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Best Practices Regarding Homelessness and Mental Illness

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Abstract

Preliminary research indicates that homelessness is a growing problem in the United States, especially in Rhode Island. It is very common for those who are homeless to also be impacted by a mental illness, which creates an additional barrier for them to overcome. This qualitative research collected stories from homeless individuals in Rhode Island regarding their perceptions of services that work best to overcome homelessness as well as related problems, including mental illness and substance abuse. This is a local and national problem, and understanding the stories from those who “live” the experience of homelessness is valuable for practice and policy considerations.

Best Practices Regarding Homelessness and Mental Illness

Those who are homeless are commonly also impacted by a mental illness. Homelessness is difficult enough to exit when individuals and families do not have other issues to resolve. Today's economy makes it especially challenging to exit homelessness, but for those who have a mental illness, it is close to impossible. The combination of homelessness and mental illness is a vicious cycle that one cannot break on their own. There have been various interventions that have been implemented in order to help those who are homeless, such as emergency shelters and subsidized housing, but these solutions, either, are not permanent or do not target the chronically homeless. It is very likely that someone who is mentally ill will find himself in and out of homeless shelters, looking for the next temporary solution. The homeless mentally ill is a population that needs a variety of services, and not solely housing.

This issue is very prevalent in the state of Rhode Island. Close to 4,000 people were homeless in 2007, and that number is only growing (Rhode Island Coalition for the Homeless, 2012). In addition, research has shown that between one-fourth and one third of the homeless population has had a mental illness such as major depression, schizophrenia, and bipolar disorder (Folsom, Hawthorne, Lindamer, Gilmer, Bailey, & Golshan, 2005). This means that at least 1,000 people in Rhode Island who are homeless also have a mental illness, which indicates a great need for services. The main issue is deciphering what types of services truly work for this population. Some services such as emergency shelters and subsidized housing do decrease homelessness for a time, but not permanently. Subsidized housing is directed towards those who can actually pay for housing, which are very few constituents. In addition, many homeless shelters do not provide the services that the mentally ill need; therefore, if their needs are not being met they are likely to return to homelessness. A revised approach to emergency homeless

shelters called Critical Time Intervention, stresses the importance of intervening during a crisis and providing a transition out of the intervention. This has shown to reduce homelessness for a longer amount of time, but it is still only a temporary solution. The Rhode Island Coalition for the Homeless (2012) is aware that the services that the homeless mentally ill need are permanent housing, with other available services and resources. If this occurs then they are more likely to obtain a job, maintain financial stability, and be less likely to return to homelessness. However, the lack of funding in the state of Rhode Island has is a major barrier that impedes on the ability for these services to be implemented. If these types of services prove to be working, then they will be much more cost effective in the long run than both subsidized housing and emergency shelters.

A program in Rhode Island that was recently implemented allows those who are homeless to have permanent home and other services that will support their variety of needs. The homeless mentally ill is a severely oppressed population. The purpose of social work is to advocate for oppressed populations and provide them with resources or direct services that meet their needs and support their human rights. This program gives people the tools to promote the overall well-being of families and individuals who have been faced with many obstacles. It provides this population with a home, and offers additional voluntary services for those who feel that they need more support in fulfilling their needs to promote their well-being. The programs that will succeed most are the ones that are based on empowerment and self-determination so that the constituents are able to support themselves in their own, unique way with the tools that the program provides. These principles are what social work is based on.

This study will explore the effectiveness of such programs for those that have a mental illness and are homeless. Representatives from this population will be asked to tell their story of

how they came into homelessness. The information sought is what circumstances brought them to seek services, what services were provided for them, and whether or not these services actually met their needs. The most valuable information comes from those who are affected by these issues because they are the ones who know exactly what they need and the best way for them to meet those needs. Further insights can be discovered on how they were treated during their services and if they felt their opinions were valued.

Literature Review

Homelessness in Rhode Island

Homelessness is a significant issue in the state of Rhode Island, and the rate of homelessness has only been growing. According to the Rhode Island Coalition for the Homeless, there were 3,926 people who were homeless in 2007 and 4,410 people who were homeless in 2011, an increase of 484 people (RI Coalition for the Homeless, 2012). Those who are homeless in the state of Rhode Island include, children, families, individuals, and elderly. In 2010, 51 percent of the homeless population experienced homelessness for the first time. About 40 percent of this population were families in which 13 percent were children, 5 years old or younger. Forty-one percent were female, and 13 percent were unemployed (RI Coalition for the Homeless, 2012). About 18% of Rhode Island's homeless population is considered to be chronically homeless. This means they have either been homeless several years at a time, or multiple times. People who are chronically homeless can also be limited by various problems that inhibit them from finding and keeping housing. Some of these boundaries include having a physical disability, mental illness, and issues with substance abuse (RI Coalition for the Homeless, 2012).

