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Providing Mental Health Services for the Formerly Homeless During COVID-19: An Autoethnographic Study

Lam, Giang and Tena

Abstract

COVID-19 has led to a global pandemic that affects many industries and population. Homeless individuals are adversely affected by COVID-19 and are subject to higher risk of infection and serious symptoms. COVID-19 exposed many gaps in treatment for formerly homeless individuals (FHIs) who currently reside in permanent supportive housing (PSH). This autoethnographic report seeks to analyze the gaps in services for agencies that serve FHI from the perspectives of both the mental health specialist (MSH) and the FHI. MSHs can include social workers, nurses, and case managers. Due to COVID-19 being highly infectious and potentially fatal to older people and others with preexisting health conditions, agencies were forced to implement safety protocols such as social distancing and shelter in place. Researchers documented the new protocols implemented by agencies to abide by shelter in place and social distancing guidelines to protect the community and the agencies' employees. Researchers analyzed the common themes that emerged from MHS while serving FHI in PSH while working under shelter in place.

Abbreviations: Coronavirus disease 2019 (COVID-19); Permanent Supportive Housing (PSP), formerly homeless individuals (FHI), housing first (HF), harm reduction (HR), mental health specialist (MHS), personal protective equipment (PPE).

Introduction

Homelessness is an extensive social concern across the United States. Individuals experiencing homelessness may suffer from mental health or substance abuse issues or a combination of both (Corinth, 2017). Roughly 567,715 (27%) members of the homeless population reside in California; 37,085 (8%) of those are homeless veterans (USDHUD, 2019). Los Angeles County consists of 91,000 homeless individuals while the city of Los Angeles is home to 49,521 (LASHA, 2020). Homelessness cost communities substantially through the use of emergency rooms, jails, and shelters (Culhane, Metraux, & Hadley, 2002). Mental health and substance abuse are prevalent in the homeless population; communities view the fiscal drain on their public resources as an intractable problem (Corinth, 2017).

Communities have begun to mitigate the number of homeless in their jurisdictions. In the past decade, there has been substantial funding and growth for permanent supportive housing (PSH) for the homeless (Corinth, 2017). As formerly homeless individuals (FHIs) are housed in PSH communities they require services to transition from the struggles of survival on the streets to living in a community. Since mental health and substance use are prevailing issues for FHIs, needed services can include case management, psychotherapy, and psychiatric medications.

Full service partnerships (FSPs) allow mental health service agencies to provide layered services to FHIs. FSPs potentially can outreach individuals exiting the criminal justice system, transitional aged youth, and older adults (Gilmer et al., 2013). FSPs can consist of case managers, psychotherapists, and a psychiatrist/ psychiatric nurse practitioner to prescribe medications. Gilmer et al. (2013) state that FSPs compare and evaluate based on distinct documentation that is necessary through the funder as well the basic operational differences, treatment philosophies, and approaches of each agency. FSPs also assists their clients in housing and treatment; the variations in FSPs can meet the needs of different populations and provide the ability to compare different methods of specific housing programs and services while meeting the same mission of serving the homeless (Gilmer et al., 2013).

In March of 2020, the United States was

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impacted by the global pandemic; unfortunately, the services previously discussed were interrupted. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), or simply COVID-19, was first discovered in Wuhan, China in December 2019 (CDC, 2020). The virus arrived in the U.S. in March, which led to shelter in place protocols in forty-two states (Mervosh, Lu, & Swales, 2020). The public was first encouraged to socially distance six feet apart and consistently wash their hands (CDC, 2020). Later, the Center for Disease and Control indicated that individuals were also encouraged to wear masks (CDC, 2020). Personal Protective Equipment (PPE) was essential to provide protection from the virus for workers whom the states deemed essential workers. California All (2020) states that California was "flattening the curve" initially, leading to different counties reopening; yet by the end of the year most counties reclosed. According to the County of Los Angeles Public Health (2020), as of December 2020, COVID-19 has been surging in the Southern California area; Los Angeles County is a major epicenter of the virus worldwide. The elderly, individuals with preexisting medical conditions, the homeless, and ethnic and racial minorities are disproportionately affected by COVID-19 (CDC, 2020). FHIs face exacerbated mental health issues due to the increase in isolation.

