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Carol T. Mowbray
University of Michigan

Shirley P. Thrasher
Wayne State University

Evan Cohen
Rainbow Rehabilitation

Deborah Bybee
Michigan State University

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CAROL T. MOWBRAY
The University of Michigan
School of Social Work

SHIRLEY P. THRASHER*
Wayne State University
School of Social Work

EVAN COHEN
Rainbow Rehabilitation

DEBORAH BYBEE
Department of Psychology
Michigan State University

Despite a proliferation of programs targeted for persons who are homeless and mentally ill, few reports in the literature detail the challenges experienced or strategies utilized by workers, the majority of whom are social workers. The present study reports results from two focus group sessions held with staff running a model service intervention for this population at two separate sites. The methodology that was utilized quanitified results, allowing presentation of themes, as well as comparisons of the frequency of responses across categories and by site. Staff perceived barriers associated with client behaviors and characteristics predominated at both sites. However, systemic and other external barriers were also frequently mentioned. Although not part of the focus group questions, staff spontaneously made mention of their personal feelings and how they were handled. Site differences were identified in the frequency with which certain strategies to handle client and systemic barriers were mentioned. The discussion focuses on implications for the education and training of social workers who provide services to individuals who are homeless and mentally ill.

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Introduction

Over the last 15 years, homelessness has become an escalating problem in this country (Federal Task Force on Homelessness and Severe Mental Illness, 1992). Of particular concern have been vulnerable subgroups, such as those who are homeless and mentally ill (Institute of Medicine, 1988; Roth, Bean, Lust & Saveanu, 1985; Tessler & Dennis, 1989). Program reports of community-based interventions for these individuals can now increasingly be found in the literature (Dennis, Buckner, Lipton & Levine, 1991; Rife, First, Greenlee, Miller & Feichter, 1991; Stoner, 1989). Most of these reports describe outreach and direct service provision. However, details of staff roles and processes in working with persons who are homeless and mentally ill are often omitted, with the exception of the engagement process (Blankertz, Cnaan, White, Fox & Messinger, 1990); specifically, the difficulties encountered (e.g., Cohen, 1989), and its long, labor-intensive nature (Barrow et al., 1989). Agreed-upon techniques for increasing the success of engagement efforts include: frequent contacts, provision of tangible assistance (such as food, medicine, housing, etc.), and establishing personal, trusting relationships (Blankertz et al., 1990; Cohen, 1989; Dennis et al., 1991). In general, however, reports offer little information on intervention techniques for overcoming the continuing challenge of maintaining the target population in service. Sheridan, Gowen and Halpin (1993) have recently proposed practice principles for work with persons who are homeless and mentally ill, starting from where the client is at and focusing on enhancing client self-determination.

Descriptions of service interventions for homeless persons have appeared in prominent social work journals (Blankertz, Cnaan, & Saunders, 1992; Blankertz et al., 1990; Cohen, 1989). Social work is the modal discipline providing homeless services (Hagen & Hutchinson, 1988; National Resource Center on Homelessness and Mental Illness, 1990). Therefore, social work educators and practitioners need to understand service delivery issues and challenges confronting staff who work with this population, in order to improve training and practice.

The purpose of this paper is to present a description of the challenges faced by staff working in community-based programs

for individuals who are homeless and mentally ill, as well as the strategies they use and their perceptions of training needs and desirable staff characteristics. The information for this analysis was obtained from focus group sessions held with line staff employed in two sites providing comprehensive services targeted to those who are homeless and mentally ill. Our discussion will contrast results from the focus group sessions with other reports in the literature and suggest implications for education and practice.

Background

The Mental Health Linkage intervention model (Mowbray, et. al., 1992) was the basis for this NIMH-funded research demonstration. It utilized a team (4 to 5 FTE's) of mental health workers to outreach to persons who were mentally ill and homeless or potentially homeless. Eligible clients were offered a variety of services, in vivo, by outreach workers: a comprehensive assessment of functionality, housing preferences, and needs; assistance in obtaining temporary or permanent housing in independent settings; help in establishing income supports; training or rehabilitation in activities of daily living and interpersonal/social skills; mental health clinical services; and short-term intensive case management. Once participating clients' living arrangements and extreme behavior problems were stabilized, the goal was to integrate them within ongoing mental health and other service systems. Project staff resources were also utilized in locating and accessing independent housing sites and working with landlords to maintain housing opportunities.

