previous three months
- Aged 60 or older
- Cirrhosis of the liver
- End-stage renal disease
- History of frostbite, immersion foot, or hypothermia
- HIV+/AIDS
- Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition

8 Steps To Use

1) Engage Stakeholders
2) Count those sleeping on street from midnight to 6am
3) Teach stakeholders to administer survey and take photo
4) Return to same spot between 3am – 6am for 3 days
5) Store data
6) Establish priority list based on data
7) Brief community on findings
8) Create housing plan as result

In The "Room"

- Would this work for you? Your agency?
- Are you determining policy and fund allocation
- Would the vulnerability index work in your day to day?
- How might pregnant women fall out of this system?
- Why? Why Not?

Homeless and Pregnant Presenting Client

- Homelessness creates trauma, often high ACE in homeless and pregnant clients
- Difficulty self regulating (hostile, angry)
- Self destructive (drug use, relapse, missing OB appointments)
  - Trafficking?
- Feeling constantly threatened (reception, agency)
- Impulsive (no shows, difficulty keeping appts, unexpected visits)
- Somatic complaints (and ignoring severe pregnancy-related concerns)
- Shame, despair, guilt
- Recollection of event, not necessarily event, re-traumatizing
- Numb interspersed with hyperarousal

Modalities to use

- Attachment-based understanding – around missed appointments, around safety
- Re-parenting – how this may be more like case management
- Trauma-informed care
- Skills-building – the 'how-to's (shelter, food, finance)
- EMDR –if trained (CBT 1st and 2nd trimester re: cortisol, resourcing 3rd trimester, processing post-36 weeks)
- IPT – What might work in population vs. not practical?
  - Case example

Should You 'Re-Parent?'

- **Re-parenting**
  - It means being flexible, allowing clients to attach.
  - It means supportive, non-punitive environment.
  - It does not means treat clients like children, but rather conceptualizing that they need a safe place and a positive parental relationship in order to heal trauma and improve well-being
- **Prepare** - educate clinicians, agency as whole about trauma
- **Feed your client** – what do they want? Can you give it to them?
- **Respond with sensitivity** – even when there is a tantrum
- **Nurture** – Activity scheduling even if homeless
- **Ensure safety** – express concern over safety
- **Consistency!** - In staff, in guidelines, boundaries, be in it for the long haul
- **Positive discipline** – consistent consequences, modeling good behavior after a mistake
- **Modeling** - Balance in your own life

Is your agency Trauma-Informed?

- Trauma- Informed Care:
- TIC (Hopper et al., 2009) is a way of presenting services that take into account the trauma of homelessness.
  - 1) Trauma Awareness
  - 2)Emphasis on Safety (triggers, clear roles, boundaries)
  - 3) Opportunity to rebuild control
  - 4) Strengths based approach
- So what does this look like with pregnant clients?

Skills-building

- More case management model
- Support groups vs. individual sessions
  - Why might support groups not work in this pop?
    - Agency bottom line/efficiency vs. individual needs
- Are clinicians trained in the basic skill building
  - Contacts at shelters, food banks, versed in disability?
  - Risk of provider burn-out

EMDR Therapy

- Why is EMDR useful in this population?
- Do you have the agency money to train providers?
  - Why burn-out and turn-over make it difficult
    - Agency bottom line/efficiency vs. individual needs
- What is resourcing?
  - How to engage in resourcing when clients don't have those models
  - CBT in beginning – but are cognitive distortions important when needs aren't being met? Case example

But what really works?

- 1) Smoothing Mechanisms (transportation, et al)
- 2) Expanding Mechanisms (increase funding)
- 3) Changing Mechanisms (decrease eligibility requirements)
- Barring that: provide easy access to food, showers, laundry, internet. Then co-located case management and therapy.
- Is your agency set up to provide these services? Why can't therapy be the only option with these clients?
- -2017 meta-analysis – Housing and case management first
- https://www.tandfonline.com/doi/abs/10.1080/10530789.2018.1442186

Managing client

- Many clients unable to articulate core *negative* belief – or a maladaptive schema (aka software)
- Numb to language of trauma
- Avoidance of uncomfortable schema or overcompensation
- Clients often unable to articulate *positive* cognitions
- May meet resistance when attempting to re-shift inner belief, goal is "know thyself and take care of thyself'
- Creating safe consistent environment for client to re-attach, permits growth

Case Presentation

- 27 year old African American female, HIV contracted at birth, in support group from young age, watched friends die (drugs, gangs, etc), 'last woman standing', homeless – couch surfing 7 months.
- Aged out of Children's system, no longer with same caregivers as in past, feeling abandoned
- Hx. of Bipolar Disorder, often present as manic, no medication - clt reports alternately given HIV Dementia dx. – certainly loss of friends, own health qualifies for PTSD
- Clt recently broke up with bf – hence housing loss, 1 child, age 3 in care with clt mother, 14 weeks pregnant, no meds.
- Looking for STRMU, not qualified given subsidized housing.
- Inability to conform to appointment time/therapeutic frame
- Reconciled with ex, housing stabilized
- Clt not stabilized but denies SI/HI
- Danger to self? Danger to baby? CPS reporting issues?

Case Presentation

- Your cases

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