The Journal of Sociology & Social Welfare

Volume 19
Issue 4 *December*

Article 12

December 1992

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Homelessness has emerged as a major social problem. In an attempt to understand this problem, attention has been focused on postulating its causes, describing the individuals who hold this status, and estimating its magnitude. This study assesses the outcome of one social service program for long-term mentally disabled homeless individuals. It includes a synopsis of the state of the art in serving homeless individuals with severe mental health problems; a description of a program created to meet their needs; and an analysis of the outcome of this program.

Introduction

The plight of homeless individuals has emerged as a serious social problem during the 1980's. It has attracted the attention of the public, policymakers, and academic researchers, as well as the service systems charged with meeting the needs of these people (Rossi, 1989). Special attention has been given to the sub-population comprised of the long-term mentally disabled, because of their recognized often overwhelming needs, their public visibility, and the controversy surrounding policy changes in institutionalization, housing, and disability benefits, which have repeatedly been targeted as causes of their homelessness. Most efforts to help these individuals have focused on alleviating immediate suffering. In response to this objective,

many communities have developed a variety of services such as outreach teams, drop-in centers, and shelters to meet basic needs of these individuals for food, clothing, and a place to sleep. Such solutions, however, are also viewed as mechanisms to institutionalize the problem and insufficient to rehabilitate people (Hoch & Slayton, 1989).

Research on homelessness is still in a preliminary state. Because of the urgency and magnitude of this problem across the nation, survey efforts which focus on estimating the size and describing the composition of the population and their service needs have predominated (Piliavin, Sosin, & Westerfelt, 1988; Rossi, 1989). Research on mentally ill homeless persons is only now moving into what is labeled as the second generation of study. So far "the great majority of policies focus on ameliorating the most direct consequences of homelessness and rarely on reversing or preventing the phenomenon." (Sosin, Colson, & Grossman, 1988) Similarly, there have been too few studies evaluating the effectiveness of programs to reverse or prevent homelessness. Among the very few are Barrow & Struening (1986), and Morse, Calsyn, Dannelet, et al. (1989). However, there is a clear void in evaluation studies regarding the effectiveness of services provided to the mentally ill homeless.

One major finding of the first generation of studies has been that the mentally disabled homeless population is a highly heterogeneous group which cannot be understood and served uniformly. Homeless individuals vary in severity of mental health problems, level of functioning, patterns of homelessness, ability to accept and adapt to structure, and program demands. They have multiple problems, including drug and alcohol abuse, malnutrition, and physical illness, as well as the poverty and unemployment which are the direct correlates of homelessness. It is important to recognize and examine the interrelated effects of disabilities on homelessness because, for many individuals, it is clearly the accumulation of disabilities that leads to homelessness (Tessler & Dennis, 1989).

Many mentally disabled homeless lack a "social margin" or a stable base of caring individuals whose concern and material support help buffer the individual against the vicissitudes of life. This deficiency may be caused by either their mental

impairment, which has exhausted the coping resources of family and friends (Rossi, Wright, Fisher, & Willis, 1987) or by their "disaffiliation" from social institutions and relationships which can be the result of withdrawal, forced exit, or lack of learned social skills (Caplow, Bahr & Sternberg, 1968; Piliavin, Sosin, & Westerfelt, 1988; Snow & Anderson, 1988). Although it has been assumed that their social networks are small or non-existent, there is evidence that the homeless may have more social relationships than generally credited, though, weaker in their ability to provide the social, emotional and material support needed to prevent homelessness (Lovell, 1989; Piliavin, Sosin, & Westerfelt, 1988; Dockett, 1989).

Utilization of services by homeless individuals is another strong concern of the provider community. Even if services are available, many homeless persons do not avail themselves of services (Morse, Shields, Hanneke, et al., 1985; Rog, 1988). Unwillingness to interact with service systems can be a sign of autonomy (Gardner, 1984) and the means of creating self esteem (Snow & Anderson, 1988) or it can be a natural reaction to either real or imagined negative experiences with service providers (Breakey, 1987) or programs (Baxter & Hopper, 1982; Dockett, 1989). It can also be an indication of differing values and needs. There is an emerging consensus that mentally disabled homeless persons tend to perceive their needs differently from the way mental health providers see those needs, and that they give basic needs priority over clinical treatment (Ball & Havassy, 1984; Barrow & Struening, Plapinger, 1988; Lauriat & Whitty, 1985; Mulkem, Bradley, Spence, et al., 1985; Plapinger, 1988).

