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PSYCHOLOGICAL NEEDS OF HOMELESS SHELTER RESIDENTS IN INTERACTION WITH THE EDUCATION OF SOCIAL WORKERS

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Abstract

High demands are placed on social workers in shelters in relation to the mental state of their occupiers, which often do not care correspond with the social workers´ education. Research question: What educational demands are placed on social workers in relation to mental state of the occupiers of shelters? The aim of the research is to map and analyze the mental health of the occupiers of shelters and the resulting demands on the education of social workers. The contribution is based on the qualitative research with the occupiers of shelters in four regions in the Czech Republic. The research was attended by 30 communication partners, out of these 13 women from shelters. The research was carried out in the form of semi-structured interviews and subsequent analysis using the constructivist grounded theory of K. Charmaz. The results of the survey point to the often poor mental state of the occupiers of shelters and their specific needs in the field of social counselling, psychological care, psychotherapy or crisis interventions that are perceived in the context of accumulation of roles. Assistance to people in the field of mental health in shelters is often considered insufficient. The solution seems to be a combination of several options: the first is the supervision, the second is the extension of the education of social workers in the field of psychological disciplines, and the third is the cooperation with external experts.

Keywords: Homelessness, psychological needs, education, social workers.

1. Introduction

The issue of helping people without their homes is a highly current topic on a global level. In 2011, 11,496 persons (CZSO, 2011) were registered homeless in the Czech Republic, although source analyses show that homelessness in the Czech Republic is a highly dynamic phenomenon and the number of homeless people will continue to increase (MLSA, 2015). In the Czech Republic, there is currently no legislative anchorage to help homeless people. The system solutions to homelessness are also non-existent. The state shifts primary responsibility for helping homeless people onto social services, in particular, onto homeless shelters. The Act no. 108/2006 on Social Services, Section 57, describes the homeless shelter as follows: "*Shelters provide temporary accommodation services for persons in an unfavourable social situation associated with the loss of housing*". The Social Services Act states that "*the Service referred to in Paragraph 1 includes the following basic activities: a) provision of food or assistance in the provision of food, b) provision of accommodation, c) assistance in enforcing rights, legitimate interests and in the procurement of personal affairs*". The Act on Social Services (108/2006) further stipulates that "*the persons pay a fee for the provision of social services in shelters...*" The stay in a shelter is limited in time, most frequently for a period of one year. Each shelter has its own system of rules and its own regime, usually including the scheduling and management of regular cleaning chores, room sharing, visiting hours, permitted outings, rules for sharing common areas, keeping animals in the facility, alcohol consumption ban, etc..

2. Problem Statement

Homeless people form a very diverse group in terms of their personal stories, interests, behaviours, health problems, the factors preceding homelessness, the social context homeless people come from and other variables on the part of society (Piechowicz, Piotrowski & Paswa-Wojciechowska, 2014). Despite all the above differences, they share a home loss experience, which is per se perceived as a very stressful factor that greatly affects their mental health (Skinner, 2009). Research by Laporte et al. (2010) shows that up to one third of the homeless population suffers from severe psychological problems (psychotic illness, depression and/or anxiety). A German study (SEEWOLF-Study, 2014) talks about the fact that up to two thirds of homeless people who participated in the research suffered from mental illness, and in most cases from more illnesses simultaneously. Furthermore, Bassuk et al. (2010) point out that the most significant risk factor of homelessness is excessive alcohol or other addictive substance consumption followed by addiction to these substances. Problems with the drug or alcohol abuse in non-homeless people have been associated with a significantly worse health, especially mental health condition (similarly, see SEEWOLF-Study, 2014). Poor psychological state of the homeless shelter population places increased demands on social workers working in such facilities (Glumbíková, 2017). There is a number of studies devoted to the mental state/health of homeless people, however, the studies linking this state to the demands regarding social workers' qualification, are almost absent.

3. Research Questions

Based on the problem statement, this paper aims to answer the following research questions: (1) What is the mental state of the homeless shelter population/residents? (2) What demands does this state place on the education of social workers?

4. Purpose of the Study

The data presented are partial data from the research study entitled Health and Use of Healthcare Services by Shelters' Users. The aim of the study was to: (1) Analyze and describe the perceived impact of homelessness on the health of the homeless shelter population. (2) Analyze and describe the perceived impact of the shelter environment on the health of its residents. (3) Make recommendations for homeless shelters based on the research findings. Based on partial data, the aim of this study is to map and analyze psychological (mental) health of the population of shelters and demands placed on the professional training of social workers.

