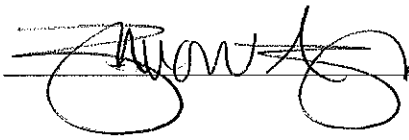
BEST PRACTICES FOR SERVICE PROVISION TO HOMELESS INDIVIDUALS

WITH CO-OCCURRING MENTAL ILLNESS AND

SUBSTANCE USE DISORDERS

Approved:  Date: 8/23/16

BEST PRACTICES FOR SERVICE PROVISION TO HOMELESS INDIVIDUALS WITH CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

A Seminar Paper

Presented to

The Graduate Faculty

University of Wisconsin-Platteville

In Partial Fulfillment of the

Requirement for the Degree

Masters of Science

in

Education

---

by

Susan Singleton

2016

Abstract

BEST PRACTICES IN SERVICE PROVISION TO HOMELESS INDIVIDUALS WITH CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Susan Singleton

Under the Supervision of Javon AlYasiri, MSSW, LCSW

This review of literature examines the risk factors for homelessness and the housing and service options that are currently available. Focus is given to the problem of homelessness among the mentally ill and those with co-occurring substance use disorders. A comparison is made of the current Continuum of Care model of service provision to mentally ill and the Housing First model. Finally, an examination of newly homeless individuals is made.

TABLE OF CONTENTS

PAGE

Chapter One: Introduction

According to the US Department of Housing and Urban Development, on one targeted night in January 2010, reporting regions of the United States identified 649,917 individuals that met the criteria of homelessness. Two thirds of them spent the night in shelters or transitional housing, the remaining third spent the night on the streets or in other places not intended for habitation. It is estimated that 46% of these individuals have either a diagnosable mental illness or a chronic substance use disorder (US Department of Housing and Urban Development, 2010). Additionally, approximately 50% of individuals with a severe mental illness have a co-occurring substance use disorder (Morse, Calsyn, Klinkenberg, Helminiak, & Wolff, 2006). This paper will examine the challenges of providing services and housing support to homeless individuals with co-occurring mental illness and substance use disorders, will review current practices and will identify the most effective methods for improving service provision and reducing homelessness in this population.

Statement of the Problem

The problem to be addressed is to identify practices that are most effective at increasing positive outcomes, service utilization and client satisfaction, while decreasing homelessness in individuals with co-occurring mental illness and substance use disorders and determining the implications for counseling.

Definition of Terms

Continuum of Care – A coordinated system of housing and services covering the full range of needs for homeless members of the community (Newman & Goldman, 2009).

Co-occurring disorder – The presence of one or more mental disorders and one or more substance related disorders, where at least one disorder of each type can be established independent of the other (Substance Abuse and Mental Health Services Administration).

Homelessness – Lacking a fixed, regular and adequate residence. This includes individuals in shelters or transitional housing, including hotels or motels, individuals living in places not intended for habitation, families who are unstably housed and people losing their primary residence within fourteen days. Individuals who were homeless prior to institutionalization are also considered homeless (United States Code, Title 42, Chapter 119, Subchapter I).

Housing First – The direct placement of homeless individuals into permanent housing with supportive services available, but not mandated (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009).

Mental Illness – The presence, currently or in the past year, of a diagnosable mental, emotional or behavioral disorder that meets the diagnostic criteria specified within the DSM-IV, which interferes with one or more major life activity (Substance Abuse and Mental Health Services Administration, 2007).

Delimitations of Research

The report presented is purposely broad in scope in terms of treatments available. The literature reviewed was collected to give the reader an understanding of the physical and psychological dimensions of homelessness. There is no intention to address social policy at a governmental level. There is an intention to provide a review of current approaches, including strengths and shortcomings. The references used for the review of literature were collected over a period of eighteen hundred (1800) days using the resources of the Karrmann Library at the University of Wisconsin-Platteville, the Andersen Library at the University of Wisconsin-Whitewater and the Colonel Robert H. Morse Library – Richard Black Information Center at Beloit College. Primary searches were conducted via the Internet through Ebsco Host, JSTOR,

Belcat and HWWilson databases with Omni File and Academic Search Complete as the primary sources. The key search terms were "homelessness", "mental illness" and "substance use".

