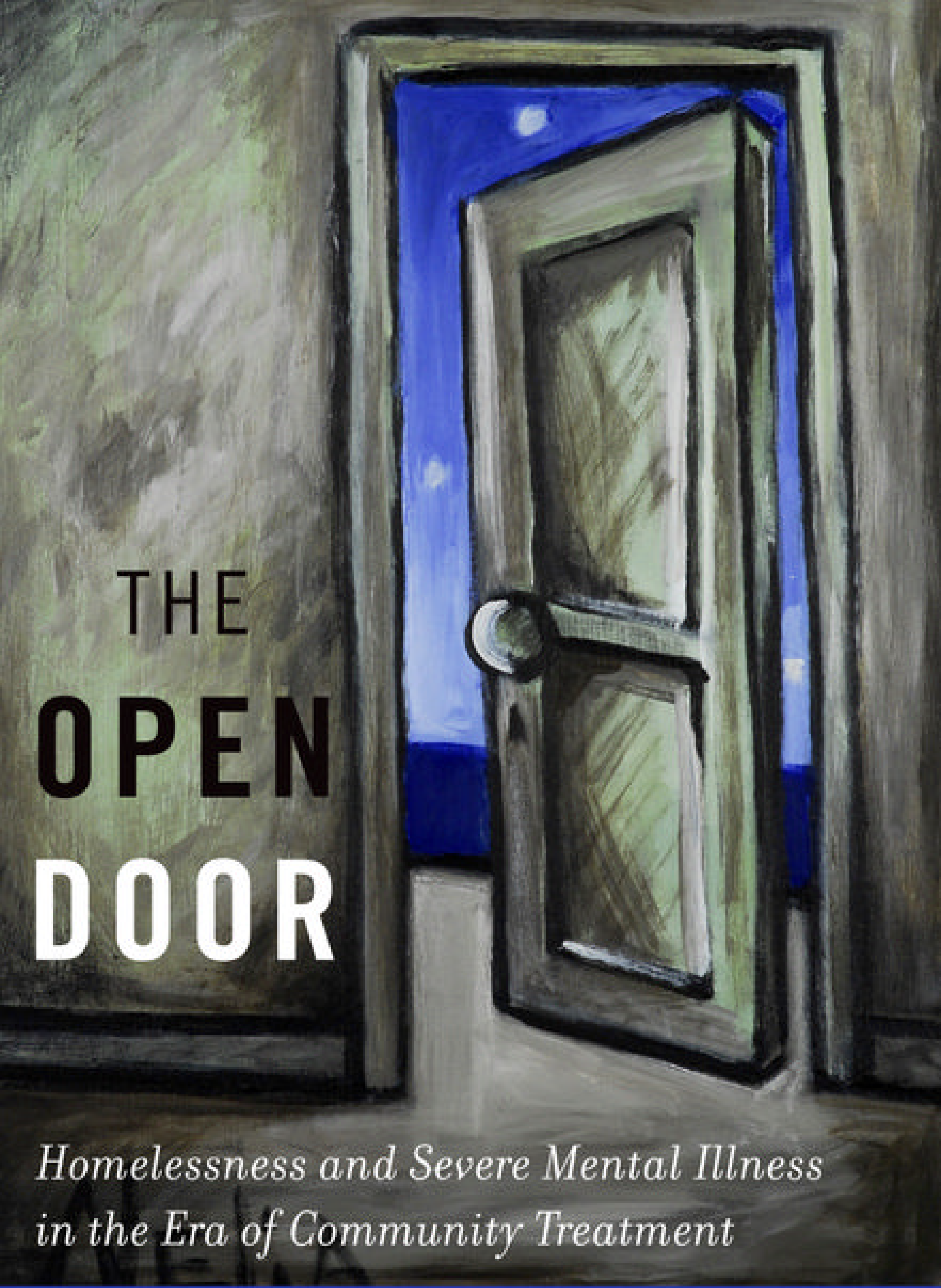

THE OPEN DOOR

Homelessness and Severe Mental Illness in the Era of Community Treatment

Carol L. M. Caton

OXFORD

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PREFACE

Among the throngs of homeless people in the streets and shelters across America, the severely mentally ill are arguably the most vulnerable. One in every three homeless people suffers from a mental disorder that is both severe and disabling. People in this group are more likely to remain homeless on the streets and in shelters for longer periods and suffer from multiple health problems that incur high social and economic costs to society. While it is widely acknowledged that the decline of the mental asylum led to the emergence of homelessness in this subgroup, there has been significant progress in finding solutions that warrants greater recognition at the public policy level.

I have been both an observer of the events that have given rise to homelessness and a participant in the quest for solutions that would bring greater stability to the lives of people with severe mental illness. Over the past 35 years, I have worked among clinicians, researchers, and advocates who have been inspired by the challenges imposed by homelessness to devise innovative service and policy interventions and creative housing initiatives. This collective body of work has advanced the evidence base in the care and treatment of the homeless mentally ill, paving the way for continued advances toward ending this American tragedy.

This ten-chapter book is a chronicle that begins with an account of the unintentional rise of homelessness following the far-reaching reforms in post–World War II mental health care, followed by descriptions of the key role of advocacy in spurring a governmental response to homelessness, the characteristics of homeless people with severe mental illness and issues related to their care, the quality of evidence for treatment and housing approaches tailored to the severely mentally ill, the challenge of bringing evidence-based interventions to scale, homeless prevention efforts, and the expanding emphasis on a recovery orientation and early enriched treatment to facilitate social inclusion. Homelessness and severe mental illness are issues that have, over the decades, aroused strong opinions and opposing views in both lay and professional circles, threatening a clear focus on the search for workable solutions. I have striven to bring objectivity to a review of the "state of the science." Guided by the available evidence, my goal has been to identify what we know about what works for preventing and ending homelessness, and where unanswered questions suggest that greater effort is necessary. Despite significant progress, the lack of evidence in some areas indicates the need to continue an aggressive research agenda. Future progress will require increased public funding and support for mental health services and research, areas that have suffered from changing priorities and persistent budget cuts at all levels of government, particularly after the 2008 recession.

Ending homelessness requires a multidimensional effort that begins with the early, consumer-focused treatment of psychotic disorders in concert with continuing treatment, rehabilitation, and housing support for as long as it may be needed. The idealists of the community psychiatry movement in mid–twentieth century America envisioned that a change in the locus of care from the mental institution to the community would enable people with severe mental illness to achieve a more lasting recovery and live meaningful, productive lives outside the walls of the mental asylum. I hope that greater understanding of homelessness, severe mental illness, and the advances in treatment and housing initiatives can strengthen the public will to ensure that people with mental disabilities have access to the interventions that could help them live successfully in the community, diminishing the chance that they will ever experience shelter or street living.

ACKNOWLEDGMENTS

Science is a collective enterprise, and I am indebted to the researchers who have increased our understanding of homeless people with mental illness, clinicians who have developed innovative housing and service programs, advocates who have successfully championed the cause of the homeless and disenfranchised, and policy-makers at all levels of government, whose work is reflected in this book. I owe a special debt of gratitude to the following people: Francine Cournos, Maria Foscarinis, Robert Hayes, Tony Hannigan, Mary Ellen Hombs, Philip Mangano, Patrick Markee, and Nan Roman, for their valuable insights on homelessness and advocacy; Susan Barrow for her beautifully crafted case examples that have breathed life into the characteristics of homeless people with mental illness described in Chapter 3; Fr. John Felice, Fr. John McVean, Julie Sandorf, Maryanne Schretzman, Sam Tsemberis, Carol Wilkins, Matthew Doherty, Richard Cho, and Brendan O'Flaherty for sharing their knowledge of housing initiatives and housing policy; Dan Herman, Bob Drake, Lisa Dixon, Greg Miller, and Bob Rosenheck for sharing their insights on the treatment of homeless people with severe mental illness; Marilyn Brown of Houston, Texas; Josh Bamberger, Dariush Kayhan, and Trent Rhorer of San Francisco, California; Heather Lyons and Sally Erickson of Portland, Oregon; Lloyd Pendleton of Salt Lake City, Utah; and Laura Zeilinger of Washington, D.C., for generously sharing their experiences in developing and implementing Ten-Year Plans to End Chronic Homelessness; and Merle Burke-Schlessel and David Rich of Coastal Fairfield County, Connecticut, for their useful information on the creation of their region-wide homeless services planning process. I am indebted to Ariel Wilmott and Nelia Gibbs of Fountain House Gallery for the cover art, and to Jeff Sheuer, Beth Carmody, and Ethan McElroy for the permission to use the photographs shown in Chapter 1 and Chapter 7.

