Homelessness, joblessness and immigration concerns are just a few of the issues that lead economically marginalized people to mental health services. Here’s how to build a successful practice that serves people in poverty.

BY REBECCA A. CLAY
If you’re in private practice, chances are most of your patients are not homeless, unemployed or considered members of the “working poor.” These are patients with great behavioral health needs that psychologists are uniquely suited to meet, says APA Past-President Rosie Phillips Davis, PhD, who made combating poverty her main presidential initiative. “But unless you’re working for an agency, a hospital or a clinic, you probably don’t see poor people in practice,” says Davis.

According to a report from APA’s Center for Workforce Studies, almost two-thirds of psychologists responding to APA’s 2015 Survey of Psychology Health Service Providers never, rarely or only occasionally worked with the working poor. For homeless people, the figure was 91%.

That shortage of practitioners is why Arlene Noriega, PhD, decided to target economically marginalized Latinx immigrants when she opened her Atlanta-area psychotherapy practice in 2000. “I’ve dedicated my professional career to the working poor,” says Noriega, whose two-person practice provides bilingual services primarily to children on Medicaid.

Shilpa Trivedi, PsyD, of Trivedi Psychological Services in Houston, is another psychologist whose patients are economically marginalized, some of them homeless or living in single-room-occupancy housing. Trivedi’s practice focuses on psychological testing, parent evaluations for child protective services and other forensic assessments.

“There aren’t enough psychologists who want to work with this population—not necessarily because of the population but because of payment issues,” Most of her patients have publicly funded health insurance, which has a reputation of low reimbursement rates for psychological services.

Want to join Noriega and Trivedi in filling the gap in services for economically marginalized individuals? To do so, they say, you may need to heighten your awareness about certain things:

» Be ready for the kind of complex needs and serious problems your training prepared you for. “Every other patient has a trauma history, which is sometimes hard to hear constantly,” says Trivedi. “They’re not getting their basic needs met.” Noriega’s patients include many children who are American citizens but have undocumented parents. “I see a lot of children who will say to me, ‘Please, doctor, can you talk to ICE [Immigration and Customs Enforcement] and tell them not to take my mommy away?’” she says. “The children I see have a great deal of anxiety and fear of the police.” In some cases, parents have returned to their countries of origin, leaving their children behind to finish their educations or look after younger siblings—scenarios that can add huge stress to young lives.

» Focus on strengths, not deficits. “[Economically marginalized patients] may not have physical assets like bank accounts, but they have friends, someone to stay with, someone who cares about them,” says Trivedi. Noriega also focuses on assessing internal and external strengths. These include a patient’s level of resilience and their history of having weathered challenges in the past, as well as more tangible assets like having two parents at home or having a car and a valid driver’s license. It’s important to communicate that strengths-based approach to clients, says Trivedi, noting that could mean using the word “survivor” rather than the word “victim.”

» Be thoughtful about what you recommend. Make sure your treatments and recommendations work for your patients, not someone else’s. “What sounds very typical, innocent, middle class may be outside the scope of reality for some individuals,” says Noriega. She recalls blithely suggesting that a young patient join a scout troop, for example. Unfortunately, Noriega remembers, that suggestion turned out to be impossible because the scout troop met in an area that was just too dangerous for him to go to. Similarly, a casual suggestion that a child join a soccer team may not be feasible when the uniform alone costs $60. To avoid such blunders, get “intel” about the local community by asking school social workers, community leaders and the patients.
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APA’S 2015 SURVEY OF PSYCHOLOGY HEALTH SERVICE PROVIDERS

themselves to help you understand the neighborhood, suggests Noriega. Gathering information can uncover alternative, more appropriate resources, such as a church in Noriega’s neighborhood that provides free classes to kids on Saturday afternoons.