The Mental Health Linkage project was sited in two Michigan communities: Factorytown and Collegetown. Each site recruited participants from three types of settings: shelters, hospitals serving public mental health inpatients, and the existing community mental health (CMH) caseloads of aftercare clients. Services offered at both sites followed the same model, with the exception that the Factorytown program offered a Transitional Boarding House.

Staffing at the two sites varied somewhat, due to differences in county-based employment practices. In Collegetown, 4 FTE's were hired as the front-line workers, all with mental health experience (1 MSW and 3 BA-level, with an MSW supervisor). In

Factorytown, county policies precluded all but the supervisor and manager for the Transitional Boarding House from working full-time. Consequently, staffing consisted of the MSW supervisor and 7 part-time staff, many of whom were students and/or had limited experience in human services (Mowbray, Cohen, & Bybee, 1991). Prior analyses documented site differences in implementation (Mowbray, Cohen & Bybee, 1993), although overall service outcomes have not differed (Bybee, Mowbray & Cohen, 1994).

Method

Focus Group sessions were scheduled separately at each site after the project had been fully operational for more than two years. In attendance were currently employed front-line staff as well as any staff who had recently left the project (10 from Factorytown and 6 from Collegetown). Participants were provided with focus group questions in advance.

Following recommendations that systematic, rigid and replicable analysis be a minimum standard for the Focus Group method (Archer, 1991), the authors went beyond the usual qualitative analyses of focus group sessions (i.e., identifying and describing themes), to produce results which could also address the frequency/importance of the themes which emerged. Thus, specific conventions were developed and agreed upon to permit counting, coding and quantitative analyses of transcribed comments: (1) A remark of a facilitator was not counted or coded unless it was followed by a rejoinder from staff. (2) Within the same utterance of a participant, repeat mentions of the same coded category were counted only once. (3) Each mention of additional coded categories was separately counted. (4) However, if one or more persons talked and then the participant re-entered the conversation, a previously used coding category could be re-used. Development of categories and coding of remarks was carried out by the first author. Reliability with the second author (independently coding four pages of transcript from each site) reached 89%.

Chi-square tests were used to determine whether county differences in response distributions across categories were significant[1].

Results

Staff in both focus groups produced about an equal number of codeable responses (265 and 298 for Factorytown and Collegetown, respectively). The two major categories for coding were barriers and strategies. These categories were further subdivided into client-level versus other levels. The majority of responses at both sites were at the client level (316/563). However, responses reflecting non-client-based barriers (systemic, operational) and strategies to address them (external agency, internal management) were also frequent (about 35% of all responses). Not unexpectedly, there were markedly fewer comments about strategies (N = 210) than about barriers (N = 343). However, the discrepancy was less for client-level than for non-client strategies versus barriers. Although not a frequent response (about 7% of total mentions), staff also related their own feelings and thoughts that interfered with effective role performance and personal strategies for coping with them. The fact that feelings were included even to this extent was somewhat surprising, since they were not the subject of direct focus group questions nor used as probes, but arose spontaneously from staff discussions. Another category, things which assist project operations, were actions or items from outside the project's actions (such as the availability of housing) and also arose spontaneously from staff in discussion. There were significant county differences across the major categories (χ^2 (8, N = 563) = 18.35, $p < .02$). "Operational barriers" were cited more frequently in Factorytown. In Collegetown, staff responses in the "Systemic barriers" and "Feelings" categories were more frequent.

Client-oriented Barriers and Strategies

Table 1 provides more detail on subcategories of Client Barriers—problematic states, behaviors, or symptoms of clients themselves.The most frequently mentioned client problems involved *disturbing* (nondangerous) client behaviors, such as being too demanding ("we can never do enough to satisfy them"), testing the rules, having "burned all their bridges", e.g.,

> She is barred from there [a crisis house] right now for going in and tearing open all their garbage bags and strewing them around the lawn. She used to be there often.

