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# “I’m Glad you Asked”: Homeless Clients with Severe Mental Illness Evaluate Their Residential Care

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*Homeless clients with severe mental illness can offer considerable insight about their residential care, but there are significant methodological challenges in eliciting their service evaluations: maximizing participation, facilitating self-expression, and preserving clients’ natural meanings. This study addresses those challenges and presents qualitative data residential care staff obtained from 210 clients. While clients prioritized meeting their subsistence needs, they emphasized attaining inner well-being and mutually respectful relationships, and that group services needed to reduce confrontational interactions in order to be helpful. For after-care services, clients sought sustained relationships with staff grounded in client initiative, combining respect for their autonomy with psychosocial support.*

*Key words: Homeless persons, consumer evaluation, residential care for severely mentally ill clients*

## Introduction

On a cold winter night in a large Midwestern city, the

symphony is over and people pour out looking for warm parking lots and taxis. As the brisk air hits them, they hear the sounds of an oboe, and twenty feet from the door a man sits dressed in layers of coats with a pail in front of him, playing soulfully. His pail says, "Homeless. Please help." The crowd streams around him, most passing by without looking, occasionally someone stopping and putting money in his pail, some others commenting to their friends about the man's condition. Although he is a familiar figure for the symphony crowd, no one knows who he actually is—why he is there, what is important to him, or how he learned to play the oboe.

People who suffer from the combined problems of homelessness and severe mental illness all too often represent others' greatest fears: destitution, delusion, abandonment, and being victims or perpetrators of violence. People who are the targets of fears, however irrational, are shunned; one of the consequences of the condition of being homeless and mentally ill is the loss of everyday human interchange—the smile of greeting, recognition, acknowledgement of fellowship, the respect of having one's opinions matter, or as Bogdan and Taylor (1989) said, a defined 'social place' in the human community. Guided by the values of reducing the dehumanization of this population and fostering their social place in our communities, this study compiles and reports the opinions of 210 homeless, mentally ill clients about their evaluations of and wishes for residential care and follow-up services. The clients readily shared their opinions about services, shedding light on how they experienced residential care. Many expressed appreciation of the opportunity to express their views and forge a bridge across social chasms—one said, "I'm glad you asked."

The data were gathered over the course of four years in the context of a residential treatment program in a large Midwestern city, as part of the normal process of program operation (rather than a part of a separate research protocol). Four central research questions were formulated:

1. Can homeless mentally ill clients coherently evaluate their social services?
2. What do the clients believe caused their difficulties to begin with?

3. What do the clients find helpful and not helpful about their services?
4. What services do clients believe would be helpful when discharged from residential care?

The use of client opinions as part of program evaluation has had a controversial past. Prominent social workers who founded the profession, such as Jane Addams, developed social services hand-in-hand with clients (Tyson, 1995). Subsequently, many followed Donald Campbell's (1969) proscription of client opinions from program evaluation research, believing they would amount to little more than "grateful testimonials." A resurgence of interest in clients' perspectives about social services occurred in the late 1980s, so that "by 1992 at least 43 studies on consumers' housing and support preferences were completed in 24 states and two Canadian provinces" (Tanzman, 1993, pp. 13-51). Some consumer evaluations focused on clients' opinions about environmental aspects of services, such as location and number of residents in the home (Davis & Gerrard, 1993); others addressed modalities of service provision, such as how much involvement with staff clients wanted in residential care (Tanzman, 1993).

One of the most influential consumer evaluation studies was authored by a formerly homeless person with an orthopedic handicap as well as severe mental illness, Howie the Harp (1990). A central problem in providing residential treatment Howie described was that clients had not experienced residential treatment as supporting their self-determination:

[If asked] The overwhelming majority [of homeless mentally ill clients] will answer, "In my own place," or "In a place shared with someone of my own choosing." Independent living is the goal of most people. Independence is so important that amongst the homeless are many who could be living in a board-and-care home or other "residential facility," where others make the rules and one's life is structured and controlled, but who instead have chosen the independence of the streets. Is that a real choice? The conditions in many of these facilities are horrendous, and like Patrick Henry said in colonial times, "Give me liberty or give me

death!" For many people, independent living is the only lifestyle that is beneficial; any loss of freedom and self-determination is harmful. (1990, p. 86)

Other consumer evaluation studies echoed his remarks, finding that a central problem has been that the residential care environment can stimulate regression and dependency and, from clients' perspectives, undermine their dignity and mastery over planning their futures. But from clients' points of view, self-determination does not mean isolation. Clients indicate an important element of supporting their self-determination is inclusion in communities (Lipton, 2000). They strongly prefer independent living arrangements and envision having a partner and children and psychosocial support in their picture of independent living (Tanzmann, 1993, p. 453; Thompson, Pollio, Eyrich, Bradbury, & North, 2004). Clients tend to prefer and do best in residential settings where there are moderate-to-low levels of structure and behavioral demand. They have poorer outcomes under conditions of high demand and structure, and these findings hold regardless of variations in demographic characteristics or diagnosis (Lipton, 2000; Owen, Rutherford, Jones, Wright, Tennant, & Smallman, 1996).