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The Open Door

CHAPTER 1

The Open Door

The Mental Health System Transformed

In twenty-first-century America, about one in every three homeless people suffers from severe mental illness. The rise of homelessness among those suffering from severe psychiatric disorders paralleled the decline of the state-funded mental institution and the creation of the system of mental health care that replaced it, a process that began slowly in the mid-1950s, accelerated in the late 1970s, and continues to the present. In the period from 1955 to 1975, the resident population of state mental hospitals dropped by 66 percent (Bachrach, 1978). By 1998, the patient caseload of state mental institutions dropped 90 percent from the 1955 peak of over a half million patients (Lamb & Bachrach, 2001).

THE DECLINE OF THE STATE MENTAL ASYLUM

For nearly one hundred years, from the mid–nineteenth century to the end of World War II, public mental health care for people with severe mental illness took place in state funded and operated mental hospitals (Caplan & Caplan, 1969; Rothman, 1971). Often located far from population centers, these institutions provided all of an individual's treatment and support needs. Publicly funded care was available to all who needed it, regardless of their ability to pay or the length of their stay in the hospital (Grob, 1991). By the twentieth century, mental hospital caseloads consisted mostly of people with chronic conditions, sometimes associated with aging or underlying somatic disorders (Grob, 1991). Many hospital admissions occurred through a process of compulsory commitment (*Duke Law Journal*, 1969). Treatment options were limited, and custodial care predominated. Patients lacked the opportunity to play an active role in their care and treatment, typically accepting whatever treatment was recommended. It was not uncommon for the more disabled individuals to live out their lives under asylum care.

During the 1930s and early 1940s, the focus on the Great Depression and World War II upstaged concern for the aging and deteriorating physical plants and chronic staff shortages of state mental hospitals. Despite these problems and efforts to reduce hospital stays (Goldman & Morrissey, 1985), the growth in the population of state mental hospitals continued to accelerate (Grob, 1991). As hospital staff members were drawn into the war effort, the shortage of trained and qualified personnel grew more acute.

It was during this time that reports of the abuse and neglect of patients and the deplorable conditions in mental asylums surfaced in the lay press. Publications in the popular press, such as Albert Q. Maisel's "Bedlam 1946" article in *Life* magazine, Mary Jane Ward's novel *The Snake Pit*, and Albert Deutsch's "The Shame of the States" exposed to the general public the conditions of state mental asylum care (Grob, 1991). Torrey (2014) notes how negative appraisals of mental asylums were also apparent within the mental health professions; and Rochefort (1984) details how scientific studies of the mental hospital (Belknap, 1956; Caudill, 1958; Goffman, 1961; Stanton & Schwartz, 1954) reinforced the conclusion that "mental hospitals were making worse the very problems they were intended to remedy."

In the early years following the end of World War II, the mounting criticism of state mental institutions in governmental, medical, and lay circles created a context for change. In the second half of the twentieth century, mental health care in the United States evolved in response to advances within the psychiatric professions, a more prominent role of the federal government in mental health policy, funding, and entitlement reform, and the expansion of civil liberties for the mentally disabled.

The Coming of Age of Psychiatry

The end of World War II ushered in changing views of the nature of mental health and illness and the care and treatment of the mentally ill.

The war effort revealed that mental illness was a greater problem than anticipated in men screened for induction to the armed forces and those discharged with a disability (Rochefort, 1984). Military psychiatrists observed that environmental stress, such as that experienced in combat, could precipitate mental maladjustment in otherwise healthy individuals (Grob, 1991). The military experience broadened the focus from hospitalized patients with serious mental illness to the potential to effectively treat high-risk and early-onset conditions in community-based inpatient and outpatient settings (Grob, 1991). Moreover, the war exposed a new generation of young physicians to the discipline of psychiatry and provided psychiatrists with opportunities to advance new approaches for the treatment of mental illness that did not require long-term hospitalization (Grob, 1991).

The successful treatment of war neuroses enhanced the public's estimation of psychiatry and its role in addressing the mental health of the nation (Grob, 1991). The importance of psychiatry's role in the prevention and treatment of mental illness was acknowledged with the passage of the National Mental Health Act of 1946. The legislation led to the establishment of the National Institute of Mental Health (NIMH) in 1949, which would eventually provide funding for professional training, research, and preventive services. Robert Felix, the first NIMH director, initiated a shift in the locus of mental health care with funding to the states for the development of community mental health services (Torrey, 2014).

The ensuing decade witnessed advances in psychiatric theory and practice, as psychoanalysis and dynamic approaches challenged the status quo and emphasized early treatment of acutely ill patients as a way to prevent chronicity (Goldman & Morrissey, 1985; Grob, 1991). With their focus on epidemiology and the impact of the environment, social scientists contributed to a greater understanding of the prevalence of the untreated psychiatric disorders in the community (Hollingshead & Redlich, 1958; Srole, 1962) helping to fuel the nascent community mental health movement and the development of new psychosocial therapies (Klerman, 1977). Early efforts to reform mental hospital care, inspired by the development of milieu therapy (Cumming & Cumming, 1962) and therapeutic communities (Jones, 1953), led to open-door policies and decreasing use of restraints, accompanied by staff training and the creation of new professional roles.

Importantly, it was the discovery in the early 1950s of the antipsychotic effects of chlorpromazine (Ban, 2007; Lehmann & Hanrahan, 1954; Lieberman et al., 2000, 2005) that catalyzed the demise of long-term institutional care. In widespread use by the middle of the decade, the new medication could, it was believed, control the florid symptoms that characterize severe mental illness, easing the return of hospitalized patients to a productive life in the community. By the mid-1950s, the shift from hospital- to community-based care was emerging, with innovative efforts to develop general hospital inpatient units, day hospitals, halfway houses, and social clubs for discharged patients (Geller, 2000).

Over time, the public perception of psychiatry grew increasingly positive. The language and principles of psychodynamic psychiatry would come to have a notable influence on art, literature, and film (Bell, 1999; Grob, 1991, p. 271; Kandel, 2012). However, the metamorphosis in psychiatric theory and practice that occurred in the post–World War II years did not occur without internal struggle. Early on, those with a psychodynamic orientation, a focus on treatment in outpatient settings, and a concern for poverty, discrimination, and social justice, clashed with the more tradition-oriented psychiatrists who emphasized somatic etiology and therapeutic procedures and were skeptical of social activism (Grob, 1991, p. 24). Others attacked the very foundations of the discipline. Psychiatrist Thomas Szasz (Szasz, 1961) contended that psychiatry was a pseudo-science that lacked reliability and validity, and he asserted that psychiatric diagnoses were based on value judgments reflective of the larger society that functioned as a form of social control for people who did not conform to society's standards of behavior. Sharing Szasz's criticism of the inadequate scientific base of psychiatry, sociologist Thomas Scheff popularized "labeling theory" in a sociological model of mental illness that challenged the prevailing medical model (Scheff, 1966). Scheff's work on labeling theory sparked a lively dialogue within the social sciences (Link et al., 1989) that has influenced the study of the effects of stigma and discrimination on people with mental illness. Elaborated to encompass the terms and conditions of the traditional doctor–patient relationship, criticism of the medical model of mental illness and treatment has persisted into the current-day recovery movement (see Chapter 10).

Mental Health Becomes a Federal Priority

In a quest to better understand the status of mental health care in the United States, Congress adopted the Mental Health Study Act of 1955 (Public Law 84-182) to conduct a comprehensive nationwide analysis of mental health needs, both human and economic. Led by psychiatrists Kenneth Appel and Leo Bartemeier, the Joint Commission on Mental Illness and Health was made up of 36 organizations representing many disciplines and areas of professional interest (Ewalt, 1957). During its three-year mandate, the Joint Commission conducted a broad set of inquiries ranging from the nature and prevalence of mental disorders, mental health promotion in the community, and importantly, detailed study of private and public mental hospitals that included personnel issues, organization, administration, available treatments, and patient outcomes. A final report, *Action for Mental Health* (Joint Commission on Mental Illness and Health, 1961) assessed the scope of mental health conditions and resources nationwide. Highly critical of state mental institutions for having "defaulted on adequate care for the mentally ill" (Torrey, 2014), the Joint Commission recommended that community mental health centers should be established to coordinate future mental health care, and advocated for greater federal involvement in the care of people with mental illness. The Kennedy administration established a Cabinet-level interagency committee to determine an appropriate federal response to the report (www.nih.gov/about/almanac/organization/NIMH.htm).

The Community Mental Health Centers Act of 1963

In October 1963, President Kennedy signed into law the Community Mental Health Centers Act (PL 88-164), which authorized federal grants for the construction of public or nonprofit community mental health centers to provide inpatient, outpatient, partial hospitalization, emergency care, and consultation and education services. Grants were awarded to the states, with the stipulation that funds could not be used for existing state mental institutions. The program was administered by the NIMH, signaling the greater involvement of the federal government in determining mental health policy and the delivery of mental health services.