Table 1

Types of Client Barriers Mentioned, By County Site

CLIENT BARRIERS	FACTORY TOWN	COLLEGE TOWN	TOTALS
Disturbing behavior problems	18 20.5%	20 23.5%	38 22.0%
Rejecting (meds, help, housing, etc.)	13 14.8%	15 17.6%	28 16.2%
Affects (fears, suspicions, anger, etc.)	8 9.1%	14 16.5%	22 12.7%
Substance use	10 11.4%	9 10.6%	19 11.0%
Delusions and hallucinations	9 10.2%	9 10.6%	18 10.4%
Mental condition/ diagnosis	7 8.0%	6 7.1%	13 7.5%
Dangerous, attacking	10 11.4%	3 3.5%	13 7.5%
Skill, functional deficits	5 5.7%	4 4.7%	9 5.2%
Other	8 9.1%	5 5.9%	13 7.5%
TOTALS % of all mentions[a]	88 33.2%	85 28.5%	173 30.7%

[a]N = 265 for Factorytown and 298 for Collegetown

Next, accounting for about one-sixth of client barriers were *rejecting* behaviors: clients leaving the program, being difficult to engage, "not on their meds", not accepting a particular housing arrangement offered ("she said she absolutely could not stay in this apartment"), or rejecting the whole system:

> I think all of these folks that we're seeing are saying what exists as the system didn't work and it doesn't work and it probably won't work and we don't want to have anything to do with it and there's a reason for that.

Client *affects* were mentioned third most frequently. These included mainly fears and suspicions, but also anger, especially concerning access to their funds (primarily Collegetown). Clients' *substance use* was the focus of 11% of comments. Clients' *delusions and hallucinations* were cited about 10% of the time. Coded for less than 10% of remarks were behaviors *dangerous* to others (attacks, violent behavior); the clients' *mental condition or diagnosis* (e.g., "borderline" diagnoses; "chronic" or "unstable" mental conditions); *skill and functional deficits* ("difficulty managing money", lack of independent living skills); and *other* client characteristics (mainly gender issues at the Factorytown site, also "transients", health, and past sexual abuse). There were no significant differences on client barriers across county sites.

Table 2 provides detail on *Client-Oriented Strategies*, e.g., strategies employed by project workers with individual clients to overcome client-level problems. Mentioned most frequently (18.4%) were *personal relationships* with clients, i.e., "engage them to see if they really want help", "you are more of a friend and you are maybe a support system," "I was always there for them." Mentioned second in frequency (16.1%) were a variety of *control mechanisms*, such as giving clients medication, utilizing payees or other control over funds, sending for the police, supervision ("you behave or we won't do this"), civil commitment petitions, and hospitalization. About one-seventh of strategies were coded as *tangible assistance*—such as cigarettes, food or clothes, getting clients entitlements or housing, "they need to know that I can give them something"; e.g.,

> . . . he relies on me for different things that naturally there aren't people there for him to provide these services.

Disconnecting strategies were used close in frequency to tangible assistance. These involved tactics mainly to defuse situations: "you have to know when to back off", "ask them to leave", or waiting until they "hit rock bottom." Also close in frequency were practices of making *regular and frequent contacts* to the client in his/her location—in the shelter, jail, hospital: "they will never forget the fact that you came in and spent time with them." *Instructional techniques* were also fairly frequent; these included skill building as well as socialization, and joint problem solving ("I like