According to the Rhode Island Coalition for the Homeless (2012), the significant lack of affordable housing, partnered with low income, has greatly contributed to homelessness in Rhode Island. In fact, this state is one of the least affordable places to live in the United States. Rhode Island has suffered the second largest increase in the country for the greatest gap between the income its residents earn and the cost to rent a home (RI coalition for the homeless, 2012). A person that is working at the minimum wage must work 102 hours per week and 52 weeks per year just to afford a two-bedroom apartment in Rhode Island (RI Coalition for the Homeless, 2012). Therefore, for many residents of Rhode Island, housing is simply unaffordable. This scarcity of affordable housing increases the difficulty of exiting homelessness and also increases the possibility of homelessness for low-income individuals and families. In addition to the lack of affordable housing and low incomes, the State of Rhode Island also had to make extensive cuts in service programs in order to balance its budget (RI Coalition for the Homeless, 2012). In 2009, it was reported to CNN that in an attempt to fill a \$350 million budget gap, Rhode Island cut community service grants that assist the elderly, the youth, and the poor in half (Luhby, 2009). The state also cut other service programs such as health care, childcare, housing subsidies, and food assistance (RI coalition for the homeless, 2012). Approximately 6.8 percent of Rhode Island residents are living in deep poverty, with an income of less than half of the poverty threshold, which is \$9,601 for a family of three (The Economic Progress Institute, 2012). A family of three with a total income of \$9,601 is likely not meeting all of their basic needs. When low income families are struggling to meet their basic needs, these service cuts can easily lead to homelessness.

It would be common that many of the residents are unemployed as well, which means these services would be sought out more than ever. The November 2008 unemployment rate of

9.3 percent was the second highest in the country. In December of 2008, the unemployment rate was 10 percent, which was the highest in thirty years and more than twice the rate in 2007. As if these employment rates were not enough to increase homelessness, the foreclosure rate in 2009 was 3.18 percent, which was the tenth highest rate in the nation (Luhby, 2009). With the state of Rhode Island's economy, and these record high rates of unemployment and foreclosure, it is inevitable that the rate of homelessness will also rise until a solution is found to end this vicious cycle. The only two ways to get out of unemployment are to drop out of the labor force or find a job. Unfortunately, in this recession there is a higher probability that discouraged workers will drop out of the labor force than find a job (Tasci & Burgen, 2012). It is also reasonable to deduce that the population which had to drop out of the labor force is more likely to develop a mental illness such as anxiety and depression, due to various stress factors and also that they may feel that they are bound for homelessness.

Homelessness and Mental Illness

Research has shown that occurrence of mental illness is far more common among those that are homeless. According to one study, between one-fourth and one-third of homeless people have a serious mental illness such as major depression, schizophrenia, and bipolar disorder (Folsom et. al, 2005). Another study of adults who were either formerly homeless or never homeless revealed that almost half of the formerly homeless group had a one-year DSM diagnosis, which was double the rate of the never homeless group (Reardon, Burns, Preist, Sachs-Ericcson, & Lang, 2003). These high rates of mental illness among the homeless have been affirmed in studies of people who were formerly homeless, but are currently institutionalized. For example, Goldstein et. al. found that among the first psychotic disorder patients who were admitted to acute inpatient units in the Suffolk County Health Project in 1998,

27 percent of patients were homeless (Goldstein, Luther, Jacoby, Haas, & Gordon, 2008). And, in a study on prevalence and risk factors for homelessness among 10,340 patients with mental illness, reported that 54.8 percent of the sample had schizophrenia, 19.8 percent had bipolar disorder, 25.2 percent were diagnosed with major depression, and 60.5 percent of these patients had substance use disorders (Folsom et. al, 2005). While the rates of mental illness vary across these studies, there is little debating that the rates are high. These rates may have something to do with the lack of basic needs. Indeed, research has shown that the perceived lack of basic needs leads to mental stress. For instance, Shugrue and Robison (2009) found that those who had a particularly low income, and are in danger of not meeting the basic needs for them or their family, were more likely to feel more anxious about getting a job in the crumbling economy (Shugrue & Robison, 2009). More in depth research showed that once the individual's basic needs were met, such as food and shelter, their mental health had improved, and if their income increased since their basic needs were met it did not improve their mental health any further (Sareen, Afifi, McMillan, & Asmundson, 2011). This is why it is so important for a person's basic needs to be met. If their needs are met, such as food and shelter, their challenges with mental illness are much more likely to subside. When a person has housing they are much less susceptible to mental illness. Therefore, there seems to be a significant correlation between homelessness and mental illness.