In creating a new type of mental health treatment facility, the landmark Act fueled the community mental health movement with its emphasis on prevention and early treatment (Caplan, 1964). Scant attention was paid to the fate of the severely mentally ill, however, who were discharged from state mental asylums in increasingly greater numbers throughout the 1960s and 1970s. Few received care in the new community mental health centers, as mental health professionals turned their attention to acutely ill patients with mild to moderate psychiatric conditions and limited treatment histories. In the context of the civil rights movement and the social change sweeping the nation in the 1960s, the community mental health movement embraced civil libertarian reform, focusing not just on psychiatric disorder, but on larger social issues like "poverty, racism, civil unrest, violence, and criminality" (Goldman & Morrissey, 1985). Although patients continued to suffer from chronic mental illness, access to the services they needed to live successfully in community settings grew increasingly limited (Cutler et al., 2003). By the end of the 1970s, only about half of planned community mental health centers were ever built, none were fully funded, and the legislation did not provide for long-term funding. In the early months of the Reagan administration, funds remaining from the Community Mental Health Centers Act were diverted into block grants to the states.

Federal Health Insurance and Income Entitlements for the Disabled Poor

Federal support for community mental health services was further advanced in 1965 with the passage of Medicaid and Medicare legislation, which provided coverage for a range of mental health services apart from state mental institutions. The new legislation prevented state mental hospital patients under age 65 from receiving Medicaid benefits. Medicaid funding for mental health services facilitated the expansion of general hospital psychiatric units, offering patients the opportunity to receive care in their local communities. The availability of federal health insurance for nursing home care provided a vehicle for the transfer of chronic patients from state-funded mental hospitals to nursing homes, allowing states to markedly reduce the cost of caring for the mentally ill and hastening the process of deinstitutionalization (Koyanagi, 2007). The cost for the shift in the locus of care from the state mental asylum to community services came from the federal purse, estimated at $2 billon by 1977, and a large measure of the treatment and support burden fell on nursing homes. By 1980, nearly half of the nursing home population consisted of the chronically mentally ill (Solomon et al., 1984).

Additional federal legislation, Supplemental Security Income for the Aged, Blind, and Disabled (Title XIV), enacted in 1972, provided income support for people who could not engage in gainful employment due to physical or mental impairment. Eligibility, based on need, was tied to an assessment of the person's source of support and available resources. Amendments enacted in 1972 extended Medicaid and Medicare protection to all Social Security Disability Income (SSDI) recipients. Entitlement income supported the ability of the severely mentally ill to live independently in the community.

The Expansion of Civil Liberties for the Mentally Ill: Actions of the Courts Facilitate the Transition from Institutional to Community-Based Care

Involuntary Commitment

Shortly after the passage of the Community Mental Health Centers Act of 1963, a series of state and federal court decisions broadened the civil liberties of people with mental illness admitted to psychiatric hospitals. These decisions have had a marked effect on both patients' rights and mental health services (Geller, 2000). Since mental hospitalization, particularly when it is of an involuntary nature, involves limitations on liberty, legislation was developed early on to clarify protections against inappropriate commitment (*Duke Law Journal*, 1969). The District of Columbia Hospitalization of the Mentally Ill Act of 1964 addressed the right of voluntary patients to seek hospital discharge within 48 hours of filing a written request. In so doing, the Act set forth a criterion for compulsory hospitalization based on the likelihood of self-injury or injury to others, established procedures of emergency hospitalization, court-mandated hospitalization, and the rights of involuntary patients to a periodic examination and release when the patient has recovered (Columbia Law Review Association, 1965).

In 1975, the United States Supreme Court ruled that states cannot constitutionally confine a non-dangerous individual who is capable of living safely in the community alone or with the willing assistance of responsible family or friends (O'Connor *v.* Donaldson, 422 U.S. 563, 1975).

The Right to Refuse Treatment

Later court decisions increased individual civil liberties concerning mental health treatment, challenging precedents that hospitalized patients had no role in treatment decisions, and that medication and physical methods of behavior control could be used without the consent of patients or their families (Melton et al., 1997). Addington *v.* Texas (77-5992), Supreme Court of the United States (441 U.S. 418.99 S. Ct. 1804; April 30, 1979) set a standard for involuntary treatment by raising the burden of proof required to commit persons for psychiatric treatment from the usual civil burden of proof of "preponderance of evidence" to "clear and convincing" evidence as required by the Fourteenth Amendment.

Rogers *v.* Okin (1975), a class action lawsuit brought by patients at Boston State Hospital, challenged the hospital's policies on the use of restraint, seclusion, and involuntary treatment that resulted in medicating people against their will and isolating them in forced seclusion. It was one of the first cases that led to the recognition that competent mental patients have the right to refuse treatment (Monahan & Steadman, 1983). The Federal District Court ruled that committed (and voluntary) patients must be assumed to be competent until proven otherwise, and as such, are capable of making non-emergency treatment decisions. Forced medication could be justified only in emergency situations where the evaluating physician determined that there was a risk of harm to the patient or another person. The court decision required that the determination of whether to treat an incompetent patient must be made in a full evidentiary hearing with counsel representing both plaintiff and defendant and expert witnesses representing both sides. The decision in Rogers *v.* Okin served as a model for other states grappling with the same issues.

Community Treatment in Integrated Settings

Two court decisions stand out in their support of community care for people with mental illness. A class action lawsuit brought by District of Columbia patients at St. Elizabeth's Hospital (Dixon *v.* Weinberger; 405 F. Supp. 974; U.S. District Court, District of Columbia, 1975) asserted that the 1964 Hospitalization of the Mentally Ill Act granted the right to care in community-based alternative settings for those unnecessarily confined to institutional care. The court ruled that treatment in community-based alternatives should be made available for those who do not meet criteria for mandatory hospitalization. Years later, in Olmstead *v.* L.C. (527 U.S. 581; 1999), the United States Supreme Court held that under the Americans with Disabilities Act, people with mental disabilities have the right to live and receive services in the most integrated settings appropriate to their needs.

The Right to Quality of Care

Finally, the decision in Wyatt *v.* Stickney (325 F. Supp 781 M.D. Alabama, 1971) is important because it helped to accelerate the emptying of state mental institutions. Wyatt *v.* Stickney was an action brought by the Department of Psychology at Alabama's Bryce State Hospital to reverse job loss for over 100 employees, including professional staff, that occurred following a state budget deficit. The action alleged that the layoffs impaired needed treatment of patients. To emphasize the point, Ricky Wyatt, a patient and relative of a laid-off staff member, was included as a plaintiff. Federal district judge Frank M. Johnson dismissed the aspect of the lawsuit brought by hospital staff, contending that the state had the right to lay off employees. However, in addressing the portion of the action focused on patient grievances, the judge ruled that patients “unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition” (http://forensicpsychiatry.standford.edu/Files/Wyattv.Stickney.htm) (Birnbaum, 1960). In his decision, Judge Johnson defined treatment adequacy in terms of staff-to-patient ratios, optimal staffing patterns, the preparation of treatment plans, the functioning of the physical plant, and other patient-care details such as frequency of showering, change of bed linens, and so forth. The inability of the state of Alabama to adhere to the standards set forth in the Wyatt decision and the high cost of transforming the grossly inadequate conditions in state mental hospitals compelled the state to rapidly discharge patients to the community. Similar court actions in other states produced the same result, accelerating the emptying of state mental institutions.

DEINSTITUTIONALIZATION AND THE RISE OF HOMELESSNESS

Within a decade of the passage of the Community Mental Health Centers Act, it became clear that although the deinstitutionalization movement spared the chronically mentally ill the inhumane conditions of state mental asylums, it left them without the services and support they needed to sustain a meaningful life in the community. Many fell through the cracks between an antiquated and declining system of asylum care and an innovative and expanding system of community care that had little interest in chronic mental illness. Community mental health programs specific to the chronically mentally ill were in short supply and unevenly distributed across the nation (Hogarty, 1971; Klerman, 1977). Follow-up studies revealed that discharged patients were living in inadequate housing or the back alleys of communities without appropriate treatment and support. Social isolation and functional decline were common (Klerman, 1977; Lamb & Goertzel, 1971; Talbott, 1979), prompting cries within the profession of psychiatry that “the care and treatment of the mentally ill is a national disgrace” (Reich, 1973; Talbott, 1979).