» Think about your patients’ potential needs. Staying open before and after regular business hours can help accommodate individuals whose jobs offer little flexibility in their schedules. Noriega’s practice, for instance, is open from 7:30 in the morning to 7:30 in the evening, with a colleague taking the early shift and Noriega taking the later one. A location near bus or subway lines is also key for people who rely on public transportation. And it’s important to provide snacks, since patients and their family members may be hungry. Trivedi’s practice offers bottled water, cheese and crackers, and other snacks in the waiting room, and she plans to add hot snacks soon. “Someone may not have eaten that day or made time to take care of themselves,” says Trivedi, adding that some may be trying to save money by skipping meals. “I want to make sure food is not an issue for them.”

» Communicate in new ways. Patients living in poverty may not have easy access to communications technology. “Some of my patients have cellphones but maybe don’t have minutes [for calls], so texting [about upcoming appointments] is the only way they can communicate for free,” says Trivedi. For others, email appointment reminders work best. Trivedi makes appointment reminder calls herself as a way of increasing the likelihood that clients will show up. “When you talk to the person you’re going to see, it means more than having a receptionist call,” she says, adding that she asks clients to give her 24 hours’ notice if they can’t make an appointment and then gives them two strikes before referring them back to their case workers.

Noriega has decreased her no-show rate significantly by implementing repeated appointment reminders. At their first appointment, patients receive a paper handout of appointment times and sign up for the practice’s patient portal, which emails a reminder the night before an appointment. Patients also get a call the day before.

» Find creative ways to market your practice. “I spend zero dollars on marketing,” says Noriega. Instead, she reached out early in her practice to local pediatricians, immigration...
How to Get Paid

One barrier to working with patients in poverty can be reimbursement. Here are factors to consider.

Becoming a Medicaid provider is one option. While it’s true that Medicaid and other public programs typically pay less than private insurers and self-pay clients, serving Medicaid patients expands access to care.

“Medicaid is an important part of building a practice that serves clients from all walks of life,” says Caroline Bergner, JD, legal and policy affairs officer for APA. Accepting Medicaid can be especially helpful for early career practitioners who want to build their practices, Bergner adds. Even if serving patients in poverty is not your focus, she suggests, “consider incorporating a small number of these patients into your practice as part of public service.”

Because there are still a handful of states that prohibit private practitioners from participating independently or outside a facility, check with your state Medicaid office to see if this is a possibility, adds Bergner.

Not all patients in deep poverty are covered by Medicaid. Offering a sliding scale or providing services pro bono are other options for those outside the program, says Connie Galietti, JD, director of legal and professional affairs at APA. Before you start offering these options to any patient, however, you should check with your state Medicaid office.

Whether patients are on Medicaid or not, it’s important to have a policy in place that lays out criteria for financial hardship for all patients, says Galietti. “You don’t want to be accused of being discriminatory because you offered pro bono services or a sliding fee scale to one person and not to someone else,” she says.

It’s also important to spell out financial arrangements in patients’ charts, says Galietti, explaining that the informed consent paperwork patients sign should include how much they’re paying per session, when payment is due and what steps you will take if patients fall behind in payment. And don’t let a balance build up, Galietti adds. If it becomes clear a patient can’t afford services even with a reduced fee, she says, you need to decide whether to offer pro bono services or refer the patient to someone else.

RESOURCES
APA Guidelines for Psychological Practice for People With Low-Incomes or Economic Marginalization
apa.org/about/policy/guidelines-low-income.pdf

Deep Poverty Initiative Toolkit
apa.org/about/governance/president/deep-poverty-psychology

Deep Poverty Initiative Practitioners Action Guide
apa.org/about/governance/president/practitioners-guide.pdf


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SHILPA TRIVEDI, PsyD
Trivedi Psychological Services, Houston

lawyers and school social workers. And while early in her career Trivedi used booths at child protective services fairs so she could meet case workers, now she, too, relies on word of mouth.

Be aware of payment-related challenges. Many psychologists are reluctant to take on Medicaid patients and other patients who get their insurance via public programs for fear of low payment rates. But that is changing, says Caroline Bergner, JD, legal and policy affairs officer for APA. Thanks to advocacy efforts, she says, Medicaid rates are now the same as Medicare rates in some states.

Expanding access to care to this underserved population is the right thing to do, and it is possible to make a good living and have a rewarding career doing so, say both Trivedi and Noriega. Says Noriega, the work is “a labor of love.” ●