Less data are available, however, to understand the crisis that Howie the Harp outlined above. How does it happen that services do *not* support clients' self-determination? Outcomes sought by clients can be quite different from those identified by clinicians or researchers (Rapp, Shera & Kisthart, 1993, p. 732). Researchers found that only one of the two clinicians considered the consumers' social background and medical status when making housing recommendations, and that consumers chose independent living for themselves more frequently in comparison to clinicians' recommendations. The researchers concluded, "Housing providers should encourage clinicians to work together with consumers to identify appropriate placements" (Schutt & Goldfinger, 1996). The emphasis on improving staff-client communication has been echoed by many researchers: "Although progress has been made toward alleviating the burdens facing people who are homeless and mentally ill, collaboration among all stakeholders—especially between the mental health community and consumer

advocates—needs to be further enhanced" (Dickey, 2000). Helping clients suffering from severe mental disorders to experience themselves as actively involved in their developmental process is a cornerstone of their improvement (Davidson & Strauss, 1992), and a solid, flexible client-worker collaboration is a critical foundation for the client's well-being, as outcomes are consistently related to the quality of the client-worker relationship (Chinman, Rosenheck, & Lam, 2000; Holmes et al., 2005). Clients' perceived control over their illnesses was found to be directly related to their sense of empowerment and progress (Young & Ensing, 1999).

Potentially, improved consumer evaluations can assist caseworkers in more accurately tuning in to clients' experiences, wishes and goals, enhancing clients' experience of self-determination. Moreover, giving staff a more active role in data collection can reduce communication barriers between researchers, staff, and clients, making it possible for research to have an active impact in improving services, and also potentially improving the ecological validity of research. Research with an empowerment focus can be more closely tied to and build on the constructive processes that occur in self-help and mutual aid groups for consumers of mental health services (Nelson, 1998). By involving staff and consumers in research about their services, we hoped to contribute to developing research methods that involve social services staff and clients as active participants in evaluating and designing their social services (Laws, Harper, & Marcus, 2003; Rapp, Gowdy, Hanson, & Kisthardt, 1994).

We decided to gather data using what was customary within the CCP program—for staff to ask clients for their opinions about their services. Much research with persons diagnosed with severe mental illness occurs by researchers coming into a program from outside of any service commitment. Conceivably, research that does not interfere with or alter the process of providing care has the advantage of not requiring clients who are already suffering and frightened to conform to research protocols. In addition, data gathered in the natural course of service provision can triangulate with data gathered by researchers coming to the program from 'outside.' Because the biases associated with both research processes are different,

a combined perspective can provide a more complete understanding and improved ecological validity (Bronfenbrenner, 1979).

While the movement to incorporate consumer feedback into service planning can contribute to improving the quality of services and outcomes by strengthening alliances between case managers and clients (Dickey, 2000), from a research standpoint asking staff to elicit client opinions yields a specific kind of Hawthorne effect. As Levois, Nguyen and Attkisson point out, "by regularly involving clients in satisfaction assessment it is possible that clients will become more satisfied as a result" (1981, p. 140). Considering that the Hawthorne effect may cause clients to feel better (more empowered) or worse (more stigmatized for having a severe mental illness), a research model that empowers clients has clear advantages.

Yet another methodological consideration is the impact of the interviewer-client relationship on the data that clients can provide. A significant advantage of staff administering consumer evaluation surveys is that the data are not subject to the biases resulting from clients being interviewed by a total stranger, biases which, for this population in particular, can be considerable. For example, one client in the program refused to give staff any identifying information about himself, saying, "I don't want to participate in that research." When he eventually trusted the staff, he confided that he had been hospitalized several times in a research institute where he had had, as a research subject, experiences he had found physically painful and very frightening. It is not uncommon for socially disenfranchised persons to greet researchers whom they do not know with fear that they will be exploited or hurt, and then they are more likely to refuse to participate or to provide data that is negatively colored by their fear. One remedy for this in some consumer evaluation studies is that clients were involved in the research as interviewers and research assistants. They carried out responsibilities completely and had very high inter-rater reliability rates (Tanzman, 1993). Because we believed it was important to improve communication between staff and clients, we hoped that the consumer evaluation process would advance this programmatic goal.

## Methodology

This survey (available from the authors upon request) arose out of staff's request that one of us help develop the instrument they used to help them understand the clients' points of view about services. The survey was expanded and revised considerably. Whereas most other consumer evaluation surveys have focused on client satisfaction with specific services, such as location and food quality, we wanted to see whether client satisfaction was related to clients' beliefs about the causes of their difficulties and their existing social supports, and whether clients would tell us more about how they experienced the services. The methodology for gathering client opinions was developed to build upon the work of previous researchers. We learned from one of the leading systematic studies of artifacts in community mental health center consumer evaluation research, by Levois, et al. in 1981. In that study, clients' overall well-being and painful psychiatric symptoms were significantly correlated with clients' satisfaction with services. When comparing survey administration with and without an interviewer, Levois et al. (1981) found that the interviewer-administered surveys were significantly more positive (they interpreted this to be an experimenter effect) and also had significantly less missing data. Our commitment to maximizing client participation and data clients could provide led us to continue to administer the surveys orally. We compensated for the effect of positive bias (clients wanting to please staff by reporting positive opinions) in the phase of data analysis, as will be described below. Thus, the survey data were gathered in the normal course of service provision, as part of staff's efforts to understand clients' opinions about services.