The Federal Response: "The Government Needs to Do More"

The concern that premature hospital discharge contributed to "the revolving door phenomenon" and persistent disability among discharged patients spurred a governmental response on several fronts. The General Accounting Office (GAO) issued a report in 1977 that addressed the problem of mentally disabled persons released from institutions without adequate community-based services. In the absence of appropriate service alternatives, the report noted, patients were inappropriately placed in nursing homes, as states took advantage of federal support through Medicaid and Supplemental Security Income (SSI) to reduce the cost burden to states for care of the severely mentally ill (Comptroller General of the United States, 1977). Noting the lack of an organized system of care for the chronically mentally ill, the report specified recommendations to federal agencies to better address the needs of the mentally disabled for adequate mental health care, social services, housing, vocational training, and income support.

Later in 1977, the NIMH launched the Community Support System Program, a pilot effort to address many of the shortcomings identified in the GAO report (Turner & TenHoor, 1978). The NIMH developed contracts with the states for demonstration projects involving treatment, rehabilitation, housing, and staff training in areas such as case management and social skills training (Cutler et al., 2003). Model programs, such as the Training in Community Living Program developed by Stein and Test in Madison, Wisconsin (Stein & Test, 1980), and Fountain House in New York City (Beard, 1979), served as examples of innovative efforts to create viable community alternatives to mental hospital treatment. Community Support System funding was short-term and did not continue into the 1980s.

The President's Commission on Mental Health

Soon after his inauguration in 1977, President Jimmy Carter established the President's Commission on Mental Health (President's Commission on Mental Health, 1978), designed to address the problems identified in the GAO report more broadly, including the unmet needs of high-risk groups such as the chronically mentally ill. The deliberations of the group, with members from government agencies and the mental health professions representing diverse perspectives on the etiology of mental illness and the role of prevention, resulted in the Mental Health Systems Act.

A national invitational conference on the chronic mental patient, held as part of the President's Commission, led to the development of the National Plan for the Chronically Mentally Ill. The Plan included recommendations to shift authority to localities for the provision of services to the chronically mentally ill, reallocate existing resources to fund a range of community-housing options using the voucher method, encourage private practitioners to become involved in the care of this population, and address the problem of discrimination against chronic patients in health insurance, housing, and employment (Talbott, 1979). Passed in the waning days of the Carter administration, the Mental Health Systems Act was promptly reversed by the Reagan administration in 1981. The Reagan administration's Omnibus Budget Reconciliation Act became law later that year with provisions for block grants to the states for mental health and substance abuse services, albeit with only 75 to 80 percent of what had been accorded to the Mental Health Systems Act. The new Reagan administration never endorsed the National Plan for the Chronically Mentally Ill (Grob, 2005, p. 425). In subsequent years, however, some of its recommendations regarding disability and medical insurance received federal support (Koyanagi & Goldman, 1991).

Homelessness and Mental Illness in the 1980s: The American Psychiatric Association Task Force Report

Despite the intense federal focus on the condition of the severely mentally ill in the late 1970s, the new decade began with mental health care largely left up to the states. The process of emptying state hospitals continued, with general hospital psychiatric services becoming the mainstay for episodes of illness experienced by state hospital discharges as well as those with an early episode of severe mental illness (Bachrach, 1981).

In the early 1980s, the United States experienced high unemployment, double-digit inflation, and gentrification of low-cost neighborhoods that reduced the availability of affordable housing—unwelcome conditions for people with disabilities trying to make a go of it in the community. During this time, reports of homeless and often mentally disturbed people wandering city streets or seeking shelter in public places were widespread across the nation (Baxter & Hopper, 1981; Carmody, 1981; Hombs & Snyder, 1982). A study of homeless people seeking assistance from a New York City emergency department revealed that most were mentally ill with psychiatric hospitalization histories (Lipton et al., 1983). A study conducted in a Philadelphia shelter for the homeless revealed a similarly high rate of mental illness among its residents (Arce et al., 1983). Although community-wide data were sparse, the mentally ill among the rising number of homeless poor existed in substantial numbers.

By 1983, the extent of the problem of homelessness among the mentally ill prompted the American Psychiatric Association (APA) to set up its Task Force on the Homeless Mentally Ill to assess the problem and devise a set of recommendations. Acknowledging psychiatry's responsibility to the mentally ill among the homeless (Lamb, 1984), its broad range of recommendations on services, training, and research included the development of supervised housing, and access to rehabilitation and psychiatric services provided through outreach when necessary (Lamb, 1984). In comments about the recommendations to the press, the APA declared that the practice of releasing people with mental illness from state mental institutions into communities that were poorly prepared to accept them had been a failure and "a major social tragedy." All levels of government, the profession of psychiatry, and mental health professionals were held to account for failing to provide adequate funding for health care and social services, and for shying away from caring for the most disabled patients (Boffey, 1984).

It was hoped that community mental health treatment would offer greater benefits than institutional care for the majority of patients with severe mental illness. While some had been able to live successfully in the community, the community service system had failed to respond to the service and support needs of a population suffering from serious and long-lasting mental disorders. Leona Bachrach (Bachrach, 1984) observed that, although the rise of homelessness among the severely mentally ill was linked to the policy of deinstitutionalization, the problem was not simply the policy itself but the absence of careful planning for the housing and service needs of discharged patients as the policy was implemented. There is no question that changes in the funding of mental health services and the increase in civil liberties for people with severe mental illness exerted a marked influence on the service system and how it was utilized.

The Young Chronic Patient and the NIMH Task Force Report

Barely two decades after the passage of the Community Mental Health Centers Act and the thrust toward deinstitutionalization, a new generation of young, severely mentally ill patients who had never set foot inside a state mental institution began to emerge. These post–World War II "baby boomers" (Bachrach, 1982) experienced illness onset at a time when long-term care provided by state mental hospitals was being replaced by acute-care services available in emergency departments, general hospital psychiatric units, and outpatient clinics. Findings from early studies of "young adult chronic patients" presaged the clinical and social issues that would challenge mental health professionals in years to come: the widespread use of alcohol and street drugs, frequent hospitalizations and use of crisis services, denial of illness and non-compliance with prescribed outpatient follow-up care, self-destructive behavior and violence, contact with the criminal justice system, and residential instability (Caton, 1981; Lamb, 1982; Pepper et al., 1981; Schwartz & Goldfinger, 1981; Sheets et al., 1982).

In the years that followed, homelessness continued to plague people with severe mental illness. In response, the NIMH established the Federal Task Force on Homelessness and Severe Mental Illness, involving federal departments responsible for aspects of service delivery to this population. The Task Force recommended greater collaboration of federal, state, and local governments, and a grants program was developed to encourage integrated systems of treatment, housing, and support (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

HOSPITAL CARE IN THE ERA OF COMMUNITY TREATMENT

The system of community mental health treatment that has evolved in the wake of deinstitutionalization is dominated by general-hospital mental health services funded by Medicaid and third-party payers. In many locales, state mental hospitals no longer exist. Surviving state facilities serve the forensic population and patients whose illnesses have not responded to services available in general-hospital psychiatric units (Fisher et al., 2009). In keeping with legal mandates, hospital admissions are restricted to people whose psychopathology indicates that there is a grave danger of self-harm or harm to others. Typically, people who do not meet hospital admission criteria are managed with psychiatric medications in emergency departments or outpatient clinics. Access to some general hospital psychiatric services is restricted by insurance type, or area of residence. The legacy of the Reagan administration's failure to endorse the National Plan for the Chronically Mentally Ill, turning public funding for mental health services over to the states through block grants, has resulted in wide variability across the 50 states in the quality and availability of mental health care (Aron et al., 2009) and lack of uniformity in implementing evidence-based approaches (Drake & Latimer, 2012).

Early studies of brief hospitalization[1] endorsed the merits of briefer hospitalization for most patients. Driven by financial pressures, the average length of a psychiatric hospital stay has been steadily eroded to days rather than weeks or months (Drake et al., 2003), with the limited objectives of crisis stabilization and safety concerns. There is heavy reliance on outpatient care to fully implement long-term medication treatment to achieve the goal of clinical and functional stability. Noting that the definitions of "brief hospitalization" in earlier studies were defined in terms of weeks with little correspondence to the current practice of limiting hospitalizations to days, Glick et al. (2011) have called for a reconsideration of current practices to ensure opportunities for sustained recoveries. A recent Cochrane review of the topic (Babalola et al., 2014) recommended a renewed effort to study the length of hospitalization for people with severe mental illness, investigating outcomes such as employment, criminal behavior, homelessness, treatment satisfaction, family relationships, and cost.

For the most part, the general-hospital psychiatric system of care is not geared to the long-term management of the social welfare needs associated with chronic and disabling conditions. Consequently, people with severe mental illness rely on multiple systems of care to meet their need for housing, income support, and an array of social and support services, which, to the individual, can upstage the need for mental health care.