To date, there has been little description and very little evaluation of programs for this population (Tessler & Dennis, 1989). This deficit has been caused partially by the strong emphasis on the quick provision of any service and partially by the intrinsic difficulty of evaluating services for the mentally disabled homeless (Morse, Calsyn, Dannelet, et al., 1989). Evaluation of complicated service delivery programs is difficult because of the multiple methods and modes of treatment; changes in client needs overtime; and highly individualized treatment plans and intervention strategies (Brekke, 1988). In addition,

some innovative services such as outreach, have been described as an art, because they depend upon interpersonal relationships and networking, which sometimes takes long periods of time to achieve results.

The most comprehensive evaluation study so far is that of Barrow et al. (1986), a longitudinal study of five differing innovative programs for mentally disabled homeless in New York. Their findings strongly suggest that innovative services such as drop in centers and on-site psychiatric services, can be effective, but that, in working with these individuals, it is imperative to respond according to their needs and values, if outcomes are to be positive. Morse and his colleagues evaluated day programs for mentally ill homeless persons. Their findings indicate that clients liked the services, however, the study was methodologically weak. Finally, Lipton, Nutt and Sabatini (1988) report that residential programs reduce hospitalization and promote stable housing for people with homeless histories.

Thus, the knowledge base as to how to best meet the needs of mentally disabled homeless persons and to engage them into rehabilitation is relatively sparse. Effective services and innovative programs must be identified, documented and evaluated and the principles that make them successful articulated so that the public and policy makers have measures of the effectiveness of monies spent and suffering can best be alleviated (Levine, Luzak & Goldman, 1986; Tessler & Dennis, 1989). Attention must be focused on finding ways to aid individuals in exiting from their homeless status (Piliavin, 1988) and to test their generalizability (Judd, 1989; Tessler & Dennis, 1989).

The purpose of this paper is to enhance the body of practice sociology knowledge regarding the effectiveness of one rehabilitation service approach serving long term mentally disabled homeless individuals. After summarizing the principles of care as stated in the literature, we describe one program providing specialized services for these individuals, a Low Demand Respite (LDR) which utilizes psychosocial rehabilitation. The outcomes of 160 clients participating in the program between 1985-88 are presented together with data analysis to determine the impact of client characteristics and specific program elements on successful outcomes.

Service Needs of The Mentally Disabled Homeless Persons

The literature in the mental health field to-date suggests several principles that should be incorporated in service programs for this target population. First, because of the severity and multitude of their problems, there must be continuous and comprehensive care. Services should include outreach; facilities for crisis stabilization; a variety of residential alternatives beyond emergency shelter; and a coordinated, individualized network of services for rehabilitation (Goldfinger & Chafetz, 1984; Lipton & Sabatini, 1984; Levine, 1984).

Second, services must be coordinated to address multiple needs simultaneously (Levine, Luzak & Goldman, 1986). For many individuals, it is clearly the accumulation of disabilities that makes the homeless condition so difficult to transcend. If each disability is treated in a serial fashion, not only will their homeless condition be prolonged but also, as in the case of those with both mental health and substance abuse problems, their health may be negatively affected (Ridgely, Osher & Talbott, 1987; Osher & Kofoed, 1989). Thus, programs must not only concomitantly meet basic needs for housing and benefits, but also provide mental and physical health care as well as chemical abuse treatment, if needed. In addition, many of these individuals also need to (re) learn basic social, vocational and daily living skills.

Third, since most service systems currently are a "fragmented labyrinth" (Levine et al., 1986) and frequently have competing and contradictory mandates, policies and procedures, they are underutilized. Thus, case managers are required to coordinate a range of psychiatric, medical, social, rehabilitative, vocational and quasi-vocational services across service systems.

Fourth, chronically mentally impaired homeless individuals need individualized programming to enable their heterogenous needs to be flexibly met (Mellen, 1985).

Fifth, programs for these individuals must be active in recruiting consumers. Traditional community mental health services are not compatible with values or the lifestyle of homeless individuals (Breakey, 1987). Even when need is evident, homeless individuals often do not follow up on referrals for mental health services or financial entitlements. Consumer needs

should be responded to programmatically not only to increase service utilization but also because there is some evidence that consumer priorities bear a direct relationship to treatment outcomes (Barrow et al., 1984; Tessler & Dennis, 1989; Rog, 1989). It is also important that services be compatible with the lifestyle of the homeless in terms of physical location and times available (Rog, 1989).