A heavily qualitative methodology has scientific advantages for consumer evaluation research with severely mentally ill and homeless clients. Knowledge about a population that is compiled based on researchers' categories and standardized instruments will be helpful for some problems, but will be missing important information about the clients' subjective experience of their difficulties, hopes, and opinions about services, in their own language. As Fossey et al. found when they conducted one of the first studies that actively



involved consumers in the research and feedback process, "Using people's own language helps to gather in-depth information and to record people's meanings authentically" (2002, p. 371). Qualitative methods allowed Rapp, et al. to: (1) capture information about service models that had not been available previously; (2) give voice to the client perspective and ensure that the model was consonant with the consumer agenda; and (3) locate weaknesses (i.e., iatrogenic consequences) of the model despite the level of achievement reflected in the outcome measures (1994, p. 392). Accordingly, data were gathered qualitatively and then quantified in the process of data analysis.

This survey was administered to all clients who had stayed in the program for more than a week and agreed to answer it over a four-year period. Clients who were illiterate were given the opportunity to dictate their responses to the staff member collecting the data. The response rate was 43%, which compares well with customary survey response rates. Client confidentiality was maintained by removing names and identifying information from all surveys before the data analysis phase. The quotes used here have been altered as needed to preserve the anonymity of the clients. The name of the program has been changed in order to safeguard confidentiality; for these purposes, the acronym CCP (Comprehensive Care Program) is used.

A combination of qualitative analysis with descriptive statistics was used to code and compile the clients' responses. Using the first 30 surveys, a qualitative coding manual was developed with several coding options for each question (the coding manual is available from authors upon request). For instance, responses to the question "What do you think caused the difficulties that led you to come to CCP?" fell into twelve categories ranging from "symptoms of mental illness" to "family problems." Since clients wrote their opinions about services in many places on the questionnaire, we included an overall coding category for whether or not the program was helpful. We refined the coding manual until there was a more than 95% agreement between coders; final inter-rater reliability of 10% of the questionnaires (seven questionnaires, 193 answer options) was 97%. Data were cleaned for accuracy of

transcription into electronic form and errors were corrected (error rate of  $74/7920 = .9\%$ ).

Since there are important reasons why consumer evaluations are valuable for social service providers, considering the limitations of consumer evaluations and of the data in this study in particular can be an opportunity. Probably the most important limitation to consider concerns self-report as a source of data (Lewontin, 1995). Because people can deceive themselves, they can unknowingly mislead others. One way this was evident in residential care is that homeless clients diagnosed with severe mental illness filled out a standardized symptom checklist upon entering and exiting the program. Clients often reported more symptoms upon leaving than they had experienced upon entering, which caused staff considerable concern. Examining the instances where this happened, however, we found that the clients had been relatively tuned-out to their difficulties upon arriving, saying for instance that they were quite satisfied with life when they had been starving and almost frozen, living huddled under rags. Such clients, upon leaving the program, now were well-oriented, well-nourished and caring for themselves, yet said they were depressed with many life circumstances and hoped they could continue to get help with them. This example also indicates the value of in-depth qualitative case analysis—it brings to light issues that otherwise might be veiled by self-reports laden with self-deception.

A second bias in self-reports is that the need to please others can cause respondents to provide answers with systematic and semi-intentional distortions, which can be amplified if clients believe doing so will increase their income or services (Levois et al., 1981). We compensated for this bias in the coding process. A client's qualitative evaluation of services was rated as positive only if the client was enthusiastic; lukewarm positive responses were coded as neutral. Readers should be aware the downside of our compensatory coding process is that it can minimize positive findings. For instance, one client came to the program having refused all mental health care, actively hallucinating, and living in a cardboard box; he left having obtained counseling on a regular basis, choosing to live in a nearby hotel, and visiting the CCP every week. He maintained this

improved functioning without re-hospitalization for several years. Yet on his survey, he confined his positive comments about the program to, "CCP gave me a home when I did not have one..." and, "all the services are helpful none of the services stand out." Despite the outstanding nature of his clinical outcome, the coding manual's compensatory process led us to code his overall opinion of the CCP services as "neutral."

Yet a third problem with self-report is that variations in meaning can lead respondents to answer a different question than the one that was asked (Lewontin, 1995). With many trials of a survey over time, the use of reflective interviewers administering the survey, and a sufficiently large sample, often the most significant misunderstandings can be detected and corrected. Yet it would be naïve to assume that all can be found, and in fact when coding the surveys we did find an example of such a misunderstanding. The survey was designed with the question "what services did you find *not* helpful" right underneath, and formatted similarly to the question "what services did you find helpful," and it seemed in some instances that some clients checked both questions the same way (e.g., perhaps not seeing the *not* helpful and then ignoring their perception that the question was repetitive). While we did not feel we could delete those responders from the overall figures, we computed the percentage of responders who made that error (6.2%), as we thought they might have been confused by the format or length of the survey.

While an unfortunate misperception might be that homeless, severely mentally ill clients would be especially prone to misleading self-reports, it seems important to consider the question 'self-report about what?' in order to reap the most scientific benefit. For instance, Lewontin (1995) points out that frank discussions of one's sexual behavior may be especially prone to specific types of self-report bias (some derive esteem from inflating, others from deflating sexual experiences, for instance). With regard to the homeless mentally ill population, existing data document these clients' capacity to report their goals and wishes for services (Owen 1996; Schutt & Goldfinger 1996). The clients responding to our survey were consistent with this pattern in the literature. When we evaluated the coherence of the respondents' self-report, we developed codes that

were used to categorize responses that were unclear, including answers that were (a) illegible or (b) ambivalent, unclear, or bizarre in their content. Very few responses had to be coded as unclear. For instance, of the responses to the open-ended question, "Who do you have to rely on when leaving the program?" 1.9% of responses were coded as unclear. A question that could be more abstract ("Can you tell us what you learned about yourself?") resulted in a slightly higher percentage of unclear responses (4.8%). Despite their homelessness and symptoms warranting a diagnosis of severe mental illness, these clients provided meaningful and coherent answers to questions about services they received.