Serious mental illnesses among the homeless lead to other serious issues such as substance abuse. Substance use is strongly associated with homelessness. In addition, comorbid substance use is often paired with a serious mental illness (Goldstein et. al, 2008). Research has shown that 50 percent of homeless people with schizophrenia also have a comorbid alcohol or drug disorder (Goldstein et. al, 2008). In addition, about 15 percent of formerly homeless people

showed the prevalence of an alcohol-use disorder that was comorbid with at least one other psychiatric disorder, which was five times that of the never homeless group (Reardon et. al, 2006). Also, the formerly homeless group with comorbid alcohol use disorder and those with at least two psychiatric disorders had an earlier onset of psychiatric disorders than the never homeless group. Substance abuse is frequently the cause of homelessness which can also influence medical and psychiatric morbidity all on its own (Reardon et. al, 2006). It is possible that this earlier onset in formerly homeless group put these individuals at an increased risk for later homelessness and alcohol use disorder, which may also indicate the presence of a more severe course of illness (Reardon et. al, 2006).

In addition to substance abuse, research has shown that homeless individuals are more likely to exhibit suicidal behaviors. For example, Goldstein (2008) found that the individuals that are both homeless and mentally ill have an increased risk of suicidal behaviors (Goldstein et. al, 2008). Within this population there was an increased risk for individuals between the ages of 30 and 39, and also an increased risk for the elderly population who have a substance use disorder (Goldstein et. al, 2008). In another study fifty-one percent of homeless people testified that they had made a suicide attempt at some point, and 26.9 percent described a suicide attempt in which they had to be admitted in a hospital (Desai et. al, 2003). This same study concluded that homeless people with mental illness were more likely to exhibit suicidal behavior because of the traditional risk factors that are imminent amongst this population (Desai et. al, 2003). These risk factors include a presence of psychiatric diagnoses with affective, impulsive, and aggressive symptoms (Nock & Kessler, 2006). Some of these diagnoses entail major depressive episodes, drug abuse or dependence, conduct disorders, and antisocial personality disorders (Nock & Kessler, 2006). In sum, the homeless population is susceptible to mental illness, substance

abuse, and in extreme cases suicide. Programs for homeless must be equipped to deal with these issues. However, most traditional programs, including the traditional shelter, are not.

Characteristics of Effective Interventions

Even though mental illness is very prevalent among homeless people, their access to health services is quite limited. It is very probable they do not have a consistent form of health care. Rents in large cities are always increasing, which means that the number of homeless people in these cities is most likely going to rise (Folsom et. al, 2008). The most common intervention for homelessness is the use of emergency homeless shelters. Research has shown that an increase in shelter beds is successful in providing homeless persons a place to sleep (Early & Olsen, 2002). However, the rate of permanently reducing homelessness through emergency shelters is very minimal. While emergency homeless shelters do reduce homelessness, it is only a temporary solution, and does not reduce the recurrence of homelessness. Another common intervention for homelessness is providing subsidized housing for those who struggle to pay for housing on their own. However, this has only proved to prevent homelessness for the small population who has a high risk of being homeless in the future (Early & Olsen, 2002). It seems as though there needs to be alternative interventions that approach homelessness from a more effective direction, in which broader homeless populations are targeted.

The Critical Time Intervention approach is a revised program for homeless intervention that seems to be somewhat more effective than emergency shelters and subsidized housing, yet still only focuses on temporary solutions. Research presented in 1997 shows that Critical Time intervention (CTI) is effective in enabling the homeless to exit homelessness (Thornicroft, 1997). CTI stresses the importance of brief transitional periods before and after the intervention stage in

order to reduce homelessness (Thornicroft, 1997). This study was conducted on what is believed to be the most difficult population to work with—mentally ill, adult men—and this method proved to be effective (Thornicroft, 1997). The key factor that contributes to the feasibility of this intervention method is that the intervention period occurs in a limited amount of time, which makes this method cost effective (Thornicroft, 1997). The effective results tend to persist after participants exit the intervention stage, which is quite rare for typical community treatments (Thornicroft, 1997). The intervention focuses on enabling in only a temporary role, particularly during a time of crisis (Thornicroft, 1997). Intervening with patients with a mental illness during a time of crisis shows that they are less likely to be admitted into a hospital (Thornicroft, 1997). In addition, this method focuses on continuity. The participants are given the contact of their staff in case of future need, and they are also given the continuity of competence, because of the short time period of intervention with the additional assistance of transition periods (Thornicroft, 1997). It is because of the stress on continuity that participants of CTI have longer periods out of homelessness after intervention (Thornicroft, 1997). Overall, CTI shows to be effective for exiting homelessness, yet persons are still likely to return to homelessness because even this solution does not show to be permanent. It should be advised that programs should focus on permanent solutions to homelessness in order for the overall rate of homelessness to be reduced.