Method of Approach

A review of literature relating to research, studies, and anecdotal evidence of the challenges to providing services aimed at reducing homelessness in individuals with co-occurring mental illness and substance use disorders was conducted. The findings were summarized and synthesized, and recommendations made.

Chapter Two: Review of Related Literature

Chronic homelessness is a complex issue that over 350 communities have committed to ending (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). Of the chronic homeless, it is estimated that 110,000 have a serious mental illness (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005). A review of the research provides some insight into issues that are faced by individuals at risk for homelessness and for those attempting to meet their needs.

Risk Factors for Homelessness

There are many factors that have been associated with increased risk of experiencing homelessness. These factors can be at a structural level, such as availability of affordable housing, or at an individual level. Individual characteristics may be sociodemographic, economic, or mental health related. Demographically, individuals that are black, male, middle aged or unmarried are at a greater risk of becoming homeless. One recent study, based on 5,251 participant responses to the National Comorbidity Survey Replication (NCSR), conducted between February 5, 2001 and April 7, 2003, using responses from the approximately 5% of respondents who had experienced past homelessness, found that being black significantly increased the odds of experiencing homelessness, while being white cut the odds in half. Men had twice the risk of experiencing homelessness as women. Low education levels and job skills, extreme poverty and high rates of unemployment are also associated with homelessness. Having ever received welfare payments meant individuals were eight times more likely to experience homelessness. Exposure to trauma also increases risk of homelessness. The study found that individuals that had experienced a traumatic environment or event were 2.6 times more likely, those that had witnessed or caused trauma to others were 3 times more likely and those that had experienced personal violence were 6 times more likely than those that had not experienced

trauma, to experience homelessness. Prior involvement with the criminal justice system was also correlated with increased risk of homelessness. Individuals incarcerated for more than 27 days, which was the cut off point used by the NCSR to distinguish long and short periods of incarceration, were 11.5 times more likely to experience homelessness (Greenberg & Rosenheck, 2010).

Of particular interest, for the purpose of this review, is the relationship of mental illness and substance use to increased risk of homelessness. Though only 6% of the general population suffers from a severe mental illness (National Coalition for the Homeless, 2009), approximately 30% of the homeless have a severe mental illness (Newman & Goldman, 2009). Schizophrenia and Bipolar Disorder are the disorders most often associated with homelessness (National Coalition for the Homeless, 2009). A serious mental illness makes it more difficult to maintain relationships with family and friends, who are often a key source of housing for the mentally ill. Mental illness also makes it more difficult to meet the responsibilities of daily living, such as money management and maintaining a household. Individuals with only severe mental illness or substance use disorder are more likely to experience temporary homelessness, compared to individuals with comorbid disorders, who tend toward more chronic homelessness (Sun, 2012). In the NCSR survey, almost all respondents who had been diagnosed with mental illness or substance use disorder had exposure to homelessness. Individuals who had used drugs were 7.4 times as likely to experience homelessness and those that abused alcohol were 6.1 times more likely. Although the relationship between mental illness and homelessness was strong, the relationship was not as strong as that of substance use disorder and homelessness. The authors offered possible explanations for this finding. The first is that individuals with diagnosed mental illness have access to income assistance, something denied, by Public Law 104-12, to individuals

whose disability is a substance use disorder. Individuals with substance use disorders may also become ineligible for public housing through the 1988 Drug Abuse Act and the 1996 Housing Opportunity Extension Act, which requires public housing agencies to use leases that allow for the eviction of a tenant if the tenant, or the tenant's family or guest, participate in a drug related crime (Greenberg et al., 2010).

Poverty is high among individuals with mental illness. Most rely on SSI and/or SSDI, which provides no more than a poverty level income. For those that do not live with family, securing affordable housing is a challenge. The Department of Housing and Urban Development (HUD) defines households that are either very low income with housing costs that exceed 50% of income or people living in severely inadequate, unsubsidized housing as "worst case needs". Individuals with severe mental illness are overrepresented in this category. They are also overrepresented in the homeless population.

Assisted Housing Options for Persons with Mental Illness

Mainstream assisted housing.