5. Research Methods

The research was implemented using a qualitative research strategy. Qualitative research is an approach utilizing the principles of unrepeatability and uniqueness, processuality, contextuality and dynamics, and within this framework we are deliberately working with the reflexive nature of any exploration (Hendl, 2016). The goal of the researcher is to understand the situation as understood by the actors themselves (i.e. "*obtain a subject's perspective*") (Denzin & Lincoln, 2011). The research was carried out in cooperation with 30 communication partners from four regions of the Czech Republic – 13 women and 17 men. Communication partners were selected using intentional selection through the institution. Intentional selection through institutions is the method when we use a certain type of service or activity of some institution that is intended for the target group we are focused on in the research. This type of intentional selection is used in this research because it is the people (men, women, single parents and families) using the services of a given institution (the shelter for homeless women and mothers with children) who are the core population of research. The data were collected using semi-structured interviews. For a semi-structured interview, a clearly defined purpose, a certain pre-determined structure of the interview, and a great diversity of the information acquisition process as a whole are distinctive.

In terms of data analysis, we used a constructivist approach to the grounded theory by Charmaz (2006, 2012). Data analysis was performed using initial coding where the codes are created and assigned; focused coding, which is based on searching for similarities and selecting "*the most useful*" codes and their re-testing in relation to other open codes. This phase is followed by "*comparing data with codes and codes with data*" and detailing of the codes. The next coding phase was axial coding that led to the creation of categories and subcategories. Table 1 lists individual codes and categories related to the research questions in this paper.

Table 01. Categories and codes

Category	Code
Mental health	"*Mentally hit rock bottom*", street life, stress from homelessness and uncertain housing, loss of beloved ones, fear of loosing beloved ones, depression, insomnia and fatigue, suicide, mental health of children, phobia, interconnectedness of mental and physical health, domestic violence, failing in the parent role
Environment of the homeless shelter and mental health	First stay in the facility, the need to adapt to the regime of the facility, lack of privacy and the need to share space, having roommates, ambivalent relationships, disease transmission
Social worker – methods/types of assistance	Accompaniment, advocacy, counselling on personal change, services of a psychotherapist or a psychologist
Perceived needs in relation to the nature of the relationship with a social worker	Establishing a good relationship, support and showing of an interest, "*not to feel alone in the problem*", "*sometimes it's enough just to be able to talk*", "*to talk openly*", one key social worker, a social worker who the client is familiar with/has been proven, long-term aspect, "*they know me from the past*", to maintain a long-term contact with the shelter/social workers for the future
Accumulation of the social worker roles	„*říct všechno*" "*To be able to tell everything*"

Zdroj: author's own.

6. Findings

6.1. Mental health of homeless shelter users

As part of mental health, the communication partners described the feelings of "*mentally hitting the bottom*." "*I mentally hit rock bottom. I got divorced, then when you loose your job, it also makes you depressed, then you have no money to purchase what you need and to live on. Then you start receiving some welfare benefits and that's not enough for you, it knocks you down on your knees*" (CPV6). "*Well, no, my physical health was rather okay, but it was hard on my psychological health, it was so unpleasant. I was kind of mentally at the bottom, that I left all my worries behind, and stopped carrying about anything*" (CPT3). Some research participants associated the "*mental bottom*" with their life on the street. "*When I realized that I hit rock bottom, I was on the street. And it really freaked me out and I took some pills, the doctor gave me some anxiety medication...*" (CPM1). Some communication partners directly associated their poor mental state with stress from the loss of housing and from uncertain housing. "*Well, you know I have because I do not have a home. A contract ends here in a month. I don't have a permanent address here, so finding a flat is a terrible problem. Excitingly. Since you can not sleep in the evening, you do not even know where to go with that baby. Well, I've been treating nerves and psyche too for years, so, I'm going to a psychiatrist now*"(CPH4). "*Well, I see a doctor every month, the psychiatrist, because what happened was that it turned out to be too much for me and I wasn't doing very well. It all was just starting to fall on me. I am only human, as they say, so I go to see a doctor every month, take medicine and try to deal with my loss of flat. Social workers here are helping me too*" (CPH4). The clients were also connecting their poor mental condition with the loss of beloved ones. "*I was supposed to*

complete my army service in four or five months, when they took my father's leg, so I went to the hospital, and then my father passed away in a month or two. And it got me" (CPM1). "*Well, when my baby died I used to go to see someone, it was before, when I was still with my husband*" (CPP1). Or they are connecting it with a fear from the loss of beloved ones. "*I'm afraid that my mom will pass away, I wouldn't be able to do anything about it right now. It put me totally down.*" (CPM1).