Sixth, special attention must be given those who staff these programs. They must be able to provide the intensive one-to-one relationships necessary to build trust and support with the chronically mentally disabled. These are individuals who cannot or have chosen not to interact with others. They live in a subjective world that may attribute different meanings (often fear) to individuals and objects (Drake & Adler, 1984). Staff must be able to communicate with the clients and to understand their needs. Staff need to become acquainted with the clients' internal world and to recognize both the symbolic nature and significance of their requests. Staff must also treat these mentally disabled clients with respect and dignity. These are individuals who have few if any positive social roles and carry the negative label of mental illness. Staff must demonstrate that they appreciate the strength that has enabled them to survive despite myriad barriers, help them through interactions, with positive regard, and assist them to (re)create a positive self-identity (Blankertz, Cnaan, White, Fox, & Messinger, 1989).

Description of the Program

Horizon House, a large Philadelphia based psychosocial rehabilitation organization has been working with the mentally disabled homeless since 1984. This paper will focus on one aspect of the service continuum for the homeless offered by this organization, the Low Demand Respite (LDR) residential option. In this respect our study focuses on the same service option studied by Lipton, Nutt, and Sabatini (1988); however, the residential services of Horizon House are unique. These specialized residential programs were developed in Philadelphia to offer services to this service-resistant mentally disabled population, as the first step toward re-engagement with the mental

health system and the community. Initially, a LDR makes few demands on its residents. This mode of residential setting is consistent with the desire of mentally ill homeless individuals to live in a non-structured environment where there are few rules, demands, and expectations (Goering, Paduchak & Durbin, 1990). As individuals adjust to life off the streets, the program adjusts and heightens its expectations of the individuals. Clients are granted the freedom to decide their preferred level of activity within the LDR, but they are gently encouraged, through the trusting relationship they develop with staff, to participate in services tailored to meet their individual needs. The major service components of the LDR program are: outreach (done before entering LDR), engagement, case-management, residential services (including day programs), and individualized rehabilitation processes.

Engagement: When individuals who seem to have mental impairments are brought to one of the LDR's, there is an immediate focus on meeting their basic physical needs. They are first offered nutritious meals, clothing, and a protected, safe environment in which to live and sleep. Clients may participate in these services at their own pace. If they refuse to sleep in a bed, they may stay on a chair or sleep on the floor. It is not demanded, but only gently encouraged that they shower or change clothes. The key service element of respite care is the development of a trusting relationship between the staff person and the resident. Staff initially offer support and encouragement, warmth and empathy, but make no further demands. Staff are trained to respect the inner strength of the clients that has enabled them to survive the rigorous life on the streets.

Case management: Case managers are assigned in principle to all clients in the LDR. This provides a continuation of the direct staff-client relationship begun in the engagement process and insures that the complex, changing, and multiple needs of the clients are met. Not only do the client and case manager have an ongoing relationship (that helps to develop the ability of clients to overcome their "disaffiliation"), but the case manager also serves as the client's advocate, coordinating the needed services across the labyrinth of bureaucracy, accompanies the client to appointments and assists in medication management.

Not all of the clients in LDR during the period of study received case management services, however. Case-management was not in place during the start-up period. Furthermore, a high turn over rate left some clients without a case manager.

Residential services: In LDRs a variety of services are offered to all clients, but no demands are made of the clients to use these or to enter into a highly structured regimen of activities. Clients may choose to participate in any of the offered services according to their needs and values. Initially these services are focused on meeting the immediate medical and financial needs of the clients, although some can introduce the clients to longer-term rehabilitative skills. There is no time limit on the acceptance of service or the sequence of movement. Whether it takes a few days or a year, most choose to partake of some of the offered services, and actively enter into the rehabilitative process.

There are two types of services offered, those within the residence and those in specialized day programs which may be on or off site. Shelter by itself does not offer sufficient supports for an individual to begin the rehabilitation process (Grunberg & Eagle, 1990). The residential counselors are responsible for delivering the services on site. For each client they perform a skills assessment and develop a rehabilitation plan with the client. They attempt to develop personal relationships with clients. They also teach specific skills based on the clients needs. These skills most often include; personal hygiene (bathing, hair care, choosing and cleaning appropriate clothing), improving interpersonal skills, money management, and medication management. Counselors also provide educational and recreational opportunities such as trips to libraries, local museums, and picnics. If clients desire, counselors help them re-establish links with their families.