This article gives perspective on the gaps in services that mental health providers encounter while serving their clients during a global pandemic. During an era of remote services, this article also expresses clients' feelings about the services they receive from providers. Observations by researchers will analyze data about how mental health specialists (MHSs) deal with difficulties of navigating through a pandemic and adjusting their protocols while simultaneously meeting the needs of their clients. Also, an analysis will be given on the clients' coping skills that develop during changes in services and the perspectives clients express about the nature of the pandemic.

Literature Review

Housing First and Harm Reduction

The journey of homeless individuals being housed within a PSH community begins with assistance obtaining affordable housing. Research has shown that applying for a housing first (HF) model is an effective way to provide PSH. In 1992 Pathways to Housing, Inc. in New York City developed a new approach to combat homelessness, HF (Tsemberis, Moran, Shinn, Asumssen, & Shern, 2003). HF posits that individuals may obtain adequate housing without the requirement for treatment of mental health and substance abuse treatment (Kirst, Zerger, Misir, Hwang, & Stergiopoulos, 2014). HF is based on five principles: immediate access to housing with no preconditions for housing needed, consumer choice, self-determination, recovery orientation, individualized and person-driven supports, and social and community integration (Geller, 2014).

The implementation of HF was a radical alternative to traditional housing, also called linear residential treatment or treatment first (TF; Evans, Collins, & Anderson, 2016; Padgett, Stanhope, Henwood, & Stefancic, 2011). TF would require the individual to seek some degree of treatment to terminate the use of drugs or alcohol before they are given access to permanent housing (Goering & Streiner, 2015). It was not until the last few decades that HF became an acceptable form of intervention for homeless individuals; society believes that FHIs would be better able to progress in life if they were allowed to have stability and a place to call home (Geller, 2014).

HF and harm reduction (HR) were developed based on the needs of the homeless population; there is a great need for mental health and substance abuse treatment for the homeless. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020), 38% of the homeless are dependent on alcohol, and 26% abuse other drugs. SAMHSA (2020) also reported that 30% of the homeless suffer from mental health issues and 50% have co-occurring substance use problems. HF has been effective in assisting the homeless with mental illness by allowing the establishment and promotion of client choice, residential stability, client satisfaction, and community integration (Patterson, Moniruzzaman, & Somers, 2014; Somers, Moniruzzaman, & Palepu, 2015). HF is viewed as a long-term solution for homelessness (Burt, Pearson, & Montgomery, 2005).

HR clinical services are approaches that HF PSH communities utilize for their participants. HR is aimed at reducing the adverse effects caused by substance use, mental illness, and crisis (Inciardi & Harrison, 2000). HR recognizes that individuals are in different stages of their recov-

ery and adjustment to their PSH; thus, each individual requires an individualized plan tailored to their personal needs (Prochaska, DiClemente, & Norcross, 1992). Homeless individuals are given self-determination regarding using substances or taking medication (Tsemberis, Gulcur, & Nakae, 2004). Their choices, even if they may adversely affect them, will have no bearing on their housing status and case management will still support them (Tsemberis et al., 2004). For the past decade, PSH, HF, and HR have become the preferred method to house FHIs (Wenzel et al., 2018).

Permanent Supportive Housing

PSH communities began to increase between 2007 and 2014 predominantly due to federal funding as well as local and private funding (Corinth, 2017). PSH combines recovery-orientated services along with informed staff to develop goals for FHIs; the aim is to meet their differing individual needs while maintaining their housing stability (Montgomery, Cusak, & Gabrielian, 2017). The U.S. Department of Housing and Urban Development (HUD) estimates that 50% of individuals living in PSH suffer from substance use disorder, mental illness, or a combination of both (USDHUD, 2019). PSH programs offer collaborative and flexible individualized support services and voluntary support to maintain housing (Rog et al., 2014). This supportive case management is what differentiates PSH programs from other housing programs (Rog et al., 2014).