Research conducted by the Rhode Island Coalition for the Homeless (2012) provides a different, more permanent, approach to solve the state's problem of homelessness. Years of intervention evaluations have shown which types of programs have worked and which have not. A targeted comprehensive solution is both cost effective and has better results than temporary solutions (RI Coalition for the Homeless, 2012). The focus of homelessness interventions must be around prevention and providing permanent affordable housing (RI coalition for the

homeless, 2012). Prevention programs that have been proven to work are discharge planning, in which vulnerable populations, such as the mentally ill, are provided with training, housing options, and other supportive services so that they will not be discharged into homelessness; diversion, in which programs assist those who are at an impending risk of becoming homeless; emergency assistance, in which a small loan or grant is provided for those who may have an unexpected illness, sudden job loss, or experience domestic violence, with the goal of allowing them to remain in their housing and maintain stability; and foreclosure prevention and tenant protection, in which laws are implemented to prevent foreclosure and protect housing tenants. (RI Coalition for the Homeless, 2012). All of these prevention programs are far more inexpensive than emergency shelter programs. Since the major cause of homelessness in Rhode Island is the lack of affordable housing, the obvious solution is to supply affordable housing. Low rent housing would allow low income individuals to stay in their housing permanently (RI Coalition for the Homeless, 2012). A sufficient supply of affordable housing can be transformed into an emergency response program, in which newly homeless residents can be put into permanent low rent housing almost immediately (RI Coalition for the Homeless, 2012).

Given that the cause of homelessness in Rhode Island is the lack of affordable housing, the obvious solution is to supply affordable housing. Low rent housing would allow low income individuals to stay in their housing permanently (RI Coalition for the Homeless, 2012). Since homelessness in Rhode Island is so high there are quite a number of organizations with the mission of helping the homeless. The Providence Center has a number of services for individuals with mental health issues. Their mission statement is as follows: “To help adults, adolescents and children affected by psychiatric illnesses, emotional problems and addictions by providing treatment and supportive services within a community setting” (The Providence

Center, p. 1, 2012). The vision of the organization is to have a behavioral health care system in which individuals can have all of their needs met, and to have a plan that is unique to each individual (The Providence Center, 2012). Some of the services at the Providence Center include counseling, medical treatment, daycare programs, substance abuse programs, school programs, and a number of other services for people who may have a mental illness and cannot afford treatment for themselves.

Housing First is also a program in Rhode Island that serves those who are chronically homeless. Housing First began in Rhode Island in 2006. This program has a 90 percent success rate and saves \$7,946 more for each person who was provided permanent housing than if they participated in temporary housing programs (RI Coalition for the Homeless, 2012). The idea of the program is to allow the chronically homeless population to have rapid access to permanent housing, as well as voluntary access to a variety of other services (Hirsch & Glasser, 2007). Allowing for chronically homeless individuals to receive permanent, non-transitional, housing as soon as possible is so that they can actually benefit from other services being available to them without having to worry about their basic needs being met (Hirsch & Glasser, 2007). Many of the people being served in this program can benefit from mental health services, substance abuse services, and services that can assist with educational goals (Hirsch & Glasser, 2007). Once a person is permanently housed, they will most likely stay in that apartment or move to other permanent housing. After this occurs participants will have improved health, mental health, access to a higher income, access to more job opportunities, they will be able to contribute to their community, and they will most likely be happier overall (Hirsch et. al, 2007). Not only is supportive housing effective to improve the quality of life, and the well-being of the homeless population, but also saves the taxpayers of Rhode Island money. If the successes of these types

of programs continue, then there is even more reason for similar programs to be implemented in the state in order to solve the problem of homelessness.

Overall, the issue of homelessness and mental illness is quite prevalent in Rhode Island. A great number of those who are homeless are also struggling with a mental illness, substance abuse, or both. Therefore, more problems need to be addressed than simply homelessness. It seems as though programs that encompass mental health issues and homelessness seem to be more effective than temporary services such as emergency shelters and subsidized housing. With this in mind, this study will be conducted by gaining information from stories of those who are homeless and have a mental illness. The information gathered will be focused on the participants' opinions of interventions. Since they are the "experts," their stories can be valuable to assess what interventions work to meet their needs to improve their quality of life and why

Methodology

A descriptive, qualitative study was conducted by asking constituents to tell their story of how they became homelessness, and how they have tried to overcome homelessness. The goal of the study was to find out what types of interventions were most successful for those who are both mentally ill and struggling with homelessness.