In addition, communication partners talked about depressions. "*I had hiked for about three weeks in the mountains. I already had a depression. When I was in the woods, I didn't feel so much like I was depressed. I've always had some sort of depression where I felt like I didn't care about anything and just wanted to be somewhere alone. So I walked a lot, and didn't even eat. Life didn't matter to me*" (CPV4). Communication partners also often described insomnia (sleep issues) and fatigue associated with it. "*No, I'm rather tired from all this here*" (CPH1). One communication partner described phobia. "*I have a phobia to cross the smooth pavement. As I'm approaching the smooth pavement, I see it and I start feeling sick and I'm shaking too*" (CPT2). Some communication partners spoke openly about the fact that they had previously considered suicide. "*After all that, one thinks to himself that he should just end it. I personally wanted to do it*" (CPV3). "*I had thoughts of death in the past, that it would finally give me peace, it was too much of suffering, really*" (CPZ2). "*When I had that buddy of mine, I wanted to hang myself once, yeah. But he cut the rope, yeah*" (CPT1). One of the communication partners spoke about her child in connection with mental health. "*I have a son who has been sexually abused, yeah. We already went to see a psychologist and we'll go to see a psychiatrist, because he may have to permanently take medication to calm down, since he's been diagnosed with ADHD, hyperactivity and concentration disorder*" (CPZ1). In relation to the psychological problems of children, it must be emphasized that children can often be more sensitive to changes, meaning that mothers living in a shelter must cope not only with their own mental situation but also with the mental state of their children.

Communication partners often talked about the interconnectedness of mental and physical health. An interesting fact was that it was women who were more likely to talk about "*mental problems*", especially in the form of depression and anxiety. Men also talked about their psychological problems, but more likely in the case when they already attended doctors with the given mental condition and were thus somewhat aware of it. So, we can conclude that psychological problems occur both in men and women in homeless shelters, but the men less often verbalize them. "*I mentally hit rock bottom. I got divorced… then when you loose your job, it also makes you depressed, then you have no money to purchase what you need and to live on. Then you start receiving some welfare benefits and that's not enough for you, it knocks you down on your knees*" (CPV5).

Mental health is especially in women associated with their past experience of domestic violence. "*He wanted half of the house, beat me, even took an axe to me. Since I've once done kung-fu, I used it so he wouldn't kill me, you see*" (CPT2). "*He turned me into a completely fat, distrustful person, who was just killing the self in me*" (CPV1).

Two of the communication partners have connected their poor mental health after experiencing domestic violence with their "*failure*" in their parenting role. "*And always after he left, I was a nervous wreck and used that anger I was feeling against my children. Not that I was somehow physically abusing them, I don't beat them, but I was screaming, throwing things around*" (CPV1). "*I then had such a*

depression that my kids were taken away from me. I wasn't able to look after them, there was nothing I could do that they took my kids away made it even worse though. Yeah, they are a support to me" (CPH5).

6.2. The environment of the homeless shelter and mental health

The shelter environment is perceived by communication partners as somewhat stressful, especially during their first stay in the facility. "*So, the stress really affects you, that you have to adapt in some way that you are being exposed to something*" (CPZ1). "*Well, in the beginning, it was quite mentally demanding. Probably the worst was to get used to the fact that I'm not living on my own anymore, that there's a shared bathroom, and so on. All this was probably the worst thing, yeah, .to get used to the fact that it's not for my own single use anymore, but that I often meet with others when I want to watch TV and so on. That's probably the worst*" (CPZ2).

The first downside was connected with the need to adapt to the facility's regime, which was compared by two communication partners to a "*military service*" and by one communication partner even to custody. "*It's like in the military service here, the chore assignments, the walks, the visits, all that*" (CPM5). "*As for the health?! I don't know, but back to our cleaning topic, yeah, we have to do chores. For example, the stairs need to be washed twice a week. And some people see it that it's like in the army service*" (CPV4).