Under city regulations, homeless individuals in low demand respites do not have to attend off-site day programs if they do not wish to attend. If they, however, wish to attend day programs, case managers will link them with social or vocational day program and will arrange daily transportation. These programs are chosen to meet the rehabilitation goals and level of functioning of the clients. For those who prefer to stay on-site, counselors run daytime skill-oriented groups on

personal hygiene, cooking, and budgeting, and psychoeducational groups on mental illness, medication, and sex education.

Clients are encouraged to view the group residence as their home and to participate in decision making activities that are directly related to the development of operational policies for the home. Clients are also encouraged to become active members of the community and to learn about and participate in a wide range of civic activities, such as volunteer work.

Individualized rehabilitation plans: Once the client decides to participate, an individualized rehabilitation plan is devised. Essential to the formulation of this plan is the completion of a functional assessment. This functional assessment, comprised both of observations of staff and client responses, delineates client skill strengths and skill deficits in such areas as personal hygiene, activities of daily living, maintenance of relationships, and ability to recognize and express feelings. This functional assessment is individualized and is a written description of the strengths and weaknesses of each individual client. The rehabilitation plan is developed jointly by the staff and the client. The plan states specific goals that the client chooses and the steps (participation in programs, learning and mastery of skills) that will be taken to reach these goals. These plans encompass all of the multiple needs of the client whether medical, financial or rehabilitative. Both the functional assessment and the rehabilitation plan are periodically reviewed and changed. This ensures that the rehabilitation process will be flexible and adapted to the needs and progress of each client.

Leaving the LDR: When clients are prepared to leave the LDR, a continuum of residential alternatives is made available, since some individuals will not have reached a level of rehabilitation which would enable them to function independently in the community. These include another low demand residence, foster homes or board and care (small, homelike residential environments, where one to three clients live with a family who provide personal care services for their residents, as well as support, encouragement and supervision), family and relatives, and independent housing (one or two bedroom units with 24-hour case management coverage). There is not necessarily a correlation between functional ability and independence of the living

arrangements. Some clients of low functional status by their own choice are living independently very successfully. What all of the alternatives have in common is their integral connection with rehabilitative services and intensive case management.

Methods

Sample. As seen in Table 1, of the population of 160 clients who had completed their stay at either of two LDRs before June 1988, 53 percent were male and 47 percent female. Sixty two percent were black with an average age of 40 (although the modal age was 29). About three fifths (61%) had graduated from high school and 16.2 percent had some college experience. Two-thirds had never married (although 59% had children). Ninety two percent had records of previous mental health treatment. Fifty three percent of the sample had criminal records. These demographic figures are consistent with those across the nation for the mentally disabled homeless (Tessler & Dennis, 1989).

These individuals had lived for 30 years, on the average, in the City of Philadelphia (i.e. they were not a transient population) and they had been homeless during their lives for an average total period of about five years. The mean length of their last period of homelessness had been about 6 months. Before this last period of homelessness, they had lived in a variety of situations, including independent living situations (5.4%), board and care (29.1%), mental hospitals or other mental health residences (9.2%), shelters (27.1%) or with family (29.2%).

Client records were examined for any of the variety of factors that singularly or in combination may explain what caused individuals to become homeless, including loss of job, income, benefits, mental or physical sickness, family conflict, and loss of rental unit. It was found that only two of these reasons yielded high number of responses, i.e., mental illness (43.9%) and having had arguments with boarding home owners (25.6%). This sample, thus, supports the knowledge regarding the multiple causes of homelessness and the individual paths leading to homelessness reflecting, unique combinations of individual deficits and structural causes (i.e. welfare policy, scarcity of low cost housing).

Table 1

Characteristics of Homeless Mentally Ill Persons in the LDRs. (N=160)

Variable Categories	Percentages
Gender:	
Men	53%
Women	47%
Age groups	
20–30	26%
31–40	33%
41–50	24%
51–60	12%
61+	5%
Race	
Black	62%
White	35%
Hispanic	3%
Education	
K–7	7%
8–11	32%
High School graduate	45%
Some college	13%
Bachelor degree	3%
Marital status	
Never married	67%
Separated	13%
Divorced	16%
Widowed	4%
No. of children	
No children	41%
One	30%
Two	16%
Three or more	13%
Reported problems	
Medical problems	21%
Personal violence	15%

Continued . . .