There are two choices for meeting the housing needs of individuals with severe mental illness, mainstream housing programs or programs intended specifically for this population. Without the assistance of family or case managers, securing mainstream assisted housing can be difficult for persons with severe mental illness. The application process for many public housing authorities can be complicated and the crowded, chaotic nature of their offices may be beyond the coping skills of the applicant with a severe mental illness. The demand for housing assistance greatly exceeds the availability and individuals with severe mental illness are competing against all low-income households for assistance. It can be years before an applicant reaches the top of the waiting list. While it is known that approximately 13% of households in assisted living have a

disabled member, the number of household members with a severe mental illness is unknown, as Federal Fair Housing Laws prevent the collection of this data (Newman et al., 2009).

The Department of Housing and Urban Development oversees three types of housing; voucher programs, public housing, usually run by local housing authorities, and privately owned developments. All of these present problems for an individual with a severe mental illness. Public housing and private developments usually consist of apartment buildings, often with a large number of units. There are not likely to be other tenants with a severe mental illness. This is an undesirable arrangement for the individual with mental illness because research has shown that people with mental illness do better in housing with fewer occupants and other tenants with mental illness. The voucher program has its limitations but is likely to provide better outcomes than the other types of mainstream housing. If an individual is able to find a landlord that is willing to rent to someone with a severe mental illness, housing stability may be increased. Because the neighborhood is likely to be more diverse and less economically depressed, there is also likely to be better mental health outcomes. Some studies, however, find that this arrangement leads to loneliness and isolation for some tenants with severe mental illness. Finding housing under the voucher program may be the biggest obstacle. In 2006, HUD received 1,516 complaints of housing discrimination against individuals with a severe mental illness. This was a 22% increase over the previous year (Newman et al., 2009).

Needs-specific housing.

The other housing options for individuals with severe mental illness are those specifically intended to serve the mentally ill. The McKinney Act of 1987 was enacted out of the recognition that the mentally ill had a significant need for housing and mental health services. The McKinney – Vento Homeless Assistance Act, the latest revision of the McKinney Act, provides

funds to local jurisdictions which can be used to provide Transitional Housing, Permanent Housing, Shelter Plus Care and/or moderate rehabilitation, single room occupancy housing. Permanent Housing and Shelter Plus Care are intended specifically for homeless persons with disabilities, the majority of which have mental illness. For Transitional Housing and Permanent Housing, McKinney – Vento also provides funds for services other than housing provision. Transitional Housing requires recipients to utilize additional mental health or substance abuse treatment services in preparation for independent living. Permanent Housing and modified rehabilitation programs do not require other service utilization. Shelter Plus Care may require tenants to utilize additional services (Newman et al., 2009). One requirement of most Shelter Plus Care programs is 6 months of perfect abstinence. This provision can lead to the denial of housing to the same homeless, mentally ill that the McKinney – Vento Act was designed to assist (Kertesz et al., 2009). Data from HUD, for 2005, shows that 46,000 homeless individuals with mental illness utilized one of these types of housing, with a significant number being housed in transitional housing (Newman et al., 2009).

Service Delivery Models

Homeless individuals with comorbid severe mental illness and substance use disorders are at risk for increased medical and psychiatric hospitalizations, depression, and suicidal ideation and behavior (Tsemberis, 2003). Despite these risks, homeless individuals with co-occurring disorders (CODs) are less likely to utilize services than individuals with CODs that are not homeless or homeless individuals with only severe mental illness (SMI) or substance use disorder (SUD) (Sun, 2012).

Although data is lacking on effective techniques for treatment of individuals with CODs, three important elements have been identified. These elements are the recognition that treatment is a long term process, the integration of mental health and substance abuse treatment, and harm reduction. Other suggested elements are outreach, support, skill building, motivation and relapse prevention (Sun, 2012).

Continuum of Care.