Subjects

The subjects were drawn from a convenience sample. They were recruited by the director of a homeless intervention program that provides permanent housing and other voluntary services for those that are homeless in Rhode Island. A total of six constituents were interviewed in order to gather data about their experience with being homeless.

Data Gathering

The subjects were first asked basic demographic information which included their gender, age, and ethnicity. The interview continued with questions about how they became homeless and what circumstances led up to their homelessness. They were asked what they needed to exit homelessness and what they wanted to occur to assist in them being able to overcome homelessness. They were also asked how the current program is helping them exit homelessness, and whether or not they think that it is successful. This information was tape-recorded, and analyzed. (See Appendix A for study questions)

Data Analysis

The data was analyzed by finding patterns in the subjects' stories, to see if they discussed any similar themes. The information was analyzed based on the circumstances that led the subjects to homelessness and what their specific needs were based on these circumstances to exit homelessness. It was interesting to see if some think that certain interventions were more effective than others. Another fascinating aspect of this study was looking at the severity of cases and learning if it was more difficult for some to exit homeless than others. Some factors that were explored in regards to this aspect were how long they were homeless, how serious their mental illness is, and if they have or had a strong support system through this process. It was also interesting to see if their views were similar or different in regards to what needed to be done for them to exit homelessness. Patterns were analyzed in order to see what types of interventions work best for each person and why.

Findings

This study intended to investigate the greatest challenges for those who are both homeless and mentally ill and to obtain their perspective on what they feel they need in order to overcome these challenges. The researcher wanted to gain insight about how the participants

became homeless. The participants were also asked their opinions about the intervention programs that they had sought out for assistance, and what type of intervention program has worked best for them thus far.

A total of six participants were interviewed who are currently receiving services from a program in Rhode Island which provides permanent housing for the homeless as well as other services such as therapy, substance abuse counseling, psychiatry, rent assistance, and medical care. All six participants were homeless before entering this program and were also simultaneously battling mental illness. The ages of the participants ranged from 49 to 55 years of age. Five participants were male and one was female. The participants included a Caucasian, African-American, Native American, Asian and a Hispanic male, while the female was Caucasian. All but one participant were employed at some point in their life, and the highest levels of education ranged from eighth grade to two years of college.

The interviews were conducted in a narrative style, in which participants were simply asked to tell their story focusing on the factors that led them to homelessness. A few follow up questions were required if the participant did not touch upon a subject that the researcher had sought out to explore. The interviews lasted between 15 to 20 minutes. The researcher analyzed the stories and looked for similar themes regarding the causes for their homelessness, what type of assistance they needed to move forward, and what barriers they needed to overcome in order to move forward.

Homelessness and Mental Illness

There were a number of factors that led to each participant's homelessness. In almost all of these cases, the most prominent underlying reason for their homelessness was because of their mental illness. Participant 1 had always felt a lot of anger growing up as the oldest of 11

children with an alcoholic father, but never addressed these issues. He developed an alcohol problem when he served in the military. He was deployed abroad for 5 years, during which, he also became addicted to drugs. He had a very hard time adjusting when he came back home and continued to drink to hide the pain. He was divorced twice because of his drinking problem and soon became homeless “[he] didn’t want any expectations or obligations, [he] just wanted to be free; but really it was just his way of hiding the pain.” It wasn’t until he was on the brink of death that he realized he needed help. He was diagnosed with Post Traumatic Stress Disorder, which now he is able to identify as the reason for his heavy drinking, substance abuse, anger, and pain. Participant 2 disclosed that he has depression; however, he was not depressed until after he was diagnosed with a physical illness which left him disabled. It was because of this illness that he lost his job and became homeless. Therefore, in this case, homelessness was the cause of his mental illness. Participant 3 was struggling with substance addiction, which led him to be homeless. Participants 4 and 5 did not disclose specifically what type of mental illness that they were diagnosed with, but alluded to a history of substance abuse. Participant 6 disclosed that he was diagnosed with severe anxiety and depression, which he feels could explain why he committed the crime he committed, which he did not feel comfortable disclosing with the researcher. It was because of his criminal history that he was not able to find a job and became homeless. All participants demonstrated that mental illness, often paired with substance abuse, played a major role in their experience with being homeless.

Characteristics of Effective Interventions

There was a recurring theme regarding the types of homeless intervention programs that work. All of the participants had very positive things to say about the current program that they are involved in because it is long term, and consistent. Participant 1 disclosed that he was in and

out of at least 60 different kinds of programs, but there was not one program that met all of his needs. Participant 1 said,

I just didn't get the total package of care that I needed. Some [programs] are strictly clinical, some strictly work on narcotics. This program here, I have my doctor here, I have groups here, I have a therapist here. It's like a wrap around service, where everything is in one place. I found it hard to keep appointments because everything was in different places on different days. If you're homeless, that's not going to happen. I can keep appointments here because everything is under one roof.