According to Rog et al. (2014), key elements of PSH are full tenancy rights, affordability (30% of income), integration, no time limitation, preference in services based on their needs, and housing not being contingent on service participation. Research has shown that PSH participants typically remain housed for one year (Rog et al., 2014). A significant number of PSH participants leave PSH programs because they either progress to independent living or return to the streets involuntarily (Wong, Poulin, Lee, Davis, & Hadley, 2008). FHIs who have demonstrated the ability to live independently from PSH are considered to have "graduated" (Rog et al., 2014). Individuals who leave voluntarily have lower rates of schizophrenia, substance use disorder, and are experiencing fewer symptoms (Montgomery et al., 2017). These individuals also require less support with employment, housing issues, transportation, making appointments, and developing a support network (Montgomery et al., 2017). Involuntary leavers on the other hand require more supportive services since they are more likely to use acute services (Wong et al., 2008). The most common reason for getting evicted from PSH was active substance abuse, illness, or hospitalization (Wong et al., 2006). Challenges may arise for FHIs in a PSH. A careful balance between a trauma-informed property management team, a trustworthy community engagement team, and competent residents' services is needed for the formerly homeless to succeed in a PSH environment. Factors that connect FHIs may be socio-economic status or veteran status.

Mental Health Services

According to Stergiopoulos, Dewa, Durbin, Chau, and Svoboda (2010), underserved populations have a high risk for severe cognitive and thought process impairments, social difficulties, safety concerns, physical health risks, and other resistive behaviors. The same populations tend to have fewer educational and social network resources available to them (Stergiopoulos, Dewa, Durbin, Chau, & Svoboda, 2010). Those with too few resources and mental illness are deemed difficult to house and are often neglected for services from providers (Stergiopoulos et al., 2010). Strengths and the ability to adapt to mental illness directly affect resistance and difficulty towards receiving services (Stergiopoulos et al., 2010). FSPs are effective in reducing the number of days of homelessness, use of inpatient and emergency mental health services, and an increase in outpatient mental health treatment (Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010).

HF provides FHIs with PSH as well as support services. Mental health services are important to keep FHIs housed due to the traumas they have experienced living on the streets. FSP treatment teams can offer a wide variety of services and mental health professionals such as case managers, clinical therapists, psychiatrists, substance abuse counselors, nurses, housing specialists, benefits counselors, vocational counselors, and education counselors (Gilmer et al., 2013). These providers and mental health specialists (MHSs) assist with the adjustment to living in PSH (Gilmer et al., 2013). Moreover, FSP provides targeted case management such as linkages, skill building, and referrals to benefits (income sup-

port, health insurance, housing subsidies) and resources or transportation. Educational, vocational, daily living assistance, social skill building, or social events are other services provided to FHIs (Gilmer et al., 2013).

Methodology

According to Ellis, Adams, and Bochner (2011), autoethnography can be effective when researchers aim to express their personal experiences to better comprehend a cultural experience, in this case providing mental health services for the formerly homeless during COVID-19. Researchers explored FHIs and their MHS needs, perspectives, challenges, difficulties, coping strategies, and creative solutions they utilize. Through an autoethnography modality, the researchers allowed participants of the study to dictate the themes that arose during their unique experiences traversing a world of global lockdowns during COVID-19. No direct interviews or surveys were used; participants were simply observed by researchers and thereafter detailed notes were kept on what was expressed. Autoethnography allows self-reflection and analysis of the data collected through these observations. Professional interactions with the community over six months of COVID-19 from June to the end of December were documented, and researchers self-reflected on the data collected in journal notes during this time. Interactions and rapport built with participants allow for critical examination of the authors' experience conveyed through an autoethnographic study. COVID-19 provided researchers a unique opportunity to analyze services rendered that had to be adjusted to ever-changing rates of infections. Clinical sessions and team meetings allowed the researchers to note themes in the gaps of services rendered and issues that arose. According to Bernard (1995), issues, themes, patterns, and trends are best analyzed with an autoethnographic modality to expose trends as they unfold.