The most widely accepted process for delivering services and housing to the homeless is the Continuum of Care model. Continuum of Care is a linear approach that moves clients through a progression of services designed with the goal of permanent housing and independent living (Tsemberis & Eisenberg, 2000). Continuum of Care is currently the recommended model for service delivery to homeless mentally ill (Greenwood et al., 2005) and is the approach required of all service providers utilizing McKinney – Vento funds (Newman et al., 2009). The premise behind this approach is that maintaining stable housing requires behavioral self-regulation and the ability to interact in a social environment, which must be either learned or relearned before the individual is ready to meet the demands of maintaining permanent housing (Kertesz et al., 2009). Care typically begins with outreach. Homeless mentally ill and those with substance use disorders are encouraged to utilize low demand temporary housing such as shelters, drop-in centers or transition settings, in order to move the person indoors. A clinical team then provides assistance in obtaining entitlements and makes arrangements for treatment. Participation in treatment for psychiatric and/or substance abuse issues is a requirement of Continuum of Care. Those that participate in treatment, are compliant with medication and remain sober are provided with transitional housing. As individuals continue with treatment and demonstrate a readiness for housing, clinical staff assists with the establishment of permanent housing. Housing may

consist of group homes, single room occupancy residences or independent housing in the community. Failure to fulfill treatment requirements or maintain sobriety results in transition back to a more restricted environment or a return to the shelter system (Tsemberis et al., 2000). Numerous studies have shown that a Continuum of Care, Abstinence Dependent housing program reduces drug use in participants. Participants who are successful in the program report satisfactory levels of community integration and increased feelings of safety. Reports of abstinence rates and retention have been mixed, however (Kertesz et al., 2009).

The Continuum of Care model has been criticized for many reasons. Its requirement that participants move through a lengthy series of steps makes it difficult for individuals to obtain long-term permanent housing and increases the likelihood that they will return to homelessness (Kertesz et al., 2009). The Continuum of Care approach may also be difficult for chronically homeless individuals with co-occurring disorders to follow. Clients' psychopathology may make it difficult for them to adhere to Continuum of Care requirements. The Continuum of Care process may also be beyond the limited social skills of many homeless clients with co-occurring disorders, as they are expected to work with new providers along each step of the process. Continuum of Care is based on the assumption that skills learned at one level can be applied at another continuum level. Studies show, however, that skills are best learned in the environment in which they will be used. The Continuum of Care model does not consider consumer choice in housing options, basing it instead on clinical status. Research indicates, however, that for populations with mental illness, choice in housing options is related to psychological well being, housing stability and housing satisfaction. Additionally, choice in housing and services has been associated with fewer hospitalizations and increased success in social roles. Finally, programs that require treatment and abstinence as a requirement for housing are contrary to what most

homeless individuals see as their greatest need. Clients view housing as being more important than treatment and consider their homelessness to be a result of income and social factors, rather than disability. Clients may feel coerced into treatment programs in order to obtain their most basic need of housing, which can undermine the value of treatment (Tsemberis, 2003). Additionally, the success of some linear models is dependent on the allocation of permanent housing by other agencies. As such, successful treatment does not always lead to long-term permanent housing (Kertesz et al., 2009).

Housing first.

Housing first models place homeless individuals directly into permanent housing. Housing First is based on the premise that meeting the most immediate need of housing will lead to better outcomes in other areas. It respects the right of homeless individuals to make choices in their living arrangements and treatment and does not view individuals as needing to be made ready for housing. Housing First provides access to mental health and substance abuse treatment, but does not make it a requirement for housing. Services for tenants are typically provided through a multi-disciplinary team (Kertesz at al., 2009). Though Housing First is based on a system of choice, many Housing First programs impose some requirements on consumers. Programs that receive HUD funding prohibit tenants from using illegal drugs on premises. Another common condition is participation in a money management program. This insures that tenants will be able to meet their rental obligation each month. Some also require that clients meet with staff at least twice a month. Housing First programs generally exercise flexibility in program requirements, in recognition of the mistrust and difficulties in transition from long term homelessness that many clients experience. Treatment programs and services are often provided in low demand ways. For instance, treatment may be brought to the consumer, rather than the

consumer having to deal with multiple service providers. Programs that involve the client in decision making, that foster relationships with clients and that provide social outlets may increase engagement in treatment for tenants with co-occurring disorders (Sun, 2012). Housing First has proven to be effective in increasing retention rates and maintaining stable housing for individuals with mental illness and substance use disorders. It is also associated with increased client satisfaction and decreased days of hospitalization for its participants (Gulcer, Stefancic, Shinn, Tsemberis, & Fischer, 2003). Research has shown that Housing First programs greatly reduce the cost of inpatient treatment post-programs and the utilization of more costly emergency shelters and emergency and acute care services (McGraw, et al, 2009). Housing first can be the best option for persons who have not been successful in treatment (Kertesz et al., 2009).