An important downside that communication partners associated with staying in a shelter and their health condition was the lack of privacy and the need to share space. "*It's not very nice when, for example, three people must share one room, but it's actually better than somewhere else. I was living outside for almost a month, so for me it was quite hard, but in the end I got used to it*" (CPV4). "W*hen you want to watch TV, you can't, because there is always someone shouting or talking and I don't want to listen to it*" (CPM4).

As part of staying in the shelter, an important topic was sharing space with other residents and being a roommate in general as well as frequently ambiguous relations with other residents of the shelter. "*I like it there better than here. Here, everyone fights over small stuff. You've got a roommate and that's rather hard. The roommate is different, I'm different*" (CPM4). "*When I lived here I shared a room with one young dude. Well, when I saw what he did and was like. So, first of all, he washed his feet in a bucket, he washed his whole body in a bucket. As I returned to the room, because I go out, I couldn't believe what I saw*" (CPT1).

The necessity of sharing space with other people has been associated with the spread of diseases by the communication partners. "*It's quite bad here, when one is sick, it spreads around" (CPT4). "So when one is sick, there are several people sick here today, it really spreads. Not even airing out the place helps. Everybody here has a cold now. If you don't want to leave sick from here you should talk to those people in a surgical mask*" (CPV5).

6.3. Assistance provided in a homeless shelter

A social worker is perceived in a shelter as a primary source of support in an area of mental health.

6.3.1. Types of assistance provided by social workers in a shelter

In terms of their relationship with social workers, the communication partners talked about many methods/types of assistance the social workers provide or what they would need them to provide. In their narrations, the following methods/types of assistance could be identified: (social) counselling (including the provision of social benefits, setting up debt repayments, setting up a system of investigation...), provision of healthcare, sorting out relevant documents, computer literacy assistance, assistance with seeking housing, jobs, information about healthy nutrition online and helping with tutoring children. Particular emphasis was put by the communication partners on the accompaniment, which was especially perceived as a source of social support: "*Caregivers are good here, and if you need it…they won't let you down and will accompany you wherever you need them to*" (CPH4). "*Yeah, in the beginning, when it started, that epilepsy… I had to be accompanied because I was feeling overall weak and didn't feel up to running errands on my own, so I needed an escort*" (CPT2). Advocacy, in other words, some support in the enforcement of clients' rights, which applies to, for example, arranging for welfare benefits or providing transport to healthcare services, was also considered an important factor by communication partners. "*Well, I didn't read it [the list] until I got back home…how many papers they needed me to be submit, oh my god. So, the next day, Mrs. T. …I mean it was about the meetings who needs to do what...I showed it to her and she said she would call them at about half past nine…I mean the welfare benefits office… and that she would try to ask about it and on Monday we would perhaps go to see a curator, if it was related to me*" (CPT2).

Some communication partners talked about their perceived need for a personal change counselling. Some associated this counselling with their past alcohol addiction. "*I just didn't care about anything else but fetching some bottle somewhere. In fact, the social workers work very intensively with me here…we talk about different things. It's an environment where certain conflicts arise*" (CPV3). "*Yeah, you can talk to her even about alcohol...when the urge comes to me, it's safe for me to tell her...when I share it, I feel better*" (CPM3).

In relation to a personal change counselling, some communication partners confused the work of a social worker with the work of a psychotherapist or a psychologist. "*When I need to talk about my problems, I go to see the social work lady…, when a depression or those states of mind attack me again*" (CPV2). "*Our social worker, Mrs .... should not just be a social worker, she should be also a psychotherapist. Because I'll tell you what, when I want to talk to her and I'm feeling aggravated, I don't want to shout at her, so I go outside first to calm down and only then I actually try to discuss it with her and come in*" (CPV3).

6.3.2. Perceived needs related to the nature of the relationship with the social worker

In terms of their relationship with social workers, the communication partners perceived establishment of a good relationship to be very important. "*Yes, she's happy to hear from me about how I did and I told her that I already got a flat. Well, she seems happy about it and me. And that helped me*" (CPV4). "*The support of social workers here helps me the most, that at any time there is a problem one can go and talk to people at least, right. They'll help you and that's probably the most important thing*"