Table 2

Types of Client Strategies Mentioned, By County Site

CLIENT STRATEGIES	FACTORY TOWN	COLLEGE TOWN	TOTALS
Personal relationships	7	20	27
	11.1%	25.0%	18.9%
Control mechanisms	16	7	23
	25.4%	8.9%	16.1%
Tangible assistance (cigarettes,	9	11	20
food or clothes, benefits, etc.)	14.3%	13.8%	14.0%
Disconnecting strategies	10	8	18
	15.9%	10.0%	12.6%
Regular contacts	6	10	16
	9.5%	12.5%	11.2%
Instructional techniques	1	14	15
	1.6%	17.5%	10.5%
Rule orientation	7	3	10
	11.1%	3.8%	7.0%
Other	7	7	14
	11.1%	8.8%	9.8%
TOTALS	63	80	143
% of all mentions[a]	23.8	26.8%	25.4%

[a]N = 265 for Factorytown and 298 for Collegetown

people to make their own choices and decisions about things"). Less than 10% of responses fell into the *rule orientation* category ("be real consistent", "set the ground rules from the beginning") or into the *other* category ("watch people for a while", use a team approach, etc.). Significant site differences were observed (χ^2 (7, N=143) = 22.36, $p < .01$), with Collegetown staff more frequently mentioning use of personal relationships and instructional techniques and Factorytown staff mentioning control mechanisms, disconnecting strategies, and rule orientations.

Systemic and Operational Barriers and Strategies

Table 3 lists the (non-client) systemic barriers and operational barriers. *Systemic barriers* related to problems in how systems operated which precluded clients receiving effective services. These were obstacles that the project could not directly influence. Four types of systemic barriers were identified. Not surprisingly, the most frequently mentioned type was not having affordable or safe *housing* (e.g., "they need privacy and they don't have it", "bad neighborhoods make them decompensate"). Barriers in the *mental health* system (about one-fourth of responses) included lack of resources for service continuity or for specialized approaches like assertive community treatment (ACT), lack of self-help groups for the dually diagnosed, "case managers who didn't have time for them", for example:

> If [you] get somebody to agree to accept services and you pass him off to a case management unit which has 60 other clients that they see and they won't notice if he shows up or not for three months, I would know that nobody had the time to care about me and I wouldn't want to have anything to do with it.

Community barriers (about another one-fourth of responses) involved general community attitudes, or problems with other agency policies (e.g., lack of substance abuse treatment availability, problems obtaining entitlements). Specific problems with the *judicial* system accounted for nearly 11% of mentions (not being able to petition clients in or enforce medication compliance).

There were significant differences between sites in frequencies of types of systemic barriers cited (χ^2 (3, N = 64) = 8.77, $p < .03$), with housing and mental health system problems cited nearly twice as frequently in Collegetown as Factorytown. More frequently cited in Factorytown were barriers with the judicial system and with the community.

A second type of non-client barrier, *operational barriers*, were those specific to project operations and to the major agencies that staff related to in getting client referrals and/or service linkages; they should be more amenable to change than systems barriers. These barriers also showed significant site differences (χ^2 (5, N = 74) = 186.09, $p < .01$). *Community Mental Health* (CMH) was

Table 3

Systemic and Operational Barriers Mentioned, By County Site

SYSTEMIC BARRIERS	FACTORY TOWN	COLLEGE TOWN	TOTALS
Housing	7 28.0%	20 51.3%	27 42.2%
Mental Health	4 16.0%	11 28.2%	15 23.4%
Community, other	9 36.0%	6 15.4%	15 23.4%
Judicial	5 20.0%	2 5.1%	7 10.9%
TOTALS % of all mentions[a]	25 9.4%	39 13.1%	64 11.4%
OPERATIONAL BARRIERS			
Resources, including information	16 38.1%	10 31.2%	26 35.1%
Staff employment	8 19.0%	16 50.0%	24 32.4%
Community Mental Health	5 11.9%	6 18.8%	11 14.9%
Homeless shelters	6 14.3%	0	6 8.1%
Police	4 9.5%	0	4 5.4%
Hospitals	3 7.1%	0	3 4.1%
TOTALS % of all mentions[a]	42 15.8%	32 10.7%	74 13.1%