The benefits of a Housing First/consumer choice model over the CoC approach is evident in one study designed to reduce homelessness for individuals with CODs. In the study, a group of 168 homeless individuals with SMI were randomly assigned to either an experimental consumer choice drop-in center or a traditional CoC styled drop-in center. The experimental drop-in center gave participants access to showers, lockers, laundry, computers, telephones, a library and television. Services that were offered, but not required, were psychiatric, medical and social services, treatment and rehabilitation planning, and socialization. Emphasis was given to housing. Clients were involved in decisions regarding their own treatment and had input into the drop-in center's operations. In addition to program design, staff characteristics differed in the experimental group, as well. In the experimental drop-in center, the same staff member was involved in all services provided to a particular client. These included community outreach, referrals, services within the drop-in center, and accompaniment to appointments. Additionally,

staff were trained in a consumer choice method of psychiatric rehabilitation. Shelter for participants in both the experimental drop-in center and the traditional drop-in center was provided through an informal church-based, first come, first serve shelter system that was staffed by either church volunteers or program staff. The CoC model control group drop-in center restricted shelter only to participants who adhered to treatment plans. Results of this study showed that members of the experimental group were better able than the control group to find food, keep clean and find a place to sleep. They sought more help from staff with things such as financial entitlements and substance abuse and utilized more services, such as day programs and self-help groups. Experimental group participants reported significant reduction in psychiatric symptoms and improvement in life satisfaction and achievement of goals. Self-esteem and mastery remained stable for both groups. Both groups spent less time homeless, with the experimental group experiencing a 55% decline and the control group experiencing a 28% decline. At the end of the study, 38% of the experimental group and 24% of the control group were residing in some type of community setting. Overall, the experimental, consumer choice group experienced significantly better outcomes in many areas than did the control group. With regard to housing, antidotal evidence indicates that the low number of participants that obtained housing was related to the stringent continuum based requirement of many housing providers, which created a barrier to housing for some members of the experimental group.

There are critics of the Housing First model of service delivery, however. In some studies, Housing First did not reduce substance use, though results were not worse than for those utilizing a Continuum of Care model. In complexes that provided housing to both abstinence-dependent and non-abstinence dependent individuals, some abstinence dependent tenants opted to give up

their apartments rather than risk their recovery by being in close proximity to those that were still using substances (Kertesz et al., 2009).

Abstinence Dependent Housing versus Non-Abstinence Dependent Housing

The question of whether an abstinence contingent or non-abstinence contingent housing program produces better outcomes, in part, depends on the desired goal. A study of 196 homeless persons with co-occurring non-psychotic mental illness and substance use disorders in Birmingham, Alabama, who were randomly assigned to a no housing group, an abstinence contingent housing group or a non-abstinence contingent housing group, provided mixed results. The study included outpatient substance abuse day treatment, work therapy and aftercare groups for all participants, regardless of abstinence success. An analysis of the results showed that there was no significant difference between groups in relation to homelessness and employment outcomes. There was strong evidence of a difference in treatment attendance between the housed and non-housed groups, but no difference between the two housed groups. When viewed from an abstinence standpoint, both housed groups showed consistently higher rates of abstinence over the non-housed group. An overall comparison of the housed groups showed the difference to be small and statistically insignificant. Researchers did find a difference between groups for consecutive weeks abstinent, however. An analysis of the effect of attendance on the relationship between housing group and sustained abstinence showed that attendance was an intervening variable for housing group effect. An adjusted mean of consecutive weeks of abstinence showed no difference between the non housed group and the non-abstinence contingent group. There was a difference between these groups and the abstinence contingent group, however, with results of 5.28, 4.68 and 7.32, respectively (Milby, Schumacher & Wallace, 2005).