Although civil commitment procedures can be implemented for mandatory hospitalizations and outpatient treatment when the safety and security of patients or members of the community are at risk, the notion of the right to refuse treatment has widespread currency in twenty-first-century America. Consequently, the system relies in large part on the personal responsibility of the individual in choosing whether to accept care and how to obtain it. Epidemiological studies reveal that many people with mental health problems do not seek treatment (Wang et al., 2005) or discontinue treatment after their initial contact with the service system and subsequently receive minimal mental health care (O'Brien et al., 2009).

Clinical studies of patients in routine-care settings reveal that the treatment received often fails to correspond to evidence-based practice guidelines. More than one-half of patients continue to experience significant symptoms and receive substandard care or no treatment (Mojtabai et al., 2009). Thus, the close monitoring required for effective pharmacological management is often undermined by widespread non-compliance with outpatient follow-up care, increasing the risk of relapse and rehospitalization.

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[1] Example of studies of brief versus standard hospitalization are Glick & Hargreaves, 1979, and Herz et al., 1979.

Comorbid substance use disorder is widespread among people with severe mental illness (Caton et al., 2007) and is associated with relapse, interpersonal and adjustment problems, arrests, detention in jails, and homelessness.

Concern for civil liberties has constrained options to enforce treatment in the absence of danger to self or others, leaving some severely ill people to muddle through life without help or support (Torrey, 2012). The problem is particularly acute in minority and impoverished communities. Jails and prisons now house thousands of people suffering from severe mental illness, of whom many also suffer from substance addiction and HIV/AIDS. The most disabled patients rotate through the "institutional circuit" of general-hospital emergency departments, homeless shelters, the streets, and jails (Greenberg & Rosenheck, 2008; Hopper et al., 1997).

MENTAL HEALTH CARE IN THE TWENTY-FIRST CENTURY: IMPLICATIONS FOR THE SEVERELY MENTALLY ILL

The second millennium began with legislative and court actions that provided greater security for people with mental illness to have access to the services they need. By 2000, the Americans with Disabilities Act (ADA) was in place, bolstered by the United States Supreme Court's decision in Olmstead *v.* L.C. affirming the ADA's rule requiring that people with disabilities be served in the most integrated setting consistent with their needs. Passage of the Mental Health Parity and Addictions Equity Act in 2007 mandated equity in coverage for treatment of mental illness within health insurance, and the Patient Protection and Affordable Care Act (PPACA) in 2010 expanded access to community-based services for homeless people with mental illness. Both the Surgeon General's Report on Mental Health (Surgeon General of the United States, 1999) and the President's New Freedom Commission on Mental Health (President's New Freedom Commission on Mental Health, 2003) endorsed the objectives of the nascent "recovery movement" in psychiatry. It remains to be seen, however, whether the provision of care through mainstream health care funding mechanisms can address the special needs of the severely mentally ill for the array of clinical, rehabilitation, social and welfare services, as well as housing required for them to achieve recovery and establish productive lives in the community (Frank & Glied, 2006; Hogan, 2014).

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Figure 1.1: The Hudson River State Hospital Kirkbride building, Poughkeepsie, New York. Now abandoned and in disrepair, the former New York State mental institution was in operation from 1871 to 2003. It is exemplary of the large-scale asylums that have been destroyed or shuttered in the era of community treatment (Kirkbridebuildings.com).

Photo credit: Ethan McElroy/KirkbrideBuildings.com

CHAPTER 2

Voluntarism and the Rise of Advocacy

Question: What are the key elements of successful advocacy to address homelessness?

The most important key is to keep it personal. Homeless children, homeless men, homeless women are human beings, not data points. Get their stories told, and their faces seen. And then, using whatever media is available, expose the need and underscore the solutions. Keep it simple, and if you can find a legal hammer to support the effort, use it. But sparingly.

Robert Hayes
President and CEO, *Community Health Network, New York, N.Y.;*
Attorney for Homeless Plaintiffs in Class Action Lawsuits to Increase Services
(Callahan *v.* Carey, *1979; and others); Founding Member, National Coalition for the Homeless*

Advocacy to address homelessness is challenging: the extreme poverty of those most directly affected typically translates into a lack of political power to make change. Critical to effective advocacy is rallying the support of those who do have political influence to work alongside and support those who are directly affected. Also critical is using a broad range of advocacy strategies, including lobbying policy makers at all levels of government, litigating to challenge unfair laws and to enforce legal rights, using the media to focus public attention, and using international human rights mechanisms to press our government to act. Creativity, persistence, and focus are essential.

Maria Foscarinis
Founder and Executive Director
National Law Center on Homelessness and Poverty;
Primary Architect, *Steward B. McKinney Homeless Assistance Act of 1987*

Political will invested in evidence-based, innovative ideas that speak the vernacular of cost efficiency and consumer preference shapes an approach to improve the lives of homeless people, community streets, and wary taxpayers.

Philip F. Mangano
President and CEO
The American Round Table to Abolish Homelessness
Former Executive Director, *United States Interagency Council on Homelessness*

The 1980s began with a recession that was marked by double-digit inflation, high unemployment, and increased hardship for those living near the poverty line (Burt, 1991). The severely mentally ill continued to be highly visible among the ranks of the homeless, which now included increasing numbers of people whose grip on residential stability was loosened by the economic downturn. The hardships of people without homes and the brutality of having nowhere else to sleep but public parks, transportation depots, and city streets was widely reported in the media (Carmody, 1981; Corry, 1983). Early studies of homeless people in New York City (Baxter & Hopper, 1981) and across the country (Hombs & Snyder, 1982), discussed the precipitants of housing loss, recommended remedies, and called for swift action. Their estimates of the prevalence of homelessness, 36,000 homeless people in New York City (Baxter & Hopper, 1981), and over 2 million nationwide (Hombs & Snyder, 1982, p. xvi) were disputed by some, but left little doubt that the problem of homelessness was deserving of the attention of policy makers, politicians, and the general public.[1]

Throughout the 1970s and early 1980s, the public response to homelessness was local. In some communities, voluntarism surged, and charitable organizations provided food, clothing, and blankets to people living in public spaces. In some cities, church basements and unused public buildings were hastily transformed to house the throngs of people seeking shelter. In other locales, vagrancy laws reminiscent of the nineteenth century were implemented, and the makeshift encampments of homeless people in parks and public spaces were destroyed or banned. By 1980, however, events in Washington, D.C., and New York City established advocacy as an abiding factor in the quest to end homelessness.

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[1] In 2001, a congressional directive for an annual report on the status of homelessness nationwide produced an annual count of the street-dwelling and sheltered homeless.

SHELTERING THE HOMELESS: ADVOCACY TAKES ON THE GOVERNMENT

With the numbers of street dwellers increasing, and no organized effort by governmental agencies to address the problem of homelessness, the concerns of ordinary citizens fueled a transformation from voluntarism to advocacy. Support of homeless people took different forms in Washington, D.C., and New York City, early centers of homeless advocacy.

Civil Disobedience and Confrontation in the Nation's Capitol: Mitch Snyder and the Community for Creative Non-Violence

Founded in 1970 by J. Edward Guinan, a former Catholic priest and chaplain at George Washington University, the Community for Creative Non-Violence (CCNV) began as a nonprofit that blended antiwar activism with advocacy for Washington's hungry and impoverished citizens. As the Vietnam War drew to a close, the group focused more intensively on the needs of people experiencing homelessness. The organization attracted dozens of volunteers, and within a few years it opened a soup kitchen, two hospitality houses for people awaiting trial, a free medical clinic, and an overnight shelter (http://theccnv.org/history.htm).

In 1974, Mitch Snyder joined CCNV and soon became one of its leaders. Throughout the 1980s, he became widely known nationally, giving voice to the movement in support of homeless people. He garnered considerable notoriety through his civil disobedience and is credited for his bold moves to awaken the nation to the plight of the homeless. As evidence of his celebrity, years later his life was the subject of a made-for-television film.

In 1978, the CCNV began holding an annual Thanksgiving dinner for the homeless and poor of Washington, D.C. It was held in Lafayette Park, across from the White House on Pennsylvania Avenue. In 1981, Mitch Snyder led a demonstration at the Thanksgiving dinner that included sleeping tents for homeless people to dramatize the fact that many were forced to sleep in parks, on the heating grates of local buildings, or in public spaces. The tent city that was created was called "Reaganville," to call attention to gaps in the new Reagan administration's public welfare policy. The Thanksgiving event captured considerable media attention in Washington and elsewhere (Associated Press, 1981).