## Findings

The demographics of the clients in the CCP program who comprised the sample for this survey correspond with those of other urban programs serving homeless, mentally ill clients. The average age was 38 years old; 64% of clients were male, and 36% were female. There were a disproportionate number of African-American clients by comparison with the general population (39%); 57% of clients were Caucasian, and 3% Hispanic. The majority (69%) said they had never been married, while 16% were divorced, 9% were separated, 3% were still married, and 1% were widowed. Most clients had no public aid or SSDI (74%), whereas 26% did have SSDI (Goodwin, 1998).

It is common sense as well as scientifically documented that the quality of social supports is critical for sound functioning, and that clients with severe mental illness often lack these supports (Marley, 1998). Knowing this, the degree to which respondents had no one on whom they could rely for support was tragic. When asked whom they could rely on when leaving the program, 54% mentioned just themselves or God; the next most frequently mentioned source of support (27%) were staff of mental health programs and support groups such as AA, and, for 9%, a therapist (36% total). Only 23% of the clients said they could count on their family, and 12% reported they had friends to count on. Recall that 26% of clients were receiving SSDI and so judged to be unable to work, so at least a third of these clients' social isolation would be aggravated by the lack

of supportive relationships that can occur in a workplace.

In sum, more than half of these clients believed they would have to leave and take care of themselves without any significant supportive relationship. More clients felt they could count on mental health staff than those who believed they could count on their family and friends. Only about a third believed they had a sufficiently strong therapeutic alliance with psychiatrists or mental health staff outside the CCP to carry them through the stress of discharge, despite the fact that a program requirement was that all clients participate in some form of psychiatric treatment. It is not surprising that discharge can be stressful for those who believe that they are, with discharge, losing the only relationships they can turn to for support.

### Clients' Beliefs about Why They Needed Services

The great majority of clients did not see their lack of social support as a cause of their need for the CCP services, but instead, when asked why they were at the CCP, they identified as causes their mental illness and their poverty: 63% of clients mentioned symptoms of mental illness. Specific painful symptoms such as stress, anxiety, and hearing voices were mentioned by the great majority of those saying their mental illness caused them to come to the program. Housing problems were mentioned by 34%, financial problems and unemployment by 28%, and relationship problems (family and nonfamily, 19%) almost tied with substance abuse (18%, note that a client could mention more than one problem).

We wondered why more clients would not see the lack of supportive family as a primary contributor to their difficulties, and found this question was answered by looking at whom the clients felt they could rely on upon leaving the program: 52% of the sample mentioned they did not have human help on which to rely but instead relied on God, no one, or just themselves. One can speculate that these clients are so accustomed to trying to manage on their own that they would not even consider that relationship problems could be closely related to their homelessness: if they don't have significant close relationships in their lives, how can they have relationship problems? It is also possible that clients assumed that without

adequate relief from their psychological symptoms, and without stable housing and financial security, they could not even expect to have close personal relationships. In this regard, one client said to staff that what he hoped above all to accomplish during his residential care stay was "to find a wife."

Clearly clients who live with so much social isolation have experienced losses of significant relationships many times over in their lives. In fact, many studies of homeless, severely mentally ill clients underscore the importance of acknowledging clients' experiences of loss and their significant fear that such losses may recur if they allow themselves to become attached once more. For instance, in a systematic study of three types of case management services for homeless clients with severe mental illness, Morse found that case managers did not ask about or help clients with losses in their significant relationships as much as the clients needed. Moreover, helping clients with those losses was central to the clients' recovery:

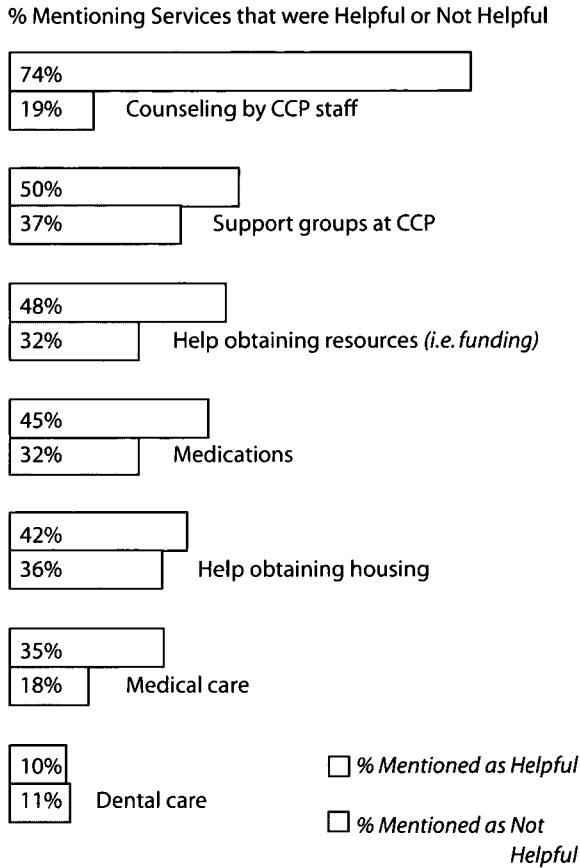
...efforts to facilitate hope and recovery must be grounded in an empathic exploration and understanding of the person's unique experiences of loss... Rather than seen as setbacks, feelings and discussions concerning losses must be viewed as fundamental—and potentially transforming—aspects of recovery. (Morse, 2000, p. 258)