Assertive Community Treatment

Assertive Community Treatment (ACT) is an evidence based team approach to intensive community outreach. ACT was developed for individuals with serious mental illness and has expanded to include the homeless and individuals with substance use disorders or co-occurring disorders. ACT has been utilized in both Continuum of Care and Housing First models. The ACT model calls for a multidisciplinary team composed of a psychiatrist, master's level clinicians and case managers, an addiction specialist and a psychiatric nurse. ACT teams have daily staff meetings and low staff to client ratios of 10:1. Shared caseloads and 24 hour a day, 7 day a week availability ensure continuity of care by staff that are familiar with, and to, each client. Assertive outreach methods include regular home visits and individually tailored treatment plans. The effectiveness of ACT has been well established through multiple randomized trials (McGraw, 2009) and studies indicate that ACT improves mental health, reduces homelessness, and increases time housed (Sun, 2012).

ACT can be difficult to implement and practice, however, in part due to the difficulty of recruiting and retaining professionals with the necessary skills and training to follow the ACT model. This is particularly true for psychiatrists, who may not be committed to working flexibly in the community, rather than in an office. The traditional division of mental health and substance abuse treatment can also be a barrier to maintaining addictions specialists. This is particularly true for ACT programs that do not stress abstinence, as some addictions specialists may be in recovery themselves, and not comfortable in settings that do not require abstinence. Effective ACT programs also require a commitment from organizational leadership to remain faithful to ACT best practices. Surveys and interviews have shown that many ACT programs omit core positions on ACT teams, including psychiatric personnel, or hire staff with limited or

no clinical training. Other programs hold weekly team meetings, rather than daily meetings. Modification of the ACT model can reduce the effectiveness of these programs. Manuals are available to guide teams on the implementation and practice of ACT, however, and adherence to the ACT model is associated with positive outcomes for individuals with severe mental illness and co-occurring disorders (McGraw, 2009). ACT has also been criticized as being an expensive approach to outreach and treatment. Research indicates, however, that costs can be reduced as some clients are able to be transitioned to less intensive services. Findings show that ACT may only be necessary for persons with severe co-occurring disorders, who have been unsuccessful with treatment-as-usual (Sun, 2012).

Motivational Interviewing

Motivational Interviewing (MI) is a method that has shown promise for increasing treatment engagement and reducing psychiatric symptoms and substance abuse in the short term. MI is intended to facilitate change by helping clients see where they want to be and what barriers are preventing them from reaching their goals (Sun, 2012). MI is a client centered method that emphasizes the therapeutic partnership between client and provider. In the MI relationship, clients set goals and providers help them to examine their ambivalence toward change, through understanding, guidance, encouragement and opportunity for self reflection (McGraw, 2009). Studies have shown MI to be more effective than educational treatment interventions for increasing abstinence and reducing drinking days (Sun, 2012). MI may also be effective for retaining clients in treatment and increasing adherence to treatment recommendations (McGraw, 2009). Some individuals with severe mental illness may have low motivation to change due to symptoms, low self-efficacy or limited resources. Modified MI or MI combined with cognitive

behavior therapy, contingency management, and social skills training have been shown in studies to be effective for different populations with co-occurring disorders (Sun, 2012).

Critical Time Intervention

There are several steps that can be taken to minimize the risk of homelessness for individuals returning to the community after being released from inpatient treatment facilities or correctional institutions. These steps can begin early in the treatment process, prior to discharge, by building relationships with clients and engaging them in their treatment. Motivational Interviewing has shown promise in this area. Studies indicate that providing motivational interviewing sessions prior to discharge and helping clients to identify their goals and take part in treatment planning, may increase the likelihood that clients attend outpatient appointments after discharge. Critical Time Intervention (CTI) is a strategy that provides support, soon after release, by way of a case worker who visits the individual in their residence, accompanies the client to appointments, provides crisis intervention and otherwise helps the client to connect with resources and form relationships within the community. Sun notes one study that found, during a 1.5 year follow-up, that clients receiving CTI experienced, on average, 30 nights of homelessness, compared to 91 nights homeless for clients receiving traditional services. Other studies have shown that CTI recipients have better outcomes with regard to psychiatric symptoms, substance abuse and housing, than those receiving treatment-as-usual services. CTI is also considered a cost effective alternative to traditional approaches (Sun, 2012).