Table 1 continued

Variable Categories	Percentages
Reported problems (continued)	
Criminal records	53%
Previous MH care	92%
Previous MR care	11%
Reasons for last episode of homelessness:	
Loss of income or benefits	12%
Family conflicts	13%
Unbearable living Conditions	5%
Living unit destroyed	3%
Mental health problem	44%
Attempting suicide	5%
Fights with others	4%
Substance abuse	5%
Inability to cope with residential structure	9%
Arguments with boarding-home owners	26%
Last living arrangement before last episode of homelessness:	
Boarding homes	29%
Shelters	27%
Family/friends	29%
Mental health institutions	9%
Living independently	5%
Detention center	1%

Procedure. An analysis was made of 160 case records of clients who received services and exited from two LDRS, one in existence since 1985 (LDR 1) and the other (LDR 2) opened in 1987 to meet the increased need for services to this population. Analyses of differences between clients from the two settings did not yield any significant difference. Clients from both settings were, therefore, studied in combination.

The authors reviewed a number of client records and composed the research instrument. All 160 records were then carefully read and all relevant information retrieved. Data were supplemented and validated through a series of interviews with workers in the two LDRs. Information from the client records and interviews was computer coded and analyzed.

Two biases may result from this procedure which may affect the validity of our results. First, this is a retrospective study and, thus, based on incomplete records and the subjective memory of the LDRs' workers. Second, this is a small single sample study. These two concerns, however, should be weighed against the originality of the study and the fact that there are very few evaluation studies for mentally disabled homeless.

Instrument. The questionnaire for collecting data consisted of 1) client background data; 2) possible reasons for homelessness (derived from the literature and debriefing of service providers); 3) housing and service history; 4) list of services provided to the client while in one of the LDRs; 5) special client problems while in a LDR; and 6) outcome measures, specifically, housing situation and contacts with community mental health services at exit.

Findings

System Impact. The LDR programs effectively engaged mentally impaired clients into the service system. Client records revealed that all had ongoing relationships with their providers. The overwhelming majority (85.6%) of clients were in the program only once; only 14.4% revolved through it more than once. The average length of staying LDR was 175 days and three quarters (75%) of clients stayed more than 30 days. As seen in table 2, the basic needs of the clients were met; about three quarters (78%) took medication regularly; almost all (98%) were linked to SSI and other benefits; and 63.8 percent had no psychiatric crises while in LDR.

Client outcomes. Rehabilitation outcomes focused on in this study were place of residence at exit and linkages to community mental health centers. It was found that the residential placement outcomes of these individuals were remarkably positive.

Table 2

Client Outcome of Homeless Mentally Ill Persons in the LDRs. (N=85)

Variable Categories	Percentages
Taking medication regularly	
Yes	78%
Infrequently	19%
No	3%
Link to benefits	
Yes	98%
No	2%
Psychiatric crisis	
Yes	36%
No	64%
Housing arrangement	
Independent living,	25%
Board & care sites	29%
Specialized care programs (MR or D&A)	13%
Moved with family	12%
MH institution	10%
Back to street	11%
Link with Community MH services	
Yes	39%
No	61%

As seen in Table 2, for the 85 individuals on which data were obtained, only 9 (10.8%) returned to the streets. Approximately one quarter (25.3%) attained independent living; 28.9 percent went to board and care sites; 13.3 percent went to specialized care centers (Drug & Alcohol or Developmental Disabilities Centers); 12 percent went back to family; and 9.6 percent went to other mental health facilities.

It is possible that the success of these results is compromised by the large number of missing cases (75 out of 160). However, even if all of these 75 clients went back to the street, which is most unlikely and the most conservative estimate, still about

half of the mentally disabled homeless persons who were cared for in LDRs did not return to the street.

Outcome data also reveal a clear shift of residential location. For the 57 individuals for whom data were available to compare their last living arrangement before they became homeless with the residential placement upon exiting the program, nine (16%) returned to the streets, an additional 16 (28%) went back to their previous type of residence, and 32 (56%) changed their type of residence. Due to the retrospective nature of the study, we were unable to determine whether this change reflects differing client needs and preferences at different times or availability of services/residential opportunities at any given time.

Much less data were available on linkages to community mental health centers. Data on linkage to community health services were found for only 44 individuals among the 160 in the sample. For 17 clients there had been positive linkage; for 27 linkage had not been achieved. This finding may indicate lack of coordination among service providers; client needs or preferences; or simply poor record keeping.

Factors associated with outcome. Data analysis was conducted to determine which client characteristics and service components impacted on rehabilitation outcomes. Only two factors—both program elements—were found to be significantly associated with rehabilitation outcomes. In addition, certain client socio-demographic characteristics, although not statistically significant at the .05 level, revealed interesting trends worthy of future research.