[a]N = 265 for Factorytown and 298 for Collegetown

mentioned in about 15% of responses, more frequently in Collegetown (for example, difficulties in transitioning clients to ongoing

services, CMH closing cases when transferred, CMH staff using project availability as coercion). *Shelters, hospital* staff and *police* were mentioned at Factorytown only (shelters being "afraid of mentally ill people" or turning away eligible participants, "we had to write down our criteria . . . because at first they [shelters] would send us anybody", "the police wouldn't come out"; hospital staff being inaccessible to the project, or not allowing project staff to see clients; etc.). At both sites, however, a more frequently mentioned operational barrier involved *staff employment* (especially at Collegetown). For example, not enough supervisory time or inappropriate supervision, employment status being uncertain or part time, not knowing what to offer prospective participants. At both sites combined, the most frequently cited barriers involved resource levels: "we don't have a lot of carrots to dangle", "we have all of this information but it is scattered", and the amount of time needed to stabilize clients ("it's such a time consuming process").

Strategies for dealing with non-client barriers were coded into those which involved working with entities outside of the project (External agency strategies) and those for working among project staff and supervisors (Internal management strategies). *External agency strategies* were not mentioned with high frequency (7.3% of all coded responses) and seemed to fall into three main categories. *Personal/social strategies* were the most common and involved spending time working closely with staff from other agencies, socializing with them, getting to know shelter staff, "keep our ties with the landlord". For example:

> I work closely with the social workers because they are going to be calling the family to see if the client can come back home. It's touchy—need to tiptoe around a lot of people—that's my job.

Informational strategies involved providing information to therapists, obtaining information from other staff to determine client eligibility, and reminding hospital staff about housing issues. *Instrumental strategies* included providing consultation to CMH and shelters ("We've done stuff for them—so now they know who we are"), walking forms through DSS, interesting landlords in renting their whole house, etc.

Internal management strategies (working on problems internal

to the project) constituted 4.5% of mentions in Factorytown and 1.7% in Collegetown. These activities involved communication methods (most common)—such as use of a calendar, logbook, posting board or staff meetings, or asking another staff person, support from other staff (team feedback, spending time talking and problem-solving); and supervision (more frequent and accessible, "more planning written out from our supervisor about each person").

Items listed as *things which assist project operations* were also infrequently mentioned . They included things external to the mental health system (availability of SRO spaces, involvement of a consumer self-help group). Assistance internal to the mental health system was also mentioned, including having ACT slots available, clients already being in the CMH system thereby avoiding eligibility determinations, and CMH casemanagers doing outreach.

Personal Feelings and Solutions

Staff feelings in response to their jobs constituted 2.6% of responses in Factorytown and more than three times that frequency in Collegetown (8.4%). The most commonly cited feelings involved boundary issues, often concerning feelings of personal responsibility for clients: " . . . where do I draw the line? How much of myself and my time can I put in to this?", feeling like you let them down, fears over clients' welfare ("It's the vulnerability of this man. It's scary. Really scary"), feeling "guilty", taking clients' problems home with you:

> When I didn't leave Bob my home phone number, I worried all weekend that he might have left the new apartment and be wandering around alone . . . and get into more trouble.

Other feelings involved personal competencies: worries about whether a response to a client was right or wrong, "I didn't feel oriented at all". Also mentioned were fears for personal safety, stress and frustration, and feeling disenfranchised: "I feel like I'm out there alone".

Staff mentioned few *personal strategies* to deal with these feelings (1.6% of responses). Those that were cited were cognitive (humor, "I couldn't get upset because I knew she was sick", "I

had to figure out what was relevant to what I was doing") and emotional/social ("I naturally have the support of the team", "I just had to let it go").

Staff were asked specific questions about their training needs. Their responses were quite limited and very specific; for example self-protection training, visits to a similar program, a written manual of information and procedures. The lack of training suggestions is perhaps explained by staff responses to the question of what would be the ideal staff to hire for the project. Personal qualities were highlighted: "sense of humor", ability to communicate, "people with a philosophy of doing outreach", supportive and caring. Also emphasized were diverse demographics: "ethnic diversity", males—especially black. Life experiences were most often mentioned as desirable characteristics: someone who "knows the territory" [of homelessness]. One individual listed a potential staff composition different from many outreach programs: "a nurse, an MSW who can do assessments" and a psychiatrist—"a cowboy doc who would go to the shelter and can speak English clearly". The ideal staff would be:

> Graduates from a Clown College who had also gone to school to be and worked in shelters as substance abuse counselors.