Engagement

An important consideration for engaging homeless individuals in treatment and housed is financial resources. Many homeless individuals are eligible for government benefits, but do not receive them. Although 30-40% of the homeless are mentally ill, statistics show that only 11%

receive SSI and 8% receive SSDI. The receipt of benefits, however, is a determinant of whether individuals are housed or homeless. Reasons why homeless individuals do not utilize benefits that they are eligible for may include lack of documentation and permanent address, lowered capacity to seek services, and bureaucracy and discrimination from service providers, which can discourage homeless from seeking benefits. Additionally, individuals may consider housing needs their highest priority and fail to address their other needs. The Substance Abuse and Mental Health Administration has implemented a program called SSI/SSDI Outreach, Access and Recovery (SOAR) to assist caseworkers and other staff with technical assistance for linking homeless individuals with entitlement programs. States that participate in the SOAR program have seen success rates in regard to SSI and SSDI applications increase from 10%-15% to an average of 73%. Processing time for applications have been reduced from as much as eight months in one state to an average of 89 days in the 32 states that participated in SOAR in 2009. Another consideration is the provision of temporary funds for rent, deposits and utility payments while clients await benefits. Providing temporary benefits has been shown to have a substantial positive effect on the housing status of individuals with co-occurring disorders, upon release from inpatient treatment or prison (Sun, 2012).

Newly Homeless

An important consideration in developing programs and policies dealing with homelessness should be the provision of services provided to the newly homeless. A longitudinal study of 377 newly homeless entrants to New York City shelters in 2001 and 2002 examined the risk factors for long-term homelessness. After assessing for psychiatric diagnosis, social and family history and service utilization, participants were followed for eighteen months, with interviews conducted at six month intervals. Risk factors identified by researchers included

substance abuse and mental illness. Educational achievement and family experiences, such as out-of-home placement or parental instability during childhood, and insufficient family support during adulthood, were also identified as factors. Of the participants, 51% had a lifetime diagnosis of an Axis I disorder, 54% had undergone some type of psychiatric treatment, 53% had a lifetime diagnosis of substance use disorder and 44% had received treatment for a substance use disorder. 58% of participants had a history of arrests. At the end of the study, researchers found that 81% of participants had returned to a housed status, with 55% living with family or friends, 29% in supportive housing and 17% living on their own. Median length of homelessness for participants was 190 days. Younger age, employment history, and family support were all related to shorter lengths of homelessness. History of substance abuse lengthened time of homelessness, but arrest history and older age were associated with the longest periods of homelessness. Although greater ego strength and coping skills were associated with shorter lengths of homelessness, there was no variation from the median length of homelessness for individuals with a DSM-IV diagnosis of Axis I disorder, post-traumatic stress disorder or antisocial personality disorder. Severity of symptoms was also not a factor (Caton, Dominguez & Schanzer, 2005). The relatively short length of the study is a shortcoming in that it does not provide sufficient time to determine whether those returning to housing through family or friends remained housed or returned to a homeless status. It does, however, raise the question of whether providing individually tailored services to the newly homeless could have an impact on lengths and costs of homelessness. It should be noted that 19% of participants remained homeless after 18 months.

Summary

Hundreds of thousands of Americans experience homelessness on any given night. Many of these meet the criteria for co-occurring mental illness and substance use disorder. Risk factors are sociodemographic, economic and mental health related. Ethnic origin, gender, age, education level, job skills, trauma and incarceration are all factors in determining the likelihood that individuals will experience homelessness in their lifetime. The number of mentally ill that experience chronic homelessness is disproportionately high when compared to the number of homeless in the general population.

Housing options for those with mental illness that do not reside with family are mainstream housing and needs specific housing. Mainstream housing may be public housing, privately owned developments with income sensitive rents or housing obtained through a voucher program. All of these can be difficult for an individual with a mental illness and co-occurring substance use disorder to secure. Programs that are designed specifically for this population are generally based on an abstinence dependent, required treatment, Continuum of Care model or a non-abstinence dependent, treatment optional, Housing First model. Continuum of Care is the preferred method for programs relying on government funds. Both Continuum of Care and Housing First have strengths and weaknesses. Continuum of Care has been associated with mixed or higher levels of abstinence, but poorer retention. Housing First has been associated with higher retention and greater client satisfaction, but mixed levels of abstinence.