As seen in Table 3, there was a significant relationship between participation in day programs and living arrangement upon exit ($x^2 = 20.04$, d.f. = 8, $p < .05$). That is, the type of day programs (none, specialized homeless programs and regular Horizon House day programs) was significantly associated with the residential placement of the clients upon exit from LDR. It was found that half of those who returned to the streets did not participate in any day programs, while more than third participated only in specialized homeless programs. About three quarters of those who attained independent living attended the regular day programs and few attended specialized homeless programs or did not participate in any day program. Half of

those who rejoined their families attended the regular day programs while less than a third attended specialized homeless programs. Half of the clients who entered board and care slots attended specialized homeless programs while the others more or less evenly either did not attend any day program or attended the regular day programs.

This finding, that participation in day program is significantly associated with housing, may be also explained by level of functioning. The participation in a certain program is often a direct indicator of the individual's level of functioning. That is, attendance in regular day programs usually indicates an overall higher level of functioning, thus, explaining why those who participate in day programs were able to attain independent living. It may be that level of functioning is the key factor in explaining housing outcome rather than differences in programming. But, regardless of level of functioning, those that did not attend any type of programming, were more likely to return to the streets.

Table 3

Living Arrangement at Exit by Type of Day Program (N=85)

	No Day Programs	Specialized Homeless Day Programs	Regular day Programs
Back to street (% = 100)	50.0%	37.5%	12.5%
Independent housing (% = 100)	15.8%	10.5%	73.7%
Living with families (% = 100)	20.0%	30.0%	50.0%
Board and Care (% = 100)	22.7%	50.0%	27.3%
MH institution and specialized programs (% = 100)	38.6%	26.6%	36.8%

$x^2 = 20.04$, d.f. = 8, $p<.05$

The second program element significantly associated with outcomes was case management. There was a significant relationship between having a case manager and being linked to a community mental health center upon exit ($x^2 = 4.76$, d.f. = 1, $p<.05$). Sixty-one percent of those with case managers were linked to community services as opposed to only 17 percent of those that lacked a case manager. Although the relationships were not statistically significant, it was also found that those with case managers tended to go to independent living arrangements and board and care situations, while those without case managers tended to go to mental health care facilities or to families. This does suggest that case management is an important support which enables clients to stay linked to the service system and off the streets. For some other clients, however, families were able to perform some of the same functions. Without either a case manager or a family, the client was more likely to stay within the structured mental health system or to go back to the street. It was also found that those who stayed less than six months at the respites were more likely to be linked up with community mental health centers while those who stayed longer than six month at the LDR were less likely to be referred to a community mental health. This trend may perhaps reflect an assessment of need by caregivers or the fact that those who stayed for shorter period of time were the stronger clients who could better utilize community services.

Client characteristics were also analyzed for indication of their role in rehabilitation outcomes. Although there were no significant associations (at the .05 level), data reveal several interesting trends. First, more black individuals (34%) than white (13%) went to board and care or foster families. More white clients (21.7%) than black (8%) went to live with their families. This finding may reflect differences in family resources based on race, but requires additional study.

Second, two personal background factors. i.e., type of previous mental health treatment and criminal record, were also weakly associated with a return to the streets. Those who had been hospitalized in a state hospital or in a VA facility were more likely to exit to the street than those hospitalized in a community hospital (21% versus 5.3%). Those with a police

record were more likely to exit to the street than those without a police record (21.4% versus 4.8%). These personal disabilities are similar to Rossi's (1989) findings.

Discussion and Conclusion

This paper has focused on the effectiveness of rehabilitation programs for the mentally disabled homeless. We evaluated the outcome of a special program, the LDR, which embodies many of the principles suggested in the literature as relevant in assisting mentally disabled homeless persons. This program meet basic needs (shelter, food, and clothing) first; it offers comprehensive rehabilitation services which can simultaneously alleviate the multiple problems of the homeless mentally disabled individual (mental and physical health care, drug abuse, and lack of social, daily living, and vocational skills), and it initially puts very low demands on clients. Clients access these services by their own choice and according to their own time table. The key element integrating the program is the generation of an intense interpersonal relationship between clients and staff.

Because the outcomes of the LDR were not compared with other modes of service, its comparative contribution cannot be attested to. However, its overall impact on the people who utilized its services can be assessed. The majority of people who went through the studied LDR program developed helping relationships with staff members, received benefits in an organized manner, took medication on a regular basis, and moved into some sort of more normatively accepted housing setting. These outcomes are impressive, considering that the client population consisted of long-term mentally disabled persons who, on the average, stayed five years on the streets and have often been described in the literature as resistant to accepting service and reluctant to change their life style (Breakey, 1987; Drake & Adler, 1984). Clearly, the LDR model of help does not harm clients and does improve their condition at least at the point of exit from the LDR service. Examination of this service model demonstrates that given a safe, humane environment and the establishment of trusting relationships with caring individuals, severely mentally impaired homeless individuals can relearn

skills and will accept the supports and services to enable them to move from a condition of homelessness to a community environment of their choice.