In general, there was little mention of formal training or specific disciplinary backgrounds being particularly helpful.

Discussion

Being less constrained by a structured format, our qualitative focus group method of data collection allowed staff to more freely communicate issues around services to individuals who are homeless and mentally ill. Many of the results reinforce what we already know or suspect concerning services to these individuals: that they are difficult to serve and are often seen as "resistant" to helping efforts (Cohen, 1989); that offering tangible assistance is a successful helping strategy (Chafetz, 1992; Herman, Streuning & Barrow; 1994; Sheridan et al., 1993); but that sufficient resources for assistance are not available (Chafetz, 1992); nor are there appropriate housing and/or mental health facilities available (Federal Task Force, 1992).

The more unique contributions of this study are to underscore the clinical complexities and the operational and systemic difficultes of serving individuals who are homeless and also mentally ill. Addressing this double burden requires providers to have clinical knowledge and skill as well as expertise in community advocacy and an understanding of organizations in order to deliver effective interventions. Differences in client strategies across sites are of particular interest given the fact that there no site differences in client problems, but rather in how staff have been trained to deal with the problems.

The Need for Clinical Knowledge and Skill

The fact that client level responses and behaviors dominate as *barriers* to positive outcomes point to the importance of a strong knowledge base concerning mental disorders in working with individuals who are homeless and mentally ill (Sheridan et al., 1993). An intellectual framework of clinical syndromes should become a backdrop for understanding and attending appropriately to client behaviors, so as not to "blame the victim" (Ryan, 1971). For example, behaviors which are too demanding and/or intense or which reject help are clues to the client's internal emotional life. These behaviors must be understood as parts of and not the total personhood of the client. The task for the worker is to stay connected with the client. This requires an empathy for clients and a capacity to accept their internal struggles even when there is a rejection of their external behaviors. The ability to take such an approach is an acquired skill, based on knowledge and practice that permits a worker to allow the client to become angry without succumbing to one's own reaction and judgement. This kind of response can occur when there is recognition that intense emotional expressions of clients must be understood from the perspective of what is behind them—usually some combination of fear, vulnerability, and pain. This approach also facilitates a collaboration with clients which enables them to risk finding themselves through the working alliance and moving ahead in the process of self determination and growth.

Medication compliance is often necessary in order for clients to achieve positive outcomes and maintain progress. Appropriately addressing noncompliance requires that workers combine

their clinical knowledge with interpersonal skills, to provide understanding, yet maintain firmness without invoking punitive or control tactics. The worker must convey the message that she/he is aware that the client is struggling to be responsible for her/his own behavior.

Being homeless is a stressful situation and is an additional burden and disempowerment for mentally ill persons. Analysis of the pervasiveness and complexity of these two conditions identifies mental illness as the basic, underlying problem (Lamb, 1984) and homelessness as the core element of broader socioeconomic issues which become intertwined with mental illness (Cohen & Thompson, 1992). This perspective requires that workers be attuned to the frailty of clients' inner boundaries and the pervasiveness of their feelings of abandonment when there is concomitantly the lack of safe and secure physical space in the external environment. The worker's heightened awareness of the internal states and external environments of clients puts substance abusing and attacking behaviors in the light of clients' attempting to alleviate their vulnerability to external and internal pain. Understanding the intersections of these conditions also underscores how workers must be adept at securing entitlements, intervening in the environment, providing concrete services, and knowing when a client is in need of self protection, such as hospitalization. Fear by workers of psychotic processes (Minkoff, 1987) and the lack of competence expressed by students in dealing with persons with mental illness (Werrbach & Deploy, 1993) can result in workers' withdrawing and failing to engage clients (Chafetz, 1992). Expertise and skill are necessary for bridging the gap between remaining connected to clients and making appropriate referrals in potentially dangerous situations.