### Satisfaction and Dissatisfaction with Specific Services

As can be seen in Figure 1, clients were most impressed by the helpfulness of counseling services: first individual sessions, then group sessions, and then help obtaining resources and housing. Medications and medical care were lower on clients' lists of helpful services. While medication compliance is often stressed in the research literature, from the client's point of view, this is of secondary importance. The clients' emphases on supportive relationships are immediately understandable if one considers the social isolation they reported. So the support of staff at the CCP met a deeply-felt need and empowered them to obtain other needed resources. As one client said, "I am feeling better. It helps me to open up. I was in

need of everything.”

Figure 1. Clients’ Satisfaction with Services



### Why Were Services Helpful and Not Helpful?

The one-to-one counseling services that the program provided were cited as helping clients make many important strides, including managing frustration, foregoing substance abuse, relieving loneliness, and enhancing self-esteem:

Table 1. Why Services Were Helpful

Category	Responses from clients
53% <i>Relationships: having someone to talk with about problems, forming friendships, feeling of community, emotional support, letting out frustration</i>	<ul style="list-style-type: none"> <li>• "Letting out frustration in...group"</li> <li>• "It helps me open up"</li> <li>• "I really needed to discuss my feelings"</li> <li>• "I think the support of 1-1's are quite helpful, they give you a chance to review the day and help with the problems you may have had"</li> <li>• "Sometimes people help me to stop drugging"</li> <li>• "I really needed to discuss my feelings"</li> <li>• "It will help me to know that there is staff available 24 hours a day"</li> <li>• "So far the staff is excellent: empathetic, patient, willing to really listen, and give thoughtful feedback"</li> <li>• "[A staff member] has been helpful to me concerning my loss"</li> <li>• "It has been an immense help to know that someone cares"</li> <li>• "When I have anger I have someone to help me through it"</li> <li>• "CCP staff especially in the evenings has helped me to become more aware of what issues are bothering me"</li> <li>• "It's hard to put into words why counseling has helped. I just feel it does."</li> <li>• "When I have anger I have someone to help me through it"</li> <li>• "The people talk to you about your problems and you feel better afterwards"</li> <li>• "It is nice to have someone to talk to when your feeling lonely on the inside"</li> <li>• "Community meeting: We all are grown individuals from different parts (communities) in which we all must live together. These meetings limit our problems so that we become one large family."</li> </ul>
51% <i>Practical help with budgeting, filling out public aid forms, housing</i>	<ul style="list-style-type: none"> <li>• "I never realized I could get a public aid medical card"</li> <li>• "I have no insurance, funds or doctor of my own"</li> <li>• "Because staff takes time out to talk to a person and are trying in everyway possible to get my SSI funding"</li> <li>• "The housing was most important and the staff support"</li> <li>• "Heavy paperwork would have discouraged my pursuit (sic) of funding"</li> <li>• "Answered questions on many forms"</li> <li>• "I've had a difficult time establishing a dentist and doctor on my own."</li> </ul>
30% <i>Personal growth: increased self-reflection, self-awareness, newfound sense of hope, discovery of capacity to cope and take care of self</i>	<ul style="list-style-type: none"> <li>• "My stay here was very helpful because I learned that I really can take care of myself"</li> <li>• "It helped me calm down"</li> <li>• "Counseling help me deal with me"</li> <li>• "To enable me to arrive at realistic goals"</li> <li>• "My therapy session is helping to start to get a better understanding of myself"</li> <li>• "Counseling with the staff is helping me to learn more about myself and these problems that keeps me in and out of these institutions"</li> <li>• "I'm learning more about myself"</li> <li>• "They give me a sense of hope"</li> <li>• "They give me peace of mind"</li> <li>• "It has let me know that someone understand and know (sic) there is hope. To be given another chance."</li> </ul>
10% <i>Structure</i>	<ul style="list-style-type: none"> <li>• "The structure and the culture of the artwork that I learn"</li> <li>• "I needed structure"</li> <li>• "All groups encourage discipline and structured living"</li> </ul>



While the situation of homeless clients might cause many service providers to focus on helping the clients meet their basic survival needs, and while those needs are clearly important to clients (51% in Table 1), the clients believed meeting their needs for supportive relationships, self-regulation, and inner well-being were just as important as subsistence needs, and perhaps even more so. Adding together those who emphasized personal growth and those who emphasized supportive relationships, the 83% of clients who emphasized relationship factors as what was most helpful are a significant majority. The clients said they sought to improve their subjective experience—they wanted hope, peace of mind, to feel calm, to have predictability in their lives and structured, productive days, to set and reach realistic goals—and they believed the relationships with staff helped them accomplish these goals.

Our findings underscore the findings of Holmes et al.'s (2005) survey of staff about the importance of services that prioritize developing an alliance with homeless mentally ill clients rather than any one type of service modality: "A central skill in working with homeless persons is the ability to provide resources in ways that do not threaten independence, autonomy or self worth" (Holmes et al., 2005, p. 65). Our findings also support those of Oakley and Dennis (1996), who have listed the characteristics of model outreach programs: a nonthreatening approach; flexibility in services offered; repeated contact over extended periods of time; quick response to needs for food, housing, and money; and patience in motivating would-be clients to accept treatment and services.