Participant 1 continued to compare this program to others that he was involved in and said he felt hopeful while he was there, but only for that time. Once he left the facility, he still didn't have a house or any place to go which left him back where he started. Participant 1 described the program in which he is currently involved in further detail: "This place offered me an opportunity to get an apartment, to get dental care, to get alcohol treatment, to get drug treatment, to get personal therapy, to get a psychiatrist, to get non-narcotic medications that won't leave me with side effects or leave me with addiction. What can I say? It's been a total transformation." Participant 1 has been sober for three years, and doesn't feel like he would have been able to be so without the help from this program.

Participant 6 also said that since he has been involved with this program he feels very hopeful about the future. After three months of struggling to get an apartment from other programs he felt that "no one lifted a finger to give [him] a hand out, [this program] stepped in and said 'we have keys for you.'" Not only did Participant 6 get an apartment, but he is also receiving care for his depression and anxiety, and is working towards getting a job, which he identified was one of his greatest challenges. Within the same program, he is taking classes to

obtain his GED. Participant 6 says that he is able to focus on the work that he needs to do and also feels much more at peace since he has been involved in this program.

Participant 3 also felt that this program was more helpful than others because of the variety of services it offers. He was able to get an apartment through this program and is also seeing a counselor, going to substance abuse meetings and groups, as well as utilizing other support groups such as a self-esteem group. He feels that this program was much more helpful than others because “they don’t turn people away. They don’t put you on a waiting list, give you a card, and tell you to come back another day, then never hear from them again.” He felt that this program was so much more helpful because of its consistency and fewer turnovers of case managers. He is currently still struggling with addiction, but since all of his services come from the same place and same people, he knows exactly where his support system is and who he can turn to when he finds himself relapsing. When Participant 3 was asked what his ideal intervention would offer, he said that it would include substance abuse counseling. He went on further to explain that he is very happy with the substance abuse counseling as well as other counseling that this program offers. Participant 2 did not have much experience with other programs, but he did tell me that this program gave him an apartment and he is able to see a doctor twice a month for his physical illness. This program is also encouraging him to see a psychiatrist for his depression, which he would be able to do in the same place. While Participant 2 said that he feels he is “suffering mentally and physically,” these are two struggles that this program can assist him with if he is willing to do so. The majority of the constituents felt that the opportunity to receive more services other than solely a homeless intervention or only mental health care was a major factor in their success of overcoming homelessness.

In addition to having “wrap around,” consistent services, these six participants also mentioned that the staff that are working with them make the experience positive or negative. Participant 2 mentioned that in other programs the people did not take him seriously. He disclosed that they didn’t think that he was actually disabled and would not assist him. He said he felt that the people at this program were much more willing to help him and treated him like any other person. Participant 5 mentioned that her favorite thing about this program was her counselor. She said that her counselor always listens to her attentively even when she is talking about “nonsense.” Participant 4 said that the people at this program “treats everyone the same. From day one they treated [him] the same way that they do now.” They accepted him in his worst state the first day that he arrived. He said that he had “long hair, a beard and was stinky” from being homeless for so long, but they still didn’t turn him away. He went on to say that he feels like a different person from who he was two years ago. The first thing that Participant 6 said was that the people treated him with respect. He was in prison from 2001 to 2010, and they still didn’t treat him like less of a person for his crime. Participant 6 said that this was the first time in a long time that he actually feels whole. He also mentioned that this was the first place that he has been to where the people were very eager to help him.

In sum, all six participants felt that this program was a major variable in their success. This program meets all of the needs of the constituents involved. It is able to provide them with a permanent home, mental health services, substance abuse services, medical care, and so much more. This program provides homeless people with the opportunity to live a normal life. Not only does this program provide this population with cumulative services, but the counselors and staff are welcoming and supportive. This population was given the opportunity for a normal life, while being treated as normal people, with respect and without judgment. If this program is

working for these six people it is very likely that it is working for others as well, for these exact reasons.

Summary and Implications

This study delved into the stories of those who are both mentally ill and homeless in order to explore their greatest challenges and what types of interventions helped them overcome these challenges. Furthermore, this study intended to find common themes in the factors that the participants described as being most prevalent in leading them to homelessness. It also looked at what interventions were sought out to overcome these challenges and which ones they found to be the most helpful and successful. Each participant had a very different story, but some common themes were found within each of them. Many of the participants were struggling with substance abuse, a mental illness, or physical disabilities which made it very difficult for them to exit homelessness. In addition, all of the participants had very positive things to say about the program in which they were currently involved. This program provides permanent housing for those who are homeless, as well as voluntary services such as therapy, psychiatry, substance abuse counseling, medical care, dental care, rent assistance, and utilities assistance. Many of the participants felt this was the most helpful program as the result of multiple services that are provided under roof, compared to other programs which only delivered services for singular issues.