The strategies employed by workers to address client barriers affirm the primary importance of the worker-client relationship. This relationship has been identified in other studies However, there is a significant difference in the two sites in the use of a relationship strategy; it ranks first in Collegetown, which employed full time workers with mental health experience; it ranks second to controlling mechanisms in Factorytown, where the workers were part-time with varying backgrounds and limited experience. The Factorytown staff responses of more

controlling and coercive strategies suggest that they were responding to the client's overt behaviors without an understanding of what the behavior meant. According to Goodman, Saxe, and Harvey (1991), the engagement process for interventions with individuals who are homeless and mentally ill should be designed to increase a sense of personal control; therefore, the coercive strategies used in Factorytown seem counter-productive. This observation supports our initial position of the need for workers to have adequate clinical knowledge and skill. Clinical knowledge provides workers with an understanding of how to reframe behaviors, and thus gives workers and clients alternatives and options in responding. Another noteworthy difference between sites is the low number of instructional techniques used with clients in Factorytown. This difference again seems to reflect different levels of expertise and orientation towards this population (Mowbray et al., 1991). The lack of a proactive and empowerment approach in Factorytown also implies that clients were perceived as less able to learn skills and assume responsibility. Interestingly, these site differences in workers' strategies parallel other documented differences between the sites; that is, in implementation, the Factorytown project initially concentrated on apparently easier to engage clients (see Mowbray et al., 1993).

Community Advocacy and Organizational Skills

While client-level difficulties predominated in staff comments, systemic and operational- level barriers combined to create nearly as great a challenge. For systemic barriers, the highest numbers reported were for housing and mental health services. Other writers have addressed the urgent need for workers to become actively involved with other service providers in seeking housing for this vulnerable population (Cohen & Thompson, 1992; Hagen & Hutchinson, 1988; Susser et al., 1990). Systemic barriers point to the need for a high level of interagency cooperation and collaboration, advocacy, and community organization in order for interventions to be effective (Chafetz, 1992; Katz et al., 1993; Sheridan et al., 1993; Susser et al., 1990). According to Rife et al. (1991), for those who work with homeless mentally ill people, "the challenge is twofold: to advocate for increased resources that may be used for housing, supportive services, and employment

programs and to identify more effective case management strategies to serve and maintain mentally ill people in the community" (p. 66).

However, despite the large volume of systemic barriers identified, workers reported many *fewer* strategies for dealing with these external (vs. client-level) difficulties. Perhaps reflecting the same problem, a recent survey of social work students working with persons who are mentally ill found that they lacked competency in advocacy skills (Werrbach & DePoy, 1993). To address the prevalent systems-level problems identified in this study, line staff and their supervisors need training of a scope much broader than one focusing on clinical and interpersonal skills. In dealing with homeless and other vulnerable populations, staff need advocacy training, as well as grounding in the basics of team management, organizational analysis, and community organizing—in order to understand, gain entry, operate efficiently, and positively affect the diversity of community agencies and programs relevant to meeting client needs.

Staff Support and Supervision

The spontaneous mention of personal feelings from the focus group members reflect the ubiquitous demands of modulating a balance in servicing this vulnerable population. If workers are unable to manage these feelings, frustration and a sense of helplessness can invariably be transferred to clients and become impediments to the helping process. It has been suggested that working with individuals who are homeless and mentally ill can evoke feelings about contagion, odors, and threatening behaviors which lead to an undermining of empathetic care (Chafetz, 1992) and early signs of burnout (Sheridan et al., 1993). These working conditions suggest a need for frequent staff meetings, ongoing training and education, and adequate levels and types of supervision. Staff meetings and regular supervision from experienced workers can permit a sharing of information, a reinforcement of collaboration, and support for joint problem solving in order to alleviate the burdens of individual staff.