Recall that one third or more of the clients found the groups that were supposed to help with funding, medications, and housing were not helpful (Figure 1), so we wondered why. Representative responses are presented in Table 2. Reviewing the responses that clients made to the opportunity to provide more information about why services were not helpful, we found that most clients who noted that support groups were not helpful were concerned that there was "bickering" or arguing by a few members, and they felt their own wishes to voice their opinions were overwhelmed by more aggressive members, as in the following comment: "With a few exceptions, such as a women's group and the [literature] group, I have found the

groups to be boring at best and often anxiety producing due to the prevailing hostility and antagonism between residents." Another resident said that when clients were criticizing each other in the groups, the group context did not feel "safe" as a place to share genuine feelings. Still another, who perhaps expressed her or his negative feelings in the group, seemed to regret not being able to regulate such actions and said, "The groups are very attacking of people. I start to act angry and all wound up."

Perhaps these clients do not feel able to redirect a group process so that it is more satisfying to them, and this likelihood is confirmed by comments below about the benefits people experienced from counseling. Many had felt incapable of even the most elemental aspects of relating, such as expressing their wishes and appreciating the impact of one's actions on others. Others may have acquired the defense of escalating attack to handle even a hint of conflict. These clients tell us that helping homeless, mentally ill clients to benefit from group experiences means the leader needs to maximize experiences of safety, minimize interactions group members might experience as attacking, and actively enlist all to offer their opinions diplomatically.

Since 10% of the clients said that the counseling relationship was not helpful enough with practical matters, it is important to underscore that helping clients meet basic needs forms a bridge for a satisfying counseling relationship. This finding mirrors those of others, who have emphasized that within the counseling relationship it is essential to respect the clients' priorities in meeting basic needs (Tsemberis, 2000, p. 488).

### What Clients Believe They Got Out of Counseling Relationships

Recognizing the importance of assisting clients with survival needs, we also wondered about the common belief that severely disadvantaged clients are not motivated to have better relationships or improve their self-regulation. Reviews of clinical outcomes emphasize the importance of the counseling that accompanies providing for basic needs in residential care

Table 2. Why Services Were Not Helpful

Category	Responses from clients
10% <i>Inadequate help with practical matters</i>	<ul style="list-style-type: none"> <li>•“They just gave me the address to welfare plus a letter (which probably helped)”</li> <li>•“Because I have not been able to find housing as of yet”</li> <li>•“I haven’t been in communication with any housing facilities since coming to CCP”</li> <li>•“Because no one has actually sat down with me about budgeting or apartment hunting.”</li> <li>•“I was not told about medical care or dental”</li> <li>•“Staff really didn’t walk me through on a thorough basis of what were my resources. There wasn’t enough patient attention”</li> <li>•“Basically because they did not help me rec. funding, housing”</li> <li>•“Had trouble in the (university) dental school when they knocked out my bridge and damaged a crown – So far no suitable housing probably because of lack of suitable low-income housing in the area”</li> <li>•“Medication should have been supplied by the hospital because my insurance always pays the bill”</li> <li>•“Help finding a job. I have not had a counseling session yet”</li> <li>•“Not having self-access to medication was annoying at times, especially when I had to arrange to go with staff to pick up my meds”</li> <li>•“I need big bucks. Bureaucrats”</li> <li>•“Nobody seemed to know more than I did re funding, so I had to find out more by myself. Strictness of times to take medications interferes with their effectiveness.”</li> <li>•“I don’t like the medication schedule but the medication is helping me”</li> <li>•“They left it up to me to obtain my own housing”</li> <li>•“The doctors cannot get the right meds. I do not react well to generic drugs.”</li> </ul>
3% <i>Personal growth: client clearly states that services were not helpful in fostering personal growth regarding relations with self.</i>	<ul style="list-style-type: none"> <li>•“I have not been able to normalize my patterns of daily functioning, existence, i.e. nutrition, exercise, etc., as much as I would like to”</li> <li>•“Too many young people working on my case.”</li> <li>•“Curfew / bedtime / meals/ locked fridge / locked doors. It feels demeaning”</li> <li>•“I found the counselors rather condescending, affrontive (sic) and patronizing”</li> <li>•“...the [counselors] were not kind”</li> <li>•“I don’t get enough time with my primary worker. I feel I don’t get listened to. This bothers me very much”</li> <li>•“Some people work well in groups, I don’t”</li> <li>•“Low mentality of residents in general, having no common ground”</li> <li>•“I couldn’t get in the groups. I didn’t know what to say, how to follow along”</li> <li>•“Some of the support groups tended to be repetitive”</li> </ul>

(continued next page)

Category	Responses from clients
2% <i>Relationships with others were in some way insufficiently supportive or conflictual</i>	<ul style="list-style-type: none"> <li>• "Support groups exasperating"</li> <li>• "Insufficient attendance [in groups] due to day program"</li> <li>• "The [groups] end up with too much bickering"</li> <li>• "[Groups] one sidedness and favoritism"</li> <li>• "The support groups where sometimes focus on negative issues and I must add very, very instance oriented; thus they didn't see both sides of matter! Differences and dislikes"</li> <li>• "[Groups were] too formal"</li> <li>• "I have not been able to feel as if I belong here when a support group is in session"</li> <li>• "The 3 large groups at CCP need a complete overhaul, from bottom to top. A new concept, approach, a new manner in dealing with the whole floor"</li> </ul>

settings: "For example, although we might wish that simply providing housing would lead to better clinical outcomes, there is scant evidence that this is so" (Dickey, 2000).