Much of what this study found paralleled preexisting literature. The participants that were interviewed reported that they had been involved in various other interventions, but once they left the program, they felt as though they were back where they had started. The programs that worked best for them were long term, rather than temporary. Preliminary research has also shown that temporary interventions are less effective. For example, Early and Olsen's (2002)

research shows that emergency shelters provide temporary housing for the homeless, and subsidized housing is targeted for those who are at high risk for being homeless because they struggle to pay for housing. Therefore, the more common homeless interventions only temporarily reduce homelessness, and cannot provide other services that this population needs to better their quality of life. In addition, another common service for the homeless population is subsidized housing. At the time the participants of this study were homeless, they were not employed and, therefore, did not have an income; and therefore, would not qualify for subsidized housing. Subsidized housing would never be an option for them unless they were employed or collecting some sort of an income, which was a common struggle for each of the participants. This study consistently underscored that long term, permanent housing interventions were the most effective.

Another finding of this study that was similar to previous literature was that Participant 1, who was homeless for over a year, said that once he left rehabilitation centers for his substance abuse he felt as though he was back where he started because he did not have a place to live. This finding coincides with the outcomes of Johnson and Chamberlain's (2008) research which reports that person who has a substance abuse issue is likely to be homeless for 12 months or more. This emphasizes the need for an intervention that provides a permanent place to live as well as substance abuse treatment, since a person with substance abuse issues are likely to be homeless for at least a year. Other participants of this study agreed that if they were not given a permanent apartment to live in, they would not be able to be successful in other aspects of their life, such as, treating their substance abuse, obtaining health care, or finding employment. Each of the six participants disclosed that this was a very positive aspect of the program they were currently in. They have a permanent home to live in, which makes the other challenges in their

life much more manageable. This parallels the research by McNaughton Nicholls and Atherton (2011) which stated that an important element of this program is providing the client with mainstream housing which will allow them to be independent and give them the opportunity to work through the other struggles in their lives.

In addition, the participants of this study put a strong emphasis on the way that they were treated in this program. It is very common that homeless persons with co-occurring disorders feel stigmatized by those they come in contact with. Some of the participants even mentioned that they felt as though they were pushed aside at other organizations where they had previously sought help. Previous literature also emphasizes this point. For example, Atherton and McNaughton (2011) state that programs that provide integrated services are very distinct because of the manner in which the clients are treated. The support of these types of programs is not time limited, which means that the relationship between the client and the provider is much deeper and meaningful. This continuity provides the security that a client with co-occurring disorders probably has never had before. It is very important to these programs to hire staff with the right value set to handle clients with the care and respect they need.

Limitations

This study included some limitations. One limitation was the small sample size. Six participants were interviewed to gather research for this study. This means that the findings of this study cannot be generalized to the greater population. However, this research was still valuable because it gathered qualitative data which deepens the understanding of the experiences of the homeless with co-occurring disorders and their perspectives as to what interventions work for them. Another limitation of this study was the methodology. Some questions that were asked by the researcher were difficult for certain participants to understand because of their

disabilities, mental illnesses, and language barriers. For example, when the participants were asked “What would the participant’s ideal intervention program consist of?” some of their responses were irrelevant which demonstrated a lack of understanding. One participant in particular mentioned that she has had multiple head injuries and was having a difficult time comprehending the question. In addition, some responses of the participants could have been delved into more by the researcher. For instance, the researcher asked them if there were other programs that the participants had been involved in to seek help, and half of the participants responded simply by saying “yes,” or “no.” When the researcher asked how their experience was in these programs, a few of the participants simply responded by saying, “Good.” Regardless, sufficient research was gathered that was relevant to the hypothesis of this study. A final limitation of this study was in designing the study. The interviewer formulated follow-up questions to guide the participant towards responses that would be relevant to the hypothesis. If the researcher wanted to gain more insight on this subject they asked additional follow-up questions. Since the interviewer was looking for specific responses, the additional follow-up questions were developed with bias.

Implications for Practice, Policy, and Research

This study can potentially provide valuable insight for practitioners who are working with the homeless population. Half of the participants mentioned how important it was to them that they were treated with respect. They also mentioned that they really liked their counselors because they were patient, pleasant, and helpful. It would be interesting to gain more insight about what techniques this specific program used, particularly in the area of substance abuse. This would be helpful for further practice as well. If there is a mainstream technique or theory

that substance abuse counselors are using in this program that has been helpful for multiple people, this would be very valuable information for substance abuse practitioners to know.