Specific themes were recognized with mental health professionals' attitudes towards providing services during COVID-19 and how clients perceived the resources they received during COVID -19. These themes were organized in field notes during interactions with clients. The authors of this research study would collaborate on video conferences and shared digital documents to further develop topics of concern with FHIs. Common themes the authors recognized from observations with mental health professionals were frustrations amongst colleagues due to an unequal share of work, relying on coworkers for in-person visits, COVID-19 protocols when seeing clients (15-minute limitations of in-person visits and use of PPE), a seeming lack of effectiveness of remote therapy and services, burn out, and video conference meetings. Common themes that came up with clients were increased depression due to isolation, increased substance use, frustrations over lack of physical contact, learning new hobbies and coping skills, overuse of emergency services, and technological issues.

Goals

The goal of this reflection is to establish how to provide competent and adequate mental health services to clients during a health crisis. There are complex interconnecting social structures within PSH communities, collaborating agencies, and city/state/federal regulators; these complexities allow for analysis of the gaps in services and recognize MHSs' unique solutions to adapt to these challenges. Clients have autonomy in choosing what assistance they seek from a variety of services offered by agencies. COVID-19 is a unique event in an era of rapid technological growth. By implementing critical analysis researchers focus on the needs of clients with their PSH communities as well as the limitations imposed on MHSs. Researchers evaluate the most daunting tasks MHSs face and the most effective solutions. During observations and data gathering for this research, the researchers realized that some common themes emerged for various MHSs.

Themes and Perspectives

Mental Health/Housing Specialist

The state of California was one of the first to implement statewide stay-at-home orders. Different counties in the state followed their guidelines based on infection rates and availability of Intensive Care Unit beds. Los Angeles County had one of the strictest lockdowns and social distancing guidelines. Homeless services agencies had to change their policies and protocols to serve their clientele. California has 27% of the U.S. home-

less population; many homeless individuals struggle with lockdown protocols. FHIs residing in PSH found difficulty managing their symptoms and barriers from their experiences of life on the streets. MHSs faced many challenges by providing seemingly adequate care and services.

MHSs that serve FHIs in PSH in Los Angeles County were forced to follow county guidelines, but many agencies implemented their own policies to protect their clients and employees. MHSs serving homeless individuals and FHIs are considered essential workers, and their services were necessary as long as they abided by these guidelines. Researchers noted these policy guidelines differed per county and agency. Researchers observed that many MHSs were frustrated by the limitations placed on them. To provide face-to-face services the Los Angeles County Department of Mental Health and Los Angeles County Department of Public Social Services allowed limited face-to-face interactions with clients when outreaching; when providing services in homes, MHSs were not allowed to enter the residences, but only allowed to speak face-to-face at the door for 15 minutes. There was also the issue with full PPE; masks were always mandatory even when in offices alone, but full PPE (mask, gown, face shield, and gloves) was required for face-to-face interactions lasting longer than 15 minutes, even if participants were 6 feet apart.

These policy limitations created unequal workloads amongst staff of FSPs and various teams. Agencies encouraged employees to rely on coworkers to assist with providing services. Many employees during the pandemic were documented to work completely remotely due to preexisting healthcare conditions that made them more susceptible to the effects of COVID-19. Researchers noted that on several occasions, half of the staff at FSP would be working remotely; therefore, the task of delivering goods and providing in-person services was reduced to the other half of the FSP. Frustrations were aired out amongst the staff who were not working fully remotely, and there seemed to be slight animosity towards those who worked completely from home. Partner agencies also felt resentful at mobile teams who now worked primarily from home. The staff located at various PSH sites were still working physically at these sites (with less staff, however) and were given the task of doing face-to-face interactions and coordinating between clients and remote MHSs. Onsite staff have expressed that these face-to-face interactions are burdensome and were unjustly putting themselves more at risk for contracting COVID-19. Some onsite staff voiced their embittered feelings concerning the lack of support they were receiving as well as the many tasks they were given while working in a remote environment. These discontented feelings were held in private between various employees and not expressed amongst team meetings due to the sensitive nature of the global pandemic, coupled with many coworkers having sensitive health risks that they may want to keep private.