Chapter Three: Conclusions and Recommendations

Despite decades of research and government interventions, homelessness continues to be a major challenge, with little to no improvement in outcome to date. Research comparing the Continuum of Care model and the Housing First model has failed to reach a conclusion on which is a more effective option for addressing the needs of the mentally ill homeless. Housing First has been proven to decrease homelessness and increase client satisfaction, but does not require possibly beneficial treatment. Continuum of Care may or may not decrease substance use, and has been proven to be effective at decreasing homelessness in a much smaller percentage of clients, but does address treatment. Ultimately, the debate at this time would seem to be whether the desired outcome is to reduce homelessness or provide treatment. Although results have been mixed regarding a required abstinence component, studies show that providing housing in conjunction with treatment and work therapy increases abstinence and provides better housing outcomes. Any housing plan must consider the newly homeless and ways to return them to a housed status more quickly. Reducing lengths of homelessness could provide more resources for addressing chronic homelessness and mitigate the effects that homelessness has on mental health and substance use.

Longitudinal studies should be performed to determine whether the benefits of an abstinence optional, treatment and work therapy required, program provides better outcomes in the long term. Future research should also consider the importance of neighborhood quality and fit for both mentally ill and the general population to determine how important this component is in maintaining stable housing.

References

Caton, C., Dominguez, B., & Schanzer, B. (2005). Risk factors for long-term homelessness: findings from a longitudinal study of first-time homeless single adults. *American Journal of Public Health, 95*(10), 1753-9. doi:10.2105/AJPH.2005.063321

Greenberg, G.A., & Rosenheck, R.A. (2010). Mental health correlates of past homelessness in the national comorbidity study replication. *Journal of Health Care for the Poor and Underserved, 21*(47).

Greenwood, R., Schaefer-McDaniel, N., Winkel, G., & Tsemberis, S. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American Journal of Community Pscyhology,* 36(3/4), 223-238.

Gulcer, L., Tsemberis, S., Stefancic, A., & Greenwood, R. (2007). Community integration of adults with psychiatric disabilities and histories of homelessness. *Community Mental Health Journal, 43*(3), 211-228.

Kertesz, S.G., Crouch, K., Milby, J.B., Cusimano, R.E., & Schumacher, J.E. (2009). Housing first for homeless persons with active addiction: Are we overreaching? *The Milbank Quarterly, 87*(2), 495-534.

Milby, J.B., Schumacher, J.E., & Wallace, D. (2005). To house or not to house: the effects of providing housing to homeless substance abuser in treatment. *American Journal of Public Health, 95*(7), 1259-65. doi:10.2105/AJPH.2004.039743

Morse, G., Calsyn, R., Klinkenberg, W., Helminiak, T., & Wolff, N. (2006). Treating homeless clients with severe mental illness and substance use disorders: costs and outcomes. *Community Mental Health Journal, 42*(4), 377-404.

National Coalition for the Homeless (2009). Mental Illness and Homelessness. Retrieved from http://www.nationalhomneless.org/factsheets/Mental_Illness.html

Newman, S., & Goldman, H. (2009). Housing policy for persons with severe mental illness. *The Policy Studies Journal, 37*(2), 299-324.

Substance Abuse and Mental Health Services Association. Definition of co-occurring disorder. Retrieved from www.fasdcenter.samhsa.gov/educationTraining/courses/CapCurriculum/glossary.cf

Substance Abuse and Mental Health Services Association. Definition of mental illness. Retrieved from http://www.coce.samhsa.gov/cod_resources/PDF/OPI-definitions&terms-8-13-07.pdf

Tsemberis, S., & Eisenberg, R. (2000). Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services*, *51*(4), 487-493.

United States Code, Title 42, Chapter 119, Subchapter I. Federal Definition of Homelessness. Retrieved from http://portal.hud.gov/HUD?src=/topics/homelessness/definition

U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2010). *The 2010 annual homeless assessment report to congress* Washington, DC: Retrieved from www.hudhre.info/documents/2010HomelessAssessmentReport.pdf