In addition, any practitioner needs to believe that their client has the ability to change. A practitioner needs to acknowledge the strengths of their client in order to implement a positive working relationship. The majority of these participants disclosed with the researcher that it takes a lot of work on their part to change, which they are fully willing to do. Participants disclosed with the researcher that they now understand what went wrong in their life, based on the choices they made and the consequences that followed. There was a moment in their life when they realized that they needed to better its quality, which was their turning point of change. This information is valuable for practice because it can change the outlook that practitioners may have about this population. If a practitioner knows that a client is willing to change, then they can give them the resources to do so without stigmatization.

This study could inform policy about what interventions need to be implemented to end homelessness. It is interesting that the most common homeless interventions, such as emergency homeless shelters, are not the most successful. Also, those who are homeless may seek help for substance addiction, or mental health, such as hospital or rehabilitation centers. Services such as these tend to be unsuccessful because they do not provide the client with the long term support they need to fully recover. The services that this program provides have been reported to be very helpful by all six constituents. In order to end homelessness and address the comprehensive services needed, it makes sense to develop programs similar to this model. Temporary, partial programs such as shelters do not address the complexity of homelessness and associated issues. Comprehensive programs such as the one described by six participants indicate increased success and improved well-being. This program, in which the six participants are involved, has the

potential to end homelessness for those who are willing to seek it out. This program shows evidence of good outcomes. Therefore, in order to use the best practices in the field, more programs and services such as this should be utilized.

This study preliminarily indicates the success of a comprehensive program for the homeless, and future research would be valuable to explore the cost effectiveness and feasibility of this program model. Future research can also further explore what counseling techniques were used that were particularly helpful for substance abuse and mental illness. The participants mentioned that one of the most helpful things about this program is their counselor. Therefore, another study would focus on counselor characteristics that facilitate the helping process. It would be interesting for further research to explore if there is a particular strategy that is used in this program for those with substance abuse issues, or if it is personalized from client to client.

Overall, these findings were very consistent with the preliminary research that was gathered. These six participants disclosed that this program has been very helpful in their journey of exiting homelessness. This program continues to not only provide them with housing, but also assists clients with other major struggles in their lives such as substance abuse, mental illness, and obtaining a job. These six participants affirmed that this program was the most helpful in exiting homelessness. This study provides evidence of successful outcomes for those who are homeless and have a mental illness. Therefore, more programs built on this model can potentially address the problem of homelessness.

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Appendix A

Demographics

What is the participant's age?

What is the participant's gender?

What ethnicity of the participant?

What city is the participant from?

How many members are in the participant's family?

What is the participant's highest education level?

What is the participant's current or previous occupation?

Study Questions

What is the participant's story?

How did they become homeless?

What major factors lead to their homelessness?

How has this affected their lifestyle and quality of life?

What were the participant's greatest challenges?

What homelessness programs have they been a part of to seek help?

How were these experiences?

What would the participant's ideal intervention program consist of?

Appendix B

Dear Potential Participant:

I am a social work major at Providence College, inviting you to participate in a study to explore the most effective approaches for those who have mental illness to exit homelessness. Data gathered in this study will be reported in a thesis paper in a social work capstone course at Providence College. It will also be added to the Providence College digital commons database.

At this time, those who are homeless are being recruited for research. Participation will involve answering questions about how one became homeless and what efforts one has made to exit homelessness. The interview time should not exceed 30-40 minutes. The interviews will be recorded using an audio recorder and the tapes will be destroyed once the data is transcribed.

There are no anticipated significant risks associated with involvement in this research. There is always the possibility that uncomfortable or stressful memories or emotions may arise while thinking about these past experiences. Participants are free to stop participation in the study at any time until identifying information is removed from the responses. The researcher, if necessary, will also provide referral resources for psychological support.

Benefits of participating in this study include helping researchers to formulate a better understanding of the life-long needs of mentally ill homeless person to potentially improve future practice and interventions.

Confidentiality will be protected by storing signed consent forms separately from data obtained in the study. Once the data are obtained, all identifying information linking the participant to his or her response will be destroyed so that responses can no longer be identified with individuals. Data will be reported by making generalizations of all of the data that has been gathered. Brief excerpts of individual responses may be quoted without any personal identifying information.

Participation in this study is voluntary. A decision to decline to participate will not have any negative effects for you. You may withdraw from the study at any time up until Thursday, March 24th when the researchers will finalize the data.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Thank you for participating in this study.

Your name here, Social Work Student, your contact information here

(Name)

(Date)