Technology has allowed MHSs to continue to support their clients and fulfill their roles/tasks, despite a global pandemic. Staff from various partnering agencies have utilized Zoom or Microsoft Teams to conduct business; this includes county employees as well. Amongst FSP team members and employees of the same agency, interactions are done digitally, typically on one of the video conference platforms. This has led to many MHSs stating that they are experiencing "Zoom fatigue" from being on so many online meetings. Many have stated that having team meetings on video conferencing throughout the day has led their work to feel impersonal and tedious. Zoom fatigue has lessened MHSs' attention spans and created fatigue barriers. Other MHSs have also expressed the lack of reliance on their equipment, such as cell phone signal or Wi-Fi access, that directly affects how they provide services.

COVID-19 shelter in place orders shut down many industries; however, many are capable of working remotely. MHSs working remotely are encouraged to interact with clients via telephone or video conference. Case managers provide linkages, referrals, skill-building, and targeted case management; clinicians, provide psychotherapy, most of which is sufficient to complete over the phone. A barrier that exists for some clients regarding interactions between clinicians is the lack of access or knowledge of technology. Sequentially, psychotherapists were advised during group clinical supervision and in meetings stressing the ineffectiveness of telephone psychotherapy and how telehealth was viable due to technical issues. Additionally, case managers felt that the services they were providing were inadequate as a result of the barriers previously discussed. Some MHS clinicians were documented by researchers

saying they are calling the clients to check in, but they feel that they are not adequately providing services that are beneficial to the client that they would provide in a face-to-face sessions. These MHSs say they do not believe they are making any strides towards the client's goals, and telephone calls were seemingly just busywork.

Formerly Homeless Individuals

Clients/residents or FHIs that reside in PSH regularly require services from MHSs. As previously discussed, many individuals encounter barriers from their experiences of experiencing homelessness that they still encounter after they are provided with housing. The comprehensive services that FSP provides meet many of the needs for FHIs; however, many FHIs expressed their concerns due to the gaps in coverage from COVID-19. Complaints that are regularly expressed included the lack of physical contact with their providers. FHIs have been addressed in such a way that they feel rejected and feel like outcasts in society when they are forced into stay-at-home orders and isolated from society. Many of these feelings are based on FHIs' beliefs they are ostracized by society due to the social stigmas associated with homelessness.

Stay-at-home orders have led to exacerbated mental health symptoms from FHIs. Depression has been journaled as the most common symptom and is evidenced by increased isolation, sadness, feelings of worthlessness, and feelings of hopelessness. These symptoms are influenced directly by COVID-19 and every changing protocol implemented. However, due to the intense political climate of the Black Lives Matter protests and a presidential election year, many FHIs were documented saying they also fear the future and the unknown. Numerous external factors affected the mental health of FHIs. Along with depression, other common symptoms included anxiety and increased substance use. Many FHIs have been documented saying they experience excessive worry and anxiety about the outcome of COVID-19 as well as their overall health. Others have coped with symptoms by increasing their substance use. A common theme that was discovered during analysis amongst this population is their distrust of the government. Black FHIs have expressed to researchers a general distrust of the government; many say historical incidents such as the Tuskegee Syphilis Study disillusioned them that the government has their best interest in mind. Black, indigenous, and people of color (BIPOC) FHIs say that COVID-19 is part of a global conspiracy. While most FHIs have a distrust of vaccines, FHIs who have stated their beliefs in COVID-19 conspiracies are from lower socioeconomic status and below high school level educational achievement. Many of these FHIs say they retrieve their information from Facebook or YouTube. While technology provides many with access to a vast variety of information, lack of variability and reliability of where the information comes from can be harmful. BIPOC FHIs stress that mainstream media tends to be harmful and disingenuous towards the BIPOC experience; thus, many BIPOC FHIs seek their information from other sources they feel speak more towards that experience.