The CCNV participants were permitted by National Park Police to serve the Thanksgiving dinner to several hundred needy people. The police warned, however, that overnight sleeping was prevented by national park policy. When CCNV did not comply with the warning, the police removed the group from the area. The CCNV initiated an appeal to the District Court on the basis that the sleeping ban violated First Amendment rights. The Court agreed, and the demonstration, including sleeping, was able to continue for several weeks over the winter months. Subsequently, the National Park Service revised its camping regulations for the National Capital Region to ban using park areas for living accommodations "regardless of the intent of the participants." The following year, CCNV planned a second demonstration including the erection of tents for sleeping. The challenge to the new national park guidelines eventually led to a United States Supreme Court decision (Clark *v.* CCNV, 1984) in support of the National Park Service.

Soon thereafter, Snyder and a group of homeless people entered and occupied an abandoned Washington building that was formerly the Federal City College. They did so as a challenge to the Reagan administration to acquire the Federal City College building and have it renovated for use as a shelter. Snyder undertook a highly publicized 51-day fast to call attention to the shelter issue. President Reagan responded on the eve of his reelection by allocating the building to the Government of the District of Columbia for its renovation and use as a shelter. The 1,350-bed shelter was opened in 1988, operated by CCNV with its comprehensive array of support services, with a restrictive covenant that it was to remain a shelter for at least 30 years.

CCNV activism continued for several more years. In 1986, CCNV members lived outdoors on the grounds of the U.S. Capitol during a five-month campaign for the passage of the Stewart B. McKinney Homeless Assistance Act. CCNV members also played a major role in organizing the 1989 National Housing Now march to demand affordable housing. After Snyder's death in 1990, CCNV held fewer public protests, focusing instead on operating the shelter.

Legal Advocacy in New York City: The Coalition for the Homeless and the Right to Shelter

In 1979, Robert Hayes, a young New York City lawyer employed by a Wall Street law firm, first became aware of the problem of homelessness through his acquaintance with men living on the street near his home. The men told him that living on the street was preferable to staying in one of the limited number of overcrowded shelters, which were both dangerous and filthy (Daley, 1987). Finding city officials unresponsive, Hayes brought a class action lawsuit (Callahan *v.* Carey, 1979) in New York State Supreme Court against the city and the state, contending that a constitutional right to shelter existed in New York State in connection with Article XVII of the New York Constitution, which states that "the aid, care, and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions . . ." (http://www.coalitionforthehomeless.org/our-programs/advocacy/legal-victories/the-callahan-legacy-callahan-v-carey-and-the-legal-right-to-shelter/).

In late 1979, the New York State Supreme Court ordered the city and state to provide shelter for homeless men, citing Article XVII in the New York State Constitution. Following negotiations between the plaintiffs and the government defendants, Callahan *v.* Carey was settled as a consent decree in 1981. The city and state agreed to provide shelter and board to homeless men who met the need standard of New York State for home relief, and who were homeless "by reason of physical, mental, or social dysfunction." In addition, the decree specified the minimum health and safety standards that must be maintained in shelters. Shortly thereafter, in a related class-action lawsuit (Eldredge *v.* Koch, 1983), the legal right to shelter was extended to homeless women.

The consent decree led to the development of a network of shelters under the auspices of the New York City municipal government, making New York City the only municipality in the nation with a legal right to shelter.[2,3] The Coalition for the Homeless, founded by Robert Hayes, Ellen Baxter, and Kim Hopper in 1981, was given the responsibility of monitoring the standards in shelters for homeless adults. The success of the New York legal challenge was a turning point in advocacy for the homeless. In 1981, advocates, activists, community-based and faith-based providers, and people who have experienced homelessness joined together to form the National Coalition for the Homeless, a nonprofit designed to conduct policy advocacy, public education, and grass-roots organizing to address the unmet needs of homeless people.

In the years following the Callahan consent decree, the Coalition for the Homeless has documented violations such as the lack of bed availability during the winter of 1996–1997 and in 2009 following the economic

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2. The lead plaintiff, Robert Callahan, was a homeless man afflicted with chronic alcoholism who slept nightly on the streets of the Bowery. Unfortunately, he died while sleeping rough on the streets of Lower Manhattan several months before the decree was signed.

3. Currently, in Washington, D.C., a right to shelter exists if the temperature falls below 32 degrees; in Massachusetts, families have a right to shelter.

recession; a 1999 attempt by the city to modify the decree to terminate or deny shelter to those who were non-compliant with social service plans and administrative rules; and a 2011 attempt by the Bloomberg administration to implement new shelter eligibility rules that threatened to deny shelter to many applicants for technical reasons, such as the inability of a homeless person to provide a complete one-year housing history, unless a family member with whom the homeless person had lived stated verbally and in writing that the person can no longer live in their home, or if a person who suffers from a physical or mental disability fails to undergo an evaluation for the impairment. The latter challenge to Callahan *v.* Carey resulted in a court action by the Coalition in collaboration with the Legal Aid Society. In addition to legal advocacy, the Coalition for the Homeless provides food, crisis services, housing, and job training to homeless New Yorkers.

The Law and Mentally Disturbed Street People: The Self-Advocacy of Joyce Brown

A New York City case involving a homeless woman with severe mental illness is illustrative of the dilemma of how best to deal with mentally disturbed people living in the streets and back alleys of cities and towns across America. The Homeless Emergency Liaison Project (Project HELP), a New York City mobile outreach unit providing crisis medical and psychiatric care to homeless people, was initiated in 1982. A unique characteristic of Project HELP was its authority to transport a mentally ill person determined to be at imminent risk of harm to self or others to an emergency department for a psychiatric evaluation. The authority to provide this service was granted by the New York City Commissioner of Mental Hygiene and was consistent with Section 9.37 of the New York State Mental Hygiene Law (Cohen et al., 1984).

In October 1987, New York City mayor Ed Koch announced a new policy applicable to mentally disturbed homeless people who were living on the streets. Based on section 9.37 of the New York State Mental Hygiene Law, the new program could involuntarily hospitalize people who were determined to be dangerous to themselves or others. The city established a 28-bed psychiatric unit at Bellevue Hospital for this purpose.

The first person under the new policy to be picked up by the outreach team and transported to Bellevue Hospital was a woman by the name of Joyce Brown (a.k.a. “Billie Boggs”) a former secretary with a history of substance abuse, assaultive behavior, a prior psychiatric hospitalization, and a five-year history of homelessness. Brown had been living on a hot air vent on Manhattan's East Side for about a year. She was committed to the hospital for allegedly running into traffic, exposing herself to passersby, making threats, and living in her own excrement. She was well known to the Project Help team, who had had contact with her on several occasions. When taken to the emergency department previously, however, doctors refused to hospitalize her, contending that she was not a danger to herself (Barbanel, 1987).

Under New York State law, a person experiencing an involuntary hospitalization is entitled to a prompt hearing before a state judge. Brown requested such a hearing, which was held before Justice Robert Lippmann of the State Supreme Court in a special courtroom located within the hospital. Robert Levy of the New York Civil Liberties Union (NYCLU) defended Brown. City psychiatrists characterized Brown as severely mentally ill and impaired to the degree that she was completely unaware of her illness. She refused to take psychiatric medications. In contrast, Brown's lawyer characterized her as an eccentric who wanted to live on the streets and be left alone (Barbanel, 1987).

During Brown's later commitment trial, Dr. Francine Cournos of the Columbia University Department of Psychiatry testified that Brown was mentally ill, but could present herself in a coherent way. She concluded that involuntary medication would not be effective in her case and it was not good to force her to do it[4] (Cournos, 1989). In January 1988, State Supreme Court justice Irving Kirshenbaum ruled that New York City could not forcibly medicate Brown. Shortly thereafter, acting State Supreme Court justice Robert Lippmann ordered Brown released, contending that although she was mentally ill, her behavior was not immediately dangerous to anyone. After nearly 11 weeks of confinement, Brown was released to the streets.

The Joyce Brown incident gained national attention when she became the first person to be involuntarily hospitalized under the new Koch administration policy. Brown was invited to Harvard University Law School, along with her lawyers, to lecture on the plight of homeless people, and she appeared on television in *60 Minutes* and the *Phil Donahue* program (Barbanel, 1988). Later she was arrested more than once on drug possession charges, but she was able to achieve stable residence at the Traveler's Hotel, a supervised residence for formerly homeless women (McQuistion, 1988).

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[4] Francine Cournos, personal communication, June 23, 2015.

Advocacy as a Spur to Federal Legislation: The McKinney-Vento Homeless Assistance Act of 1987

In the early 1980s, Maria Foscarinis, a young lawyer working for a New York City law firm, became involved with the Coalition for the Homeless. A pro bono case involving a homeless family in Nassau County that was denied shelter influenced the course of her career. In 1985, Foscarinis relocated to Washington, D.C., to establish an office for the National Coalition for the Homeless. Advocacy in the nation's capital was deemed important because the Reagan administration did not view homelessness as a national problem. Although a federal task force on homelessness was established in 1983 to provide information to local governments on how to obtain surplus federal property for the homeless problem, there was no attempt to address homelessness with new programs or policy initiatives.