To more deeply understand what the CCP clients might find helpful in their counseling relationships with staff, we asked "do you think that your work with the staff helped you to understand yourself and your relationships better?" Although 18% did not answer this question and 11% said "no," a hefty 70% said "yes." Clients were then asked an open-ended question, "Can you tell us more what you learned about yourself?" To answer the question, the clients had to come up with their own answer in their own words. While 49% said they learned more about the problems they needed help with, 46% learned they had positive capabilities they had not known about previously—suggesting a growth in their autonomy that occurred via the supportive relationships with staff. Following are some representative comments from those two broad groups of answers, with examples from the most frequently-mentioned subcategories:

Clients were almost equally divided between having learned about their strengths (46%) and about the problems that had been troubling them (49%). When discussing difficulties they tended to use diagnostic categories that clearly had been explained to them, calling to mind the controversy about whether it is helpful or exacerbating of stigma to focus on clinical diagnosis with clients (Corrigan, 2007). A common theme in the clients' comments (included in Table 3) is the pervasive loss in their lives, especially loss of important relationships

Table 3. Two Types of Learning by Clients

Category	Responses from clients
<i>49% Learning about what one needs help with</i>	
<i>25% Learning more about one's psychopathology, problems, or unhealthy characteristics</i>	<ul style="list-style-type: none"> <li>• "Yes, about PTSD and bipolar."</li> <li>• "I have a lot of anger and get mixed up easily."</li> <li>• "I am 37 and still depend a lot on my mother and father."</li> <li>• "When I'm in a closed environment I lose my sense of self-esteem."</li> <li>• "I was a well-functioning person before this program and realize that my problem is that I haven't had any reliable housing."</li> </ul>
<i>15 % Learning more about one's own motives for help or recognition of need for work in certain areas</i>	<ul style="list-style-type: none"> <li>• "I learned that there are times when I can't make it on my own and I need some help."</li> <li>• "I learned that I have a lot more to learn"</li> <li>• "That if I'm to live long and prosper, I have a long way to go."</li> </ul>
<i>46% Learning about one's strengths</i>	
<i>12% Learning more about coping skills</i>	<ul style="list-style-type: none"> <li>• "Learning to put things on hold."</li> <li>• "Help cope with problems of lonely life."</li> <li>• "[This program] helped me communicate with others and myself."</li> </ul>
<i>12% Recognizing positive characteristics client previously was unaware of</i>	<ul style="list-style-type: none"> <li>• "I'm not as bad a person as I thought I was."</li> <li>• "I've learned while here that I am not alone, that there are others like me too."</li> <li>• "That I'm a good person."</li> <li>• "That I'm not as sick as I thought I was."</li> <li>• "That it was natural to miss my husband, family, and baby I lost."</li> <li>• "I learned more about my inner feelings."</li> </ul>
<i>8% Learning about one's motives for positive relationship experiences</i>	<ul style="list-style-type: none"> <li>• "I learned that I need more friends."</li> <li>• "I am a little more comfortable in a community."</li> </ul>
<i>8% Awareness of self-efficacy and self care-taking</i>	<ul style="list-style-type: none"> <li>• "I can sleep by myself."</li> <li>• "That meeting my goals is not impossible if approached one segment at a time."</li> <li>• "That I can talk more if I want to."</li> <li>• "I've learned to help myself better."</li> <li>• "I learned how to take my medication on time."</li> <li>• "I learned that I can overcome my anxiety and illness."</li> <li>• "I've learned to be more responsible."</li> </ul>
<i>6% A more self-reflective relationship experience, recognition of impact on others</i>	<ul style="list-style-type: none"> <li>• "That I can listen to feedback and look at the way other people see me."</li> <li>• "That my actions affect others more than I was aware."</li> <li>• "I learned how other people see me when I relate to them."</li> </ul>

and the loss of painful symptoms of anxiety, delusions, or depression. An important area for service providers to address is empathetic responsiveness to clients' multiple experiences of loss, which according to Morse may be neglected in

treatment planning.

...it is ironic that people who are homeless and mentally ill, who experience a multitude of severe losses, receive few inquiries or services for their issues of loss. It is rare that a shelter worker or even a mental health provider will ask about specific losses that may have occurred, or about the individual's own emotional and cognitive experience of the loss. In this way, the common social service response may further reinforce the experience of being overlooked and forgotten, inadvertently contributing to the developing sense of alienation and depersonalization. (Morse, 2000, p. 249)

With regard to the strengths that clients discovered through interactions with staff, many were poignantly simple, such as being able to sleep alone, to express oneself with others, to make friends, to affect others through one's actions, to benefit from feedback and be part of a community. It seems that the clients had come to feel that these elemental capabilities were more than they could accomplish, shedding light on a depth of despair and isolation from the human community that it is important to understand. A great many clients said that for the first time in their life they felt good about themselves and hopeful; one client summarized the comments of many, "Self-respect, esteem, that just maybe life can be good."