The staff's failure to identify training, education, and ongoing supervision as a strategy to enhance their service effectiveness is a cause for concern. Knowledge is power for both workers and

clients. According to the National Resource Center on Homelessness and Mental Illness (1990), ongoing training and support are vital. Perhaps, workers were so immersed with the tasks involved in serving this population that they were unable to step back, separate out the appropriate use of personal and professional self, identify learning and skill needs, and thus use these processes for professional and program enhancement.This inattention to training and education may also reflect the disparate levels of training of the workers at the two sites. It also suggests that more intensive training should be provided (to both staff and supervisors) before innovative programs are initiated and repeated on a periodic basis. This should be of concern to many homeless programs, as the relative inexperience of much of their staff has been documented (Hagen & Hutchinson, 1988) as has the special communication skills needed to establish rapport with an often alienated, disenfranchised population (Blankertz, Cnaan, & Saunders, 1992; Hoffet al., 1992).

Implications for Education and for the Structure of Practice

A major implication of the results of this study for practice is the need for administrators and program developers working with persons who are homeless and mentally ill to recognize the necessity of hiring experienced and appropriately trained staff. The importance of expertise and skill in working with mental illness was reflected in major differences in strategies at the two sites. To adequately provide services to individuals who are homeless and mentally ill, we not only need clinical knowledge of the behavioral challenges that go along with psychiatric disabilities and the complicating effects of homelessness, but we also need a wide repertoire of supportive responses that are aimed at engaging clients into long-term service relationships, rather than mere compliance with agency routines.

To educators, we suggest that social workers serving individuals who are homeless and mentally ill need knowledge and skills in both interpersonal and macro practice methods. Workers need to understand the context presented by mental illness; they need to be prepared for acceptance of and empathy towards clients' internal turmoil as a frequent cause of negative external

behaviors and of their psychiatric disability as a source of periodic challenges, rather than attributing manipulative intent to them.However, clinical knowledge and skills are not sufficient for effective interventions: the double burden of mental illness and homelessness requires workers to remain connected to clients, while advocating and intervening in the environment for access to and maintenance of stable housing and other needed supports. The startling discrepancy between the prevalence of nonclinical barriers identified by staff, e.g., systemic and program-operational barriers (a quarter of all responses) versus the mention of strategies to deal with these barriers (about 10% of responses) should be an area of great concern to educators. The discrepancy underscores the importance of staff receiving training in community organizing, systems change practices and advocacy. Unfortunately, our professional training often limits this skill development to those in administrative/community tracks versus clinical or interpersonal practice orientations. Staff working in communities with difficult and/or disenfranchised populations have an urgent need for expertise in the "macro" practice skills as well. Many academic social work programs are still organized around methods concentrations, interpersonal versus "macro" practice, thereby making it unlikely that recent graduates will have acquired the broader training they need. This is ironic in an era wherein social workers are likely to be seeing increased numbers of clients who, more and more, present needs for clinical services and for organizing and advocacy on their behalf.

The final set of implications relates to educators and administrators alike and concerns inservice training and support for staff. Working with a population which has extreme problems and vulnerability evokes personal feelings from workers which need to be understood and managed so as not to impede their work with clients. Staffs, unfortunately, failed to identify training as a resource for improved service delivery. Ongoing education and supervision for workers is imperative if individuals who are homeless and mentally ill are to have positive outcomes from service interventions.

In summary, components necessary for success with those who are homeless and mentally ill include: clinical expertise and knowledge about the intersection of mental illness and home-

lessness, advocacy and collaborative skills to work with other agencies, attention to personal feelings, and ongoing education, supervision, and training. These are all topics appropriate for and congruent with professional social work training. Since the social work profession appears to contribute the modal number of staff working with homeless persons, the profession's training and knowledge dissemination efforts need to incorporate increased attention to homelessness, given its expanding significance as a social problem. With homeless populations and others, we have seen that traditional service approaches are often ineffective. To correct this situation, curriculum development and revision should follow more closely research results documenting real practice experience and problems.

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Note

1. Because cells for some distributions contained expected frequencies less than 5, extensions of Fisher's exact test were also applied (Mehta & Patel, 1992). However, in all cases, results from these tests vis a vis significance were the same as those from the chi-square and so the statistics are not separately reported.

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