As noted in the literature, the homeless population, even the long-term mentally disabled homeless population, is heterogenous. The findings presented here indicate that those who entered the program with greater strengths than others managed to come out of it in better shape. For example, those with no police records, mental health service in the community only (no prior mental health hospitalizations), and those who function well enough to attend the regular day programs by and large showed higher rates of positive outcomes. This finding indicates, that even among the very needy, there are levels of needs and that more specialized programs for sub-groups of this population should be developed. Even when homeless people are categorized into sub-groups (such as the mentally disabled homeless) there is a high variability among them which calls for individualized service delivery.

In this study we focused only on one point of time, i.e., exit from service. Despite the high rate of successful exits, previous studies (Dockett, 1989; Morse et al., 1985; Piliavin, 1988) indicated that many of these individuals will eventually return to the streets, cycling in and out of homelessness in an episodic fashion. For this sample, the total average time of homelessness is about five years, however the latest period lasted on the average only six months. Given the lack of occupational skills, the mental disabilities, and the low income levels of these individuals, it is very likely that they will become the "static poor", or a permanent underclass. Society has made a conscious decision (i.e., deinstitutionalization) that these individuals should have the freedom to live in the community. This study as well as that of Lipton, Nutt and Sabatini (1988) demonstrated that given intensive supports and skill training, these individuals can attain independent living. Allocation of the necessary resources is critical to insure decent housing, and a high level of service supports so that these individuals can maintain this independence and not regain a homeless status. However, given the negative stigma attached to this group of people and the powerlessness resulting from their disabilities,

although they are a part of the "deserving poor", it is unlikely that the needed level of resource re-allocation to meet their needs will occur in the near future. Thus, successful exit from an LDR should be followed by appropriate community support services.

This study has demonstrated that with proper investment mentally disabled homeless individuals can be helped to attain residences. However, two questions remain open for further study. The first is whether the improvement is for a long term or whether the LDR impact last only for a short period after the program ends? This study measures clients at the exit point-follow up a year or so later is required to ascertain the permanency of change. Longitudinal studies of those that attained residential placement would make it possible to determine the critical points of intervention so that return to the streets is prevented. Second, the results from this model of service should be compared with other models of service for indication as to which type of service is more effective. Thus, more "second generation" of studies are needed to determine which types of programs are effective for which subgroups.

References

Ball, F. J. & Havassy. B. E. (1984). A survey of the problems and needs of homeless consumers of acute psychiatric services. *Hospital and Community Psychiatry, 35,* 917–921.

Barrow, S., Struening, E., Plapinger, J., Hellman, F. & Lovell, A. (1986). *Effectiveness of Services for Mentally Ill Homeless.* N.Y. CSS Evaluation Program. N.Y. Psychiatric Institute.

Baxter, E. & Hopper, K. (1982). The new mendicancy: homeless in New York City. *American Journal of Orthopsychiatry, (52),* 343–408.

Blankertz, L., Cnaan, R. A., White, K., Fox, J. & Messinger, K. (1990). Outreach efforts with dually diagnosed homeless persons. *Families in Society, 71,* 387–397.

Breakey, W. R.(1987). Recent empirical research on the homeless mentally ill,in D. Dennis, (Ed.) *Research methodologies concerning homeless persons with serious mental illness and/or substance abuse disorders* (pp. 27–38). Washington, D.C.: DHHS.

Brekke, J. (1988). What do we really know about community support programs? Strategies for better monitoring. *Hospital and Community Psychiatry, 39,* 917–921.

Caplow, T., Bahr, H. M. & Sternberg, P. (1968). Homelessness. *International Encyclopedia of the Social Science.* New York: MacMillan, 1968.

Drake, R. E. & Adler, D. A. (1984). Shelter is not enough: Clinical work with the homeless mentally ill. In Lamb, R. (ed.) *The Homeless Mentally Ill.* (141–151). Washington, D.C.: American Psychiatric Association.

Dockett, K. H. (1989). *Street homeless people in the District of Columbia: Final report.* Washington D.C.: University of the District of Columbia.