COVID-19 prevented MHSs from performing the much-needed task of assisting with transportation. FHIs say their physical and mental health needs have not been adequately met because of social distancing guidelines. MHSs can typically take them to urgent care or local emergency care when FHIs have health care needs. Due to the inability to transport clients during COVID-19, FHIs have been observed excessively using 911 and emergency services. Some clients called 911 for ailments such as difficulty breathing and dehydration numerous times.

MHSs encouraged clients to seek self-care activities and hobbies they can accomplish during stay-at-home orders. MHSs are observed utilizing Cognitive Behavioral Therapy for clients to assist with negative thought processes as well as adopting effective/healthy coping skills. The willingness to seek healthy hobbies and coping skills as opposed to adverse activities like oversleeping, isolating, crying, experiencing sadness and depression, experiencing anxiety, or substance use was important towards reaching treatment goals through mental health services; however, few clients will keep doing their hobbies for a prolonged period. Many clients will begin an activity but shortly quit. Clients say they are just overwhelmed with everything being shut down and being forced to stay indoors. Clients have said they only feel a short temporary relief but would prefer the instant gratification of medications.

Major issues that have been journaled occurring for most clients are the lack of technological access or capability. Poor reception, lack of video

conference technology capacity or knowledge, and consistently losing their mobile phones have made services difficult. Most clients dislike the impersonal services they receive over the phone. Typical services would be at their home, but since most services are over the phone, clients tend to not answer calls due to their feelings of ineffectiveness. Many clients receive free government-issued phones and misplace them while traveling on the bus and will regularly get a new free phone but with a new number, thus making contacting them for appointments more difficult. FHIs have also stated their difficulties with utilizing technology and would prefer in-person services, believing in-person services to be more effective.

The current political climate during these six months of observation included a global pandemic, statewide stay-at-home order, Black Lives Matter protests (including rioting during a protest), and a presidential election. Clients have expressed that as a result of these events, they are unsure of their future. Dining out and being able to socialize within their communities were major concerns FHIs faced. FHIs say they do not know when shelter in place orders will be lifted, exacerbating symptoms of anxiety. Some African American clients expressed fear for their safety, while other clients question if things will ever return to normal. COVID-19 prevented MHSs from performing the critical task of assisting with transportation. The role of MHSs to assist FHIs in alleviating stressors is dramatically stifled by COVID -19 safety concerns.

Discussion

FHIs that reside in PSH are a particularly vulnerable population as a result of the traumas they have experienced while experiencing homelessness. Henwood, Redline, and Lahey (2020) state FHIs housed in PSH must cope with changes such as premature aging, in-home support needs, and early onset of geriatric conditions that are similar to those of nursing homes. During shelter in place and social distancing due to COVID-19, many homeless services agencies and PSH communities had to modify the services they previously provided. Barriers such as a lack of access to food, medications, and hygiene products were common during shelter in place for FHIs living in PSH (Henwood, Redline, & Lahey, 2020).

COVID-19 presented a unique problem for this vulnerable population. According to the CDC (2020), those with preexisting conditions, the homeless, and the elderly are susceptible to the effects of COVID-19. Due to shelter-in-place protocols, many of these FHIs in PSH lived in a renewed state of uncertainty and fear. FHIs were a highly vulnerable group to contracting the virus. FHI support networks were closed down due to shelter in place and their service providers' reluctance to provide face-to-face contact; many experienced increased mental health symptoms. COVID-19 implied to MHSs and agencies that they had to create remote services for social distancing, causing many to feel they were not providing enough resources for clients during this crucial time.

Henwood et al. (2020) state that MHSs will need to utilize telehealth and other means to provide resources for food and medication so they can maintain social distancing. While many agencies have been observed adhering to social distancing protocols, collaboration difficulties with onsite partners have developed. Onsite partners say there is an unequal distribution of tasks with onsite employees tasked with in-person contact. Onsite partners have expressed that they are at more risk of contracting COVID-19. The technological capacity of clients was a common issue as well; while most services are remote, onsite partners were asked to show FHIs how to use their devices by remote workers. While there are no perfect methods to adjust to social distancing during COVID-19, researchers have documented many effective ways that homeless services agencies have implemented.