(CPZ2). The characteristic of a good relationship is the support and interest. "*It always made me feel a bit better, but ... now I felt like I had people around me who were all trying to help me*" (CPV4). Another characteristic of the relationship is '*not to be alone in it*'. "*It's important. Maybe it's because you're feeling that I'm not alone in this problem. So many people are in the same situation as I am*" (CPV4). "*But on the one hand it's good that one is not alone. That you're not in the street with your child*" (CPH4). In terms of "*not to be alone with a problem*", the communication partners talked about "*sometimes it's just enough to be able to talk*", …so the "*mere*" sharing opportunity is perceived as very valuable by the communication partners. "*We have that kind of opportunity here. Either we can talk to staff or they offer us psychological help in case of stressful situations and so on*" (CPZ1). "*We have a chat about what it is like here and what's going on or if we have some problem and so on. Then they leave, they drop by twice or three times a day*" (CPM2). One of the communication partners saw an opportunity to "*talk openly*" as very important. "*For me, it's important to be able to talk as openly as I can just to speak my mind, that's what helps me, not to just say some things or whatever*" (CPP1). Some communication partners perceived the relationship with one key employee, who is familiar to them, to be important. "*I always go to see one social worker here...we have known each other for some time...*" (CPV3). "In the context of contact with "*one key social worker*", the long-term nature of this relationship was perceived as important. As part of the long-term contact, the communication partners described the experience of "*they know me from the past*"). "*I think it's important that they already know me...know who I am, what all I've been through...all that...and I don't have to repeat it all again...they just know exactly what my situation is*" (CPM2). In this context, the communication partners also talked about the need to maintain a long-term contact with the homeless shelter/social workers in the future. "*They're...they're like my family, those social workers. I'm sure we'll stay in touch*" (CPV4).

6.3.3. Accumulative roles of a social worker

Given the above needs of the clients, it is obvious that the role of a social worker in a homeless shelter is accumulative. The accumulation of these roles may be in conflict with clients' requests and expectations in relation to assistance (see Glumbíková & Gojová, 2015). In relation to the above-mentioned possibility to talk openly, some communication partners pondered about whether they could afford "*telling everything*" to social workers when they were the facility employees and had some control over their compliance with the shelter rules; and they are also the ones who can make any recommendation for the starting apartment (if owned by a non-profit organization). "*The chat now and then wouldn't probably be bad. But everyone is afraid that it could be used against them, especially here*" (CPV1). "*You can't tell them everything, since they are the ones who decide about housing, right… and so...you should rather try sharing it with someone from outside*" (CPZ4).

7. Conclusion

Homeless people living in shelters have talked about a number of psychological problems. In relation to the assistance provided by social workers from homeless shelters, the communication partners have, therefore, multi-disciplinary and multi-activity demands. Social workers mediate the following

services for them: counselling, "*therapy*", "*substitution*" of psychologists, providing crisis intervention, while helping to find housing, do networking with other services for their clients, mediating healthcare, etc. Social workers are thus put under a great deal of stress. The solution seems to be a combination of several options: the first is the supervision, the second is the extension of the education of social workers in the field of psychological disciplines, and the third is the cooperation with external experts

In order to help homeless people living in shelters, a combination of several options seems to be the solution on a social worker's part. The first option is that coping with the described accumulation of roles could be facilitated by the regular supervision and intervision of social workers. Another option that could help reduce the impact of role accumulation is an increase of a number of social workers in shelters. In relation to the frequently present psychological disorder described by the communication partners, training of social workers on the basics of diagnostics of the most common mental illnesses of homeless people (e.g. depression, anxiety, post-traumatic stress disorder, phobias, etc.) could lead to the improvement in prompt identification of those who may need mental health assistance. In relation to the accumulation of social worker roles and increased demands placed on him/her in relation to the frequently occurring mental illnesses of their clients, social workers could benefit in their work from further education, for example, in the form of crisis intervention or trauma-oriented approaches.

As for the health condition of shelter residents, the networking of particular social services appeared to be particularly important, both in the field social work, which often directly led the clients to a homeless shelter, and in the area of networking of services targeting a specific target group such as Bílý kruh bezpečí [*White Circle of Safety*] (domestic violence) or Renarkon (drug abuse). Several communication partners directly mentioned the need for psychological help. In relation to psychological help, the views of the communication partners differed on whether the shelter should have their "*own*" psychologist (e.g. part-time) or whether it would be better for the clients to see an outpatient therapist. "*It's hard ... I'd rather go somewhere out of the shelter than here... since that information is spreading here*" (CPH4). "*Well, it would also be good to have a psychologist in this facility*" (CPV3).

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