Gardner, J. (1984). The homeless. *Psychosocial Rehabilitation Journal, 8* (1), 17–20.

Goering, P., Paduchak, D. & Durbin, J. (1990). Housing homeless women: A consumer preference study. *Hospital and Community Psychiatry, 41,* 790–794.

Grunberg, J. & Eagle, P. F. (1990). Shelterization: How the homeless adapt to shelter living. *Hospital and Community Psychiatry, 41,* 521–525.

Hoch, C. & Slayton, R. A. (1989) *New homeless and old: Community and the skid row hotel.* Philadelphia: Temple University.

Judd, L. (1989) NIMH makes homeless mentally ill persons a top priority. *Access,* 2(1), 1–2.

Lauriat, A. & Whitty, D. (1985) A Homelessness Service Provider's Perspective. *Psychosocial Rehabilitation Journal, 8* (4), 25–31.

Levine, I. S. (1984). Service programs for the Homeless Mentally Ill in Lamb, R. (ed.), *The Homeless Mentally Ill.* Washinaton, D.C.: American Psychiatric Association.

Levine, I. S., Luzak, A. D. & Goldman, H. (1986). Community support systems for the homeless mentally ill. in Bassuk, (ed.), *The Mental Health Needs of Homeless Persons: New Directions for Mental Health Services,* San Francisco: Jossey-Bass.

Lipton, R., Nutt, S. & Sabatini, A. (1988). Housing the homeless mentally ill: A longitudinal study of a treatment approach. *Hospital and Community Psychiatry, 39,* 40–45.

Lipton, R. & Sabatini, A. (1984) Constructing support systems for homeless chronic patients. In Lamb, R. (ed.) *The Homeless Mentally ill,* (153–172). Washington, D.C.: American Psychiatric Association.

Lovell, A. M. (1989) Social Networks and social supports. Workshop conducted at NIMH meeting on Homelessness and mental illness: the next generation of research studies. Rockville, Md.

Mellen, V. (1985). A response to the American Psychiatric Association report on the homeless mentally ill. *Psychosocial Rehabilitation Journal, 4,*

Morse, G. A., Calsyn, R. J., Dannelet, M., Muether, R. O. & Harmann, L. (1989). Community services for the homelessness: Preliminary experimental results. Paper presented at the 141st Annual meeting of the American Psychiatric Association, May 7–13, Montreal, Canada.

Morse, G. A., Shields, N. M., Hanneke, C. R., Calsyn, R. J., Burger, G. K. & Nelson, B. (1985). *Homeless people in St. Louis: A mental health program evaluation, field study, and follow up investigation.* Jefferson City, MI: Missouri Department of Mental Health.

Mulkern, V., Bradley, V., Spence, R., Allenin, S. & Oldham, J. (1985). *Homelessness needs assessment study: Findings and recommendations for the Massachusetts Department of Mental Health.* Boston: Human Services Research Institute.

Osher, F. C. & Kofoed, L. L. (1989). Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital and Community Psychiatry, 40,* 1025–1030.

Piliavin, I., Sosin, M. & Westerfelt, H. (1988). *Conditions contributing to long-term homelessness: An exploratory study.* Madison, WI: Institute for Research on Poverty, University of Wisconsin-Madison.

Plapinger, J. D. (1988). *Program service goals: Service needs, service feasibility, and obstacles to providing services to the mentally ill homeless.* New York: New York State Psychiatric Institute.

Ridgely, M. S., Goldman, H. & Talbott, J. A. (1986). Chronic mentally ill young adults with substance abuse problems: a review of relevant literature and creation of a research agenda. Baltimore: University of Maryland School of Medicine.

Rog, D. J. (1988). Engaging Homeless Persons with Mental Illness into Treatment. Alexandria, Va: National Institute of Mental Health.

Rossi, P. (1989). *Down and out in America.* Chicago: University of Chicago.

Rossi, P., Wright, J., Fisher, B. & Willis, G. (1987). The urban homeless: Estimating composition and size. *Science, 234.* 1336–1371.

Snow, D. A. & Anderson, L. (1987). Identity work among the homeless: The verbal construction and avowal of personal identities. *American Journal of Sociology,* 92, 1336–71.

Sosin, M. R., Colson, P. & Grossman, S. (1988). *Homeless in Chicago: Poverty and pathology, social institutions and social change.* Chicago: The Chicago Community Trust.

Tessler, R. C. & Dennis, D. (1989). A synthesis of NIMH funded research concerning persons who are homeless and mentally ill. Washington, D.C.: NIMH, Division of Educational and System Liaison.