FHIs have to adjust to the type of services available. While there are many concerns that many FHIs have with the increased isolation, anxiety, and depression, most countries worldwide have implemented a shelter in place order in one way or another. Clients sometimes have to be reminded the global pandemic has affected everyone. Everyone has had to adjust to a different way of life and compromise with the services they receive. Many FHIs have adjusted and accepted that remote services are the new normal. Even though some FHIs have stated frustrations about social distancing, they understand community safety and following protocol are very important. Stergiopoulos et al. (2010) expressed that researchers, policymakers, MHSs, and housing providers need to ensure adequate services personal-

ized towards each FHI's unique needs and preferences. Many FSPs already actively provide layered services, and agencies provide a diverse selection of services available to FHIs. FSPs need to stress the importance of variable services based on need. FSPs must adapt their care plans in accordance to specific needs of clients and based on which clients can cope and thrive with remote services and which require more face-to-face interaction. Collaboration and understanding between agencies working towards similar goals are important for successful MHS services. Teams of MHSs and FSPs can assist each other and partners with new shelter in place and social distancing protocols and allowing flexibility; when clients also show equal patience and an ability to alter their needs, then FHIs and MHSs can meet each other in the middle.

Implications

The number of PSH communities and low-income housing is flourishing in the United States; however, more research needs to be conducted to properly assess the mental health needs of this growing population to adequately provide services. This empirical research study seeks to give mental health providers and researchers unique perspectives on challenges MHSs faced while serving this population during a global pandemic. FHIs that transition into PSH faced barriers due to the past traumas they faced in their upbringing and being accultured to life on the streets. Mental health, physical health, vocational, educational, social barriers, and myriad other problems are issues that FHIs require assistance to overcome. During COVID-19, an era of social distancing and global lockdowns, these needs were hard-pressed to be met adequately. FHIs faced increased isolation, stunted connection with communities, increased difficulty meeting medical needs, and strained rapport with service providers due to social distancing. Remote services provided some linkages and services for FHIs, but adjustment was necessary from both client and provider to ensure everyone's safety so the virus did not spread. Homeless services agencies who were able to adapt to stay-at-home protocols were able to meet the needs of many clients as best they could. Collaborations between providers, increased use of technology, and reliance on peers for additional support allowed many FHIs to have many different support systems. Remote services, adjustments to practice, and policy can be derived from the implications inferred from this research. Mental health practitioners can promote more remote or hybrid programs to align with the needs of FHIs during times of crisis.

Conclusion

As the world continues to brace through the second wave of COVID-19, Los Angeles County has become the epicenter of the pandemic from December 2020 through January 2021. Shelter in place orders have been renewed. However, there is a glimmer of hope; in December 2020 the Food and Drug Administration authorized two vaccines, Pfizer and Moderna, and the federal government in conjunction with state and local governments has begun to roll out these vaccinations in Los Angeles County. MHSs in Los Angeles County have been deemed front-line workers and are considered first responders, so many MHSs serving FHIs in PSH have begun getting the first of two injections. Through this autoethnographic study, researchers were able to convey what they observed while serving this vulnerable population during COVID-19. Many issues arose from remote services from both MHSs and FHIs. Frustrations about the ineffectiveness of services were a major issue on both sides as well as several other grievances.

Agencies were able to tailor their services to preserve the valuable services they provide for FHIs while keeping everyone safe as well. Telehealth and technology filled the gap that in-person services could not. Fortunately, many services were able to be tweaked slightly to allow for FHIs to receive help while allowing MHSs to collaborate with partners and coworkers to coordinate care more fluidly. The researchers did see room for improvement in workload between partners and teams; hopefully, the vaccine can give everyone confidence to be more active in their employment.

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