Foscarinis led the campaign that produced the McKinney-Vento Homeless Assistance Act. She lobbied members of Congress, and by 1986 she put together a draft bill—The Homeless Persons Survival Act. The three elements of the bill were emergency shelter, homelessness prevention, and long-term solutions. Then Foscarinis worked to get support for the draft bill across the country, tutored in part by a law firm lobbyist introduced to her by Mitch Snyder. Only pieces of the proposed legislation were enacted into law, such as the Homeless Eligibility Clarification Act, which reformed existing laws by removing permanent address requirements and other barriers as eligibility for federal programs such as Supplemental Security Income (SSI), veterans' benefits, the food stamp program, and Medicaid (Foscarinis, 1996). In 1986, the Homeless Housing Act was also passed, creating the Emergency Shelter Grant Program and a demonstration program for transitional housing, administered by the Department of Housing and Urban Development (National Coalition for the Homeless, 2006).

Later that year, Foscarinis and Mitch Snyder put together a larger blueprint that contained Title I of the Homeless Persons' Survival Act (provisions for shelter, food assistance, health care, and transitional housing), which eventually became McKinney-Vento. During the winter of 1986–1987, advocates launched "an intensive legislative campaign" (Foscarinis, 1996, p. 161) in which supporters across the country were urged to lobby their legislators to endorse the bill. In an effort to call attention to the need for legislation to support homeless people, Mitch Snyder led a group that camped out in the nation's capital. With effective lobbying and bipartisan support, both houses of Congress passed the legislation in 1987, and President Ronald Reagan signed it into law in July of that year. The act was renamed the Stewart B. McKinney Homeless Assistance Act, in honor of the late Republican sponsor of the bill, a representative from Connecticut.[5]

The Stewart B. McKinney Homeless Assistance Act was the initial federal legislative action to address homelessness, and it remains the primary source of federal funding for programs serving homeless people.[6] The original McKinney Act consisted of 15 programs providing an array of services, including emergency shelter, transitional housing, food assistance, job training, primary health care, education, and permanent housing (National Coalition for the Homeless, 2006). Various federal agencies, such as the Federal Emergency Management Agency (FEMA), the Department of Housing and Urban Development (HUD), the Department of Health and Human Services (DHHS), and the Veterans' Administration (VA), implement the McKinney Act's many programs. The Act established the Interagency Council on Homelessness as an independent entity within the executive branch of the federal government (later made part of the Domestic Policy Council of the White House), consisting of the directors of federal agencies providing services to homeless people. Since the passage of the McKinney Vento Homeless Assistance Act, there have been many amendments and changes and funding priorities (Foscarinis, 1996; National Alliance to End Homelessness, 2015; National Coalition for the Homeless, 2006). Current funding is markedly greater than it was in 1987, but some aspects of the program have not survived or have received reduced funding (National Coalition for the Homeless, 2006). Challenges presented by the persistence of homelessness into the twenty-first century have necessitated continued advocacy to protect the legislative gains and address the unfinished task of ending and preventing homelessness.

THE PERSISTENCE OF HOMELESSNESS AND THE PERMANENCE OF HOMELESS ADVOCACY

A Shelter Is Not a Home: Is Decent Housing a Basic Human Right?

Despite the successes achieved in Washington, D.C., and New York City, gaining access to crisis shelter care for homeless people, although

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[5] In 2000, President William Clinton renamed the legislation the McKinney-Vento Homeless Assistance Act, after the death of Representative Bruce Vento, a leading sponsor of the bill.

[6] The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the Department of Health and Human Services, sponsors a number of mental health and substance abuse treatment programs for services to people at risk of, or experiencing, homelessness.

important, is not a solution to the problem of homelessness (Hopper & Barrow, 2003). It soon became clear that people were languishing in shelters, with limited opportunities to obtain permanent housing. In New York City, a class-action lawsuit on behalf of homeless mentally ill people (Koskinas *v.* Cuomo, 1993) was filed to compel the New York City Health and Hospitals Corporation to implement the individual service plans of mentally ill patients ready for hospital discharge under Mental Hygiene Law 29.15. This law stated that, at the point of discharge from the hospital, it was the responsibility of the hospital to ensure that the service plans addressed a patient's need for access to adequate and appropriate housing in the community. The New York State Supreme Court affirmed the order of the Appellate Court that the responsibility of implementing Mental Hygiene Law 29.15 fell to the New York City Health and Hospitals Corporation. However, the Court determined that "neither the statute nor the affirmed judgment imposes upon the Health and Hospitals Corporation the explicit duty to build, create, supply, or fund such housing" (Koskinas *v.* Cuomo, 1993).

The observation that crisis shelters were merely a stopgap measure with no possibility of permanent homes for the homeless made the achievement of legislative support for shelters and temporary housing a Pyrrhic victory. Moreover, in the 1980s, federal funding for housing had been sharply reduced, resulting in a lack of low-income housing nationwide. The belief that "all human beings have the right to a basic standard of living that includes safe, affordable housing" (mission statement, National Law Center for Homelessness and Poverty, www.nlchp.org; see also Hartman, 1998) has motivated advocates to press for policies that would not only increase the availability of low-cost housing, but would also assist people on entitlements or limited income to obtain stable housing. Despite the lack of national consensus that housing is a human right, the belief that permanent housing is the solution to homelessness has stimulated the development of an array of innovative housing opportunities and has given rise to permanent supportive housing for people with severe mental illness (see chapters 6 and 7).

Advancing the Unmet Needs of the Poor and Homeless

In the years following the passage of the McKinney-Vento Homeless Assistance Act, advocacy organizations with a national reach have become firmly established as essential actors in the development of homeless and housing policy and advocacy at all levels of government.

National Alliance to End Homelessness

In 1983, a citizens group of five Washington, D.C., individuals representing both political parties, including local leaders, a rabbi, and Susan Baker (the wife of James Baker, former Secretary of State in both the Reagan and first Bush administrations), came together to address the newly emerging problem of homelessness. Named "the National Citizens Committee for Food and Shelter," it was viewed as a stopgap effort that would outlive its purpose when homelessness subsided with an improved economy. The Committee was able to obtain excess commissary goods and blankets to distribute to people sleeping in public places, and a food bank was established. The group was later renamed the Committee for Food and Shelter.

By 1987, with homelessness still common, the organization became "the National Alliance to End Homelessness," with the chief goal of developing housing solutions. Over the years, the National Alliance has become a leader in advocating for improved federal policy by actively engaging in the legislative process. In the development and analysis of enacted and proposed legislation, the Alliance works collaboratively with colleagues in the public, nonprofit, and private sectors to advocate for policy solutions to homelessness. Another objective of the Alliance is to assist communities to turn policy solutions into real-world programs by providing capacity-building on best practices, technical assistance, and training through its Center for Capacity Building. The Alliance's Homelessness Research Institute is intended to foster the intellectual capital around solutions to homelessness developed through research to inform policymakers, service providers, and the general public about trends in homelessness and emerging best practices (www.endhomelessness.org). In 2000, the Alliance's policy initiative, focused on chronic homelessness, influenced the development of the federal initiative to "End Chronic Homelessness in Ten Years" (see Chapter 8).

The National Law Center for Homelessness and Poverty

Buoyed by the success of the McKinney-Vento Homeless Assistance Act, Maria Foscarinis founded the National Law Center for Homelessness and Poverty in 1989 to "use the power of the law to advocate for the legal rights of homeless and economically vulnerable people" (www.nlchp.org). The nonprofit she developed gave her the opportunity to address the many obstacles on the long journey to improving the lives of people experiencing economic hardship and homelessness. Effective advocacy by the National Law Center prompted Congress to pass the Protecting Tenants at Foreclosure Act in 2009, which prevents the abrupt eviction of tenants living in foreclosed properties, allowing them time to find alternative housing. The National Law Center has challenged voter-identification laws in Indiana and Wisconsin preventing homeless people without valid IDs from exercising their constitutional right to vote (www.nlchp.org).

A major advocacy effort of the National Law Center is focused on addressing the criminalization of homelessness and protecting the civil rights of homeless people. Homeless people are often treated as criminals because they live in public places, even when no alternatives exist. In many American cities, it is a crime to sleep in public places. Loitering in public places, panhandling, and begging are also prohibited in many locales (www.nlchp.org). Because criminalization is damaging, expensive, and hampers integration into job and housing opportunities, the National Law Center urged the Interagency Council on Homelessness to encourage cities to pursue constructive alternatives to criminalization. In addition, the National Law Center persuaded the United Nations Human Rights Council to adopt its recommendations condemning state and local laws in the United States that criminalize homeless people. Recently, the United States Department of Justice declared criminalization of homeless people to be unconstitutional. The National Law Center has advocated for the federal government to use the power of the purse to prevent criminalization. HUD could, for example, use their funding authority to prevent criminalization.[7]

National organizations such as the National Law Center, the Coalition for the Homeless, and the National Alliance to End Homelessness often work together and involve advocacy groups across the nation in efforts to address the housing needs and civil rights of homeless and impoverished people. Moreover, the importance of public funding for housing and services has made advocates of service providers as they strive to obtain funding in routine budget requests from state and municipal governments.