An overwhelming majority of these clients had a sufficiently positive experience in counseling that they valued it greatly and said they were still motivated to participate: When asked whether they would use counseling to help them when they left the CCP program, 91% said yes. While 54% of the clients said that they had only themselves or God to rely upon when leaving the program, 90% of the clients wanted some form of supportive service relationship upon leaving. Providing supportive relationships is clearly essential to the healing process for these clients, and the clients articulately expressed their preference for counseling and community support over any other aspect of service.

Accordingly, although at times the behavior of clients with severe mental illness may appear to be isolative, one can assume that clients retain a significantly powerful motive to

be involved in supportive relationships as part of the healing process. What they want corresponds with what practitioners and researchers working with severely mentally ill clients say is restorative for them: "the process of rediscovering and reconstructing an enduring sense of the self as an active and responsible agent provides an important, and perhaps crucial, source of improvement" (Davidson et al., 1992, p. 131). In addition to improving mental health, supportive relationships with service providers, family and friends are the most important factors in helping people exit homelessness and achieve psychosocial stability (Thomson et al., 2004).

#### *Clients' hoped-for aftercare services*

Discharge can be stressful for clients who feel they do not have supportive relationships to turn to and who have experienced the trauma of homelessness. Fortunately, as a way of managing this stress, the majority of clients wanted to continue the relationships with staff and other clients that they formed at CCP; when asked whether they would like to stay in touch with CCP staff or patients after leaving the program, 63% said yes. The majority of clients preferred to take the initiative in the relationship, as 71% said that they would want to be able to contact staff, again reflective of clients' wishes to maximize the combination of autonomy and support. Our next question was about specific services that clients wanted, and again the most sought-for services were those that combined maximal autonomy and a social-recreational focus with support: the ability to contact staff "as needed," being called regularly by staff to "touch base," being part of a drop-in center and going on outings. The more structured activities of an alumni group, regular visits by staff, and case management were somewhat less popular, but still sought by a substantial number of clients (43% and 36%, as in Table 4).

A possible interpretation of the clients' preferences is that they prefer those services that maximize their experience of self-determination in the context of a supportive relationship, and that are the least stigmatizing and the most normalizing in relation to society. The clients' preferences fit with and shed light on the findings from Morse et al.'s (1997) comparison of assertive community treatment with brokered case

management. More assertive case management approaches that were more personalized (with more frequent contact and a smaller number of clients per worker) were the most effective in facilitating recovery.

Table 4. After-Care Services Desired after Leaving CCP

Desired Service	Percentage
You contact staff for assistance as needed	71%
Staff calls you regularly to touch base	54%
Participate in a drop-in center	48%
Go on outings with staff and other clients	46%
Participate in an alumni group	43%
Staff visit you regularly	43%
Case management	36%

## Conclusion

Despite the barriers erected by poverty and mental illness, clearly people suffering from homelessness and severe mental illness want what we all want: autonomy, dignity, inner well-being, a choice of housing, supportive and fulfilling relationships, food, shelter, and clothing. The seeming dependency of homeless persons in residential care can obscure what is, from their standpoint, a fundamental priority: the need for supportive service relationships where their dignity and autonomy (self-determination) are respected. Staff in residential treatment programs function as the major lifeline for at least two-thirds of these clients, who lack any other relationship support, and 90% of clients want this lifeline to continue when they leave. These findings suggest that the most helpful staff-client relationships are those in which clients feel listened to patiently and uncritically, helped to unburden themselves with regard to losses and frustrations they experience, and feel cared for by staff who reach out to them regularly. Clients benefit from structure that is respectful of their priorities, especially group and milieu processes safe from antagonism and conflict.

Considering the methodological implications of this study leads to the question of how one might develop a participatory model of consumer evaluation of services for homeless



mentally ill clients that a program can use on an ongoing basis. From a socio-political standpoint, consumer participation in improving services is highly charged (Goering, 1992), as questions are commonly raised about how much client input in service design and implementation is optimal. Alan Pearson, editor-in-chief of the *International Journal of Nursing Practice*, articulated this dilemma for the general population of health care service recipients when he wrote, "To date no effective model of consumer participation has been developed that satisfactorily addresses the issue of consumer involvement in health-service delivery" (Pearson, 2002, p. 67). Concerns about the validity of client opinions as a base for designing services have been expressed especially with regard to homeless, mentally ill, and substance-abusing clients, whose symptoms can seem to compromise their credibility: there is a "need for caution in adhering to homeless mentally ill persons' housing preferences" (Schutt et al., 1996). Soffe, Read, & Frude (2004) commented that mental health professionals at all levels can experience consumer involvement as threatening the professionals' autonomy and potentially reducing the scope of professional services. In one context (New Zealand), psychiatrists and psychiatric registrars were less informed and more negative about possible outcomes of consumer evaluations, suggesting that psychiatric training could actually "make it harder to recognize the knowledge and skills of service users" (Soffe et al., 2004, p. 591).

Yet the findings of this study emphasize the benefits to service providers in paying close attention to clients' evaluations of services, including clients who still suffer from symptoms of severe mental illness. Our study as well as others (Goering, 1992; Linhorst, Eckert, & Hamilton, 2005) indicate that involving consumers as evaluators and planners of the services in which they participate offers significant advantages for improving understanding of the service process, as well as for planning services that will most effectively respond to clients' concerns. In particular, supporting clients' participation in service design and planning may be a way to maximize client autonomy while also providing structure and support. Perhaps the most valuable aspect of consumer evaluations of services for program development is that they make it possible

to have a more direct connection with the universal humanity in every person, alongside the differences that can at times seem to divide us from each other.

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