

Teaching BSN Students to Provide Empathic Behavioral Health Assessments with People Experiencing Homelessness

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Abstract

People experiencing homelessness have substantial behavioral health needs and often encounter geographic, transportation, language, stigma, and workforce barriers to care. This program evaluation describes a nurse-led street medicine model that prepares Bachelor of Science in nursing students to conduct empathic, trauma-informed behavioral health assessments during community outreach. Students received preparation in trauma-informed care, cultural humility, therapeutic communication, mobile outreach safety, mental status examination, and validated screening. The field workflow combined immediate-needs assessment, foot soaks and rapport building, faculty-supervised screening, individualized education, crisis resources, referral, and navigation. Across the broader program, 177 nurse-led clinics served 783 unique individuals during 1,757 encounters; 98 clients were directly connected with care, 114 referrals were made, and 193 students and registered nurses participated. Among two recently graduated cohorts, 96% reported greater empathy, 100% reported improved communication, 100% viewed street medicine as a positive learning experience, and 96% reported improved attitudes toward people experiencing homelessness. Comfort working with a person with major mental illness increased descriptively from 3.67 before participation to 4.00 afterward. Within the behavioral health component, 40 psychiatric-mental health nursing students documented 111 screening and education encounters and directly connected seven clients with behavioral or mental health services. Presence-based Street medicine may integrate behavioral and physical health assessment while strengthening student empathy, communication, and readiness for community practice.

Keywords: Homelessness, Nursing Education, Street Medicine, Behavioral Health Screening, Trauma-Informed Care

Teaching BSN Students to Provide Empathic Behavioral Health Assessments with People Experiencing Homelessness

People experiencing homelessness carry a disproportionate burden of behavioral health conditions while navigating fragmented systems of care. A recent systematic review and metaanalysis estimated that 67% of adults experiencing homelessness had a current mental health disorder and 77% had a lifetime mental health disorder [1]. Yet need does not reliably translate into access. Transportation challenges, geographic distance, language discordance, stigma, prior experiences of discrimination, fear, and shortages in the behavioral health workforce can delay assessment and interrupt continuity. These barriers are especially consequential in geographically dispersed communities such as the Coachella Valley.

Nurses are well positioned to bring assessment, education, harm reduction, and referral into settings where people live and gather. Undergraduate education, however, must do more than teach screening instruments in classrooms. Students need supervised practice that develops cultural humility, nonjudgmental communication, de-escalation, and the ability to recognize behavioral health needs without separating them from physical health concerns. Expert-validated competencies for nursing care of people experiencing homelessness similarly emphasize

knowledge, skills, attitudes, and learning activities that prepare nurses to address inequities and stigma [2].

This article describes a nurse-led street medicine model developed by the Department of Nursing at California State University, San Bernardino. The model joins psychiatric-mental health and community health nursing competencies through field-based service learning. Its educational aim is to prepare Bachelor of Science in nursing (BSN) students to conduct empathic, trauma-informed behavioral health assessments with people experiencing homelessness and to connect assessment findings with practical pathways to care.

Practice Gap and Educational Need

Behavioral health assessment can become inaccessible when it is tied to traditional appointments, transportation, or unfamiliar clinical environments. Street medicine reverses that arrangement by delivering care where community members live, gather, and receive services. The approach also creates an authentic setting for students to learn that trust is not a preliminary task completed before care- it is part of the care itself.

Attitudes toward homelessness influence how health professionals understand and enact caring behaviors [3]. Structured, meaningful contact can counter stereotypes and help learners connect social conditions with health. In a prospective study, a foot soak experience was associated with more positive

nursing student attitudes toward homelessness and provided opportunities for genuine human interaction [4]. These findings support experiential education that combines practical service with guided reflection and faculty supervision.

Trauma-informed care offers a complementary framework. It asks clinicians and organizations to recognize the prevalence and effects of trauma, avoid trauma exacerbation, support safety and choice, and build collaborative relationships [5]. In street outreach, this orientation is operationalized through respectful introductions, permission before assessment, transparent explanations, attention to immediate priorities, and acceptance when a client declines a question or service.

Program Model

The nurse-led clinics deliver low-barrier physical and behavioral health services during community outreach. Services include vital signs, wound care, foot soaks, behavioral health screening, individualized education, referrals, and navigation. Physical and behavioral health care are intentionally integrated so that a client does not have to enter a separate pathway before discussing depression, anxiety, trauma, substance use, cognition, or other concerns.