THE MEDIA'S ROLE IN ADVOCACY

For more than a century, the general public has been exposed to the problem of homelessness in the writings of celebrated American authors (Kennedy, 1979; London, 1907; Riis, 1890). Homelessness has been explored in scores of journalistic accounts in the print media, television, and film in the post-deinstitutionalization era, beginning in the 1980s (Carmody, 1981; Finder, 1984; Kerr, 1985; Levine, 1984; Nelson, 1983), and continuing to the present

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[7] Personal communication, Maria Foscarinis, September 4, 2015.

(McCoy, 2015; Nagourney, 2015; Reuters, 2015; Stewart, 2015). There is little doubt that the focus on homelessness by the media has played a role in advocacy by informing the public about the nature of homelessness, factors in its genesis, proposed solutions, and obstacles to bringing about successful resolutions. Television and film accounts of the experience of homeless people provide vivid illustrations of how mental illness can interfere with functioning and, if left untreated, lead to homelessness. In Tim Hunter's 1993 film, *The Saint of Fort Washington*, Matt Dillon portrays a young man with schizophrenia who is kicked out of his home and ends up in a homeless shelter. Joe Wright's 2009 film, *The Soloist*, is a true story of Los Angeles journalist Steve Lopez's reporting on the life of Nathaniel Ayers, a homeless street musician and Juilliard dropout who suffers from schizophrenia.

ADVOCACY IN THE TWENTY-FIRST CENTURY: A COLLABORATION OF THE CONCERNED

No longer the purview of a single organization, group, or individual, advocacy on behalf of the homeless, poor, and disabled has become the cause of many. The synergy created by the collective efforts of advocacy organizations, the media, law, and concerned citizens constitutes an effective force for bringing about change. The case involving the severely mentally ill residing in New York State adult homes is illustrative.

In the years following deinstitutionalization, thousands of former state hospital patients, mostly from impoverished and minority communities, were placed in privately operated and state-regulated adult homes. Some residents also had histories of street and shelter living. Operated for-profit as business enterprises funded with public dollars, a typical facility provided room and board to hundreds of people. Adult home staff lacked clinical training, although they were charged with dispensing medications and overseeing the welfare of people with severe disabilities and extensive psychiatric and medical histories.

In 2001, the *New York Times* began a year-long study of adult homes in the New York City area, involving site visits to adult homes, interviews with residents, staff, and family members, and a review of annual state monitoring and inspection reports (Levy, 2002). The investigation revealed a litany of environmental offenses, neglect and abuse of adult home residents, and a shockingly high death rate, prompting the *New York Times* reporter to conclude that many of the adult homes "have devolved into places of misery and neglect, just like the psychiatric institutions before them" (Levy, 2002).

Soon after the *New York Times* investigation was published, Disability Advocates, an organization representing people with mental disabilities, filed a court action against New York State's governor and other state officials (Petrila, 2014). The Court action invoked the Rehabilitation Act of 1973 and the Olmstead *v.* L.C. (1999) decision regarding the Americans with Disabilities Act of 1990 (ADA) specifying the state's obligation to provide care in the most integrated community setting possible. In 2009, United States District Court judge Nicholas G. Garaufis ruled that New York State had violated the ADA and the Rehabilitation Act and ordered that all affected individuals who desired a placement in supportive housing be given one. In directing New York State to create housing, Judge Garaufis's decision challenged whether Olmstead *v.* L.C. could be used to require states to create housing when it would represent a fundamental change of state policy or services. Consequently, New York State appealed the decision. The Federal Court of Appeals for the Second District reversed Judge Garaufis's decision, contending that Disability Advocates lacked proper legal standing, releasing New York State from any obligation to create housing for adult home residents (Petrila, 2014). Later, the United States Department of Justice (DOJ) announced that it intended to bring a new action against New York State, requesting the same remedy as that of Judge Garaufils (United States *v.* State of New York, 2014). In 2014, more than a decade after the publication of the *New York Times* investigation, the State of New York agreed to a settlement decree for the creation of supportive housing and other community services for nearly 4,000 individuals residing in 23 large New York City adult homes (Petrila, 2014).

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CHAPTER 3

Homeless People with Severe Mental Illness

People with severe mental illness have the types of psychiatric disorders that would have typically placed them in a state mental institution in the era of the asylum. It has been noted that at the dawn of the twenty-first century, over 95 percent of those who were or would have been in government psychiatric hospitals were then "living in the community" (Frese et al., 2009).[1] Despite the burden of illness associated with these disorders, opening the doors of the asylum has given many an opportunity to develop productive lives in the community. For others, however, life in the community has posed insurmountable challenges, among which homelessness looms large.

A homeless person is defined by the U.S. Department of Housing and Urban Development (USDHUD) as an individual who lacks a fixed, regular, and adequate nighttime residence, but instead has a primary nighttime residence in a place not designed for or ordinarily used as a regular sleeping accommodation, such as a car, park, abandoned building, bus or train station, airport, camping ground, publicly or privately operated shelter, transitional housing, or a hotel or motel paid for by the government or a charitable organization. In addition, a person is considered homeless if discharged from an institution where he or she has been a

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[1] Affective and non-affective psychotic disorders such as schizophrenia, bipolar disorder, major depression, and obsessive compulsive disorder have the potential to interfere with functioning in social and occupational roles and can recur over time and become chronic (Insel, 2011).

resident for 90 days or less and resided in a shelter or place not meant for human habitation immediately prior to entering that institution. Moreover, a person is considered homeless if evicted within 14 days from a primary nighttime residence and no subsequent residence has been identified, or lacks the resources or support networks needed to obtain other permanent housing (USDHUD, 2011). Homelessness is a common experience among people with severe mental illness, even though it is unlikely that mental illness alone is a risk factor for housing loss (Sullivan et al., 2000). While all homeless people share a need for an adequate and stable residence, the nature of severe mental illness imposes needs that set people with these conditions apart from those whose homelessness is due primarily to economic and social disadvantage (Shinn & Weitzman, 1996).

The prevalence of homelessness in a sample of over 10,000 patients with serious mental illness in a California mental health system revealed that 15 percent had been homeless in the period of one year (Folsom et al., 2005). Of the 564,708 people in the United States who are homeless on any one night (USDHUD, 2015), it is estimated that one-quarter to one-third have a serious mental illness (SAMHSA, 2011; https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers). Men far outnumber women in this population, accounting for between 60 and 75 percent of the single adult homeless population (Burt et al., 2001; North et al., 2004; SAMHSA, 2014). The majority of these people are between 24 and 50 years of age (SAMHSA, 2014).

POVERTY, DISADVANTAGE, AND ISOLATION

Poverty and social disadvantage are inveterate fellow travelers with homelessness. People with severe mental illness whose childhoods are marked by these characteristics constitute a very high-risk group. Homeless people in general are extremely poor; their average monthly income in 2015 was less than 350 dollars. Over 25 percent indicate that they do not get enough to eat (National Law Center, 2015). Early lives of social disadvantage and academic underachievement, and limited opportunities for gainful employment in adulthood are common. Among homeless people with severe mental illness, one-quarter to one-half have not completed high school. Unemployment is rife, often exceeding 80 percent (Burt et al., 2001; Caton et al., 1994; Caton et al., 1995; North et al., 2004). Thus, they are dependent on Supplemental Security Income (SSI), which averaged $733 a month ($8,796 annually) in 2016. (https://www.ssa.gov/OACT/COLA/

SSI.html), hardly adequate to sustain a home in the community without additional help.

Minorities are overrepresented among the ranks of the homeless, particularly those who are African-American.[2] Currently, African-Americans are three times as likely as whites to live in poverty (www.pewsocialtrends.org/2013/08/22/rce-demographics/), so it is not surprising that their vulnerability to homelessness is greater. The social disadvantage of African-Americans is deeply rooted in American history, and homelessness in one form or another has been part of the African-American experience from the Civil War through Reconstruction, the black migration north, the Great Depression, urban renewal, and the deindustrialization of the American economy (Hopper & Milburn, 1996, p. 126; Johnson, 2010).[3]

Typically, people with severe mental illness are homeless alone, having divorced, separated, or never married (Burt et al., 2001, p. 58; Caton et al., 1