Foot soaks serve both a practical and relational function. While attending comfort and basic needs, the student can remain present, listen reflectively, and learn about the person's priorities without rushing into a checklist. The interaction creates time for rapport and may open a natural path to screening. The procedure is never treated as a precondition for behavioral health care; rather, it is one low-barrier option within a broader relationship-centered encounter.

Teaching Approach

Before outreach, students are oriented to trauma-informed care, cultural humility, therapeutic communication, nonjudgmental language, harm reduction, language access, and mobile outreach safety. Psychiatric-mental health nursing students practice mental status examinations and screening for depression, anxiety, posttraumatic stress, substance use, and early cognitive changes. Faculty emphasize that a screening score supports, but does not replace clinical judgment and conversation.

The assessment toolkit includes the Patient Health Questionnaire-9 for depressive symptoms, Generalized Anxiety Disorder-7 for anxiety symptoms, a primary care posttraumatic stress screening instrument, the Mini-Cog for early cognitive changes, substance use screening, mental status examination, and referral documentation. The PHQ-9 and GAD-7 are brief measures with established diagnostic and severity-monitoring applications [6,7]. Students use instruments only within the program's scope, with faculty supervision and an immediate plan for education, crisis response, referral, or navigation when a concern is identified.

Field Based Assessment Workflow

Outreach Intake and Immediate Needs

Each encounter begins with a nonjudgmental introduction and an assessment of the client's stated priorities and immediate physical or safety needs. Students explain their role and available services, establish language access when needed, and seek permission before proceeding. This first step helps the team avoid imposing a behavioral health agenda when a different concern is more urgent.

Foot Soaks Rapport and Therapeutic Communication

When desired and clinically appropriate, foot soaks and basic care create space for therapeutic presence. Students use open-ended questions, reflective listening, and affirming language. Faculty coach students to tolerate silence, avoid assumptions, and recognize strengths as well as needs.

Validated Screening with Faculty Supervision

Screening follows consent and rapport. Students complete focused mental status assessment and selected validated tools based on presentation and priorities. Faculty supervise administration, review findings, assess urgency, and help distinguish a positive screen from a diagnosis. Safety concerns trigger the program's crisis procedures and escalation pathways.

Education Crisis Resources Referral and Navigation

Students provide individualized education in plain language and offer crisis resources, referrals, or navigation appropriate to the findings. Warm referral is preferred when possible because a phone call, direct introduction, appointment connection, or coordinated handoff reduces the burden placed on the client. Documentation captures the assessment, education, referral, and direct connection with care.

Evaluation Approach

The program used operational service data, student participation data, student-reported educational outcomes, Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI) results from two recently graduated cohorts, and client experience responses. The HPATHI was developed to assess health professionals' attitudes toward people experiencing homelessness [8].

The behavioral health component was also summarized separately by the number of psychiatric-mental health nursing students trained, screening and education encounters documented, and clients directly connected with behavioral or mental health services. Program-level counts describe reach and activity and should not be interpreted as unique outcomes unless explicitly identified as such.

Results

The broader street medicine program conducted 177 nurse-led outreach clinics. Across these clinics, 783 unique individuals received services during 1,757 client encounters. Ninety-eight clients were directly connected with care, and 114 referrals were made. A total of 193 students and registered nurses participated.

In the HPATHI evaluation of two recently graduated cohorts, 96% of respondents reported greater empathy, 100% reported improved communication, 100% considered street medicine a good learning experience, and 96% reported improved attitudes toward people experiencing homelessness. Mean comfort working with someone with major mental illness increased descriptively from 3.67 before participation to 4.00 after participation, a change of 0.33 points.

Within the focused behavioral health initiative, 40 psychiatric-mental health nursing students were trained in assessment tools and trauma-informed, culturally responsive engagement. Students documented 111 behavioral health screenings and individualized education encounters. Seven clients were directly connected with behavioral or mental health services. Program data also indicated substantial behavioral health needs,

including substance use concerns and frequent trauma, anxiety, and depressive symptoms.

Client experience findings were favorable: 92.7% of respondents reported trust in the provider, and 96% reported being very likely to return to the CSUSB street medicine program.

Table 1: Program Reach and Reported Outcomes

Indicator	Reported value
Nurse-led outreach clinics	177
Unique individuals served	783
Client encounters	1,757
Clients directly connected with care	98
Referrals	114
Students and registered nurses participating	193
Psychiatric-mental health nursing students trained	40
Behavioral health screening and education encounters	111
Clients directly connected with behavioral or mental health services	7
Reported greater empathy	96%
Reported improved communication	100%
Reported improved attitudes toward people experiencing homelessness	96%
Viewed street medicine as a good learning experience	100%
Comfort with major mental illness, pre to post	3.67 to 4.00
Reported trust in provider	92.7%

Discussion

This nurse-led street medicine model demonstrates a practical way to teach behavioral health assessment as an integrated nursing activity rather than a service separated from physical care. The reach data show that students practiced within an active program serving hundreds of community members across repeated encounters. The behavioral health component added structured screening and education while preserving the low-barrier, relationship-centered character of outreach.

The reported educational outcomes suggest that field experience may strengthen empathy, communication, attitudes, and comfort with major mental illness. These patterns are consistent with literature showing that meaningful service-learning contact can improve nursing students' attitudes toward people experiencing homelessness [4]. The model also aligns with the premise that caring behaviors and attitudes are related and that education must address stigma directly, not only expand clinical knowledge [3].

The role of foot soaks deserves attention. Their value in this model is not the procedure alone, but the time, proximity, and reciprocity it permits. A task that meets an immediate comfort need can slow the encounter enough for the student to listen and for the client to decide what to share. In that sense, foot care becomes a humanizing entry point to assessment, education, and trust.

Direct connection outcomes are particularly important. Screening without an actionable response can identify distress while leaving the same access barriers in place. Pairing screening with immediate education, warm referral, crisis resources,

and navigation makes the assessment clinically useful. Future evaluation should therefore distinguish referrals offered, referrals accepted, successful direct connections, and sustained engagement with care.

Implications for Psychiatric Mental Health Nursing

Psychiatric-mental health nursing competencies can be practiced in routine street medicine encounters through focused assessment, therapeutic communication, harm reduction, crisis recognition, and referral. This integrated model helps students see how trauma, substance use, mood symptoms, cognition, physical illness, and social conditions interact. It also positions psychiatric-mental health nursing as a mobile and collaborative practice rather than one limited to specialty settings.

Faculty preparation and clinical partnerships are essential. Programs should use one screening and referral documentation workflow across faculty, students, and partner sites; orient learners to language access and nonjudgmental introductions; and maintain clear escalation procedures. Behavioral health providers, mobile care teams, prescribers, pharmacies, and community organizations can strengthen warm handoffs and continuity.

Limitations

The evaluation is descriptive and does not establish that participation caused the reported changes. Self-report outcomes may be influenced by social desirability and response bias. Program counts also represent different units, including clinics, encounters, unique individuals, referrals, and direct connections, and should not be combined as if they measure the same construct. Finally, results from one university-community program may not generalize to other settings.

Recommendations and Next Phase

The program should standardize screening and referral documentation across all participating groups and track the full referral pathway, including follow-up and verified connection with care. Student evaluation should retain pre-post measurement while adding response denominators, scale ranges, reliability, missing-data handling, and inferential analysis where appropriate. Client experiences measurement should include consistent administration procedures and opportunities for qualitative feedback.

The planned next phase is an integrated mobile behavioral health model that adds prescriber consultation, pharmacy coordination, medication counseling and dispensing, nurseadministered medications when ordered, and follow-up in community settings. The goal is to reduce transportation barriers and shift care from crisis-driven emergency use toward proactive stabilization and recovery support. Implementation should be accompanied by role clarification, medication safety procedures, privacy safeguards, partnership agreements, and outcome measures that capture continuity and client-defined goals.

Conclusion

Empathic, field-based behavioral health assessment is teachable when nursing students meet people where they are with presence, humility, validated tools, faculty supervision, and practical pathways to care. The CSUSB street medicine model integrates psychiatric-mental health and community health competencies while providing low-barrier services to people experiencing

homelessness. Early descriptive findings support continued development of the model and a more rigorous evaluation of student learning, client experience, referral completion, and sustained behavioral health engagement.

Author Note

The authors report no relevant financial relationships or off-label use. The program does not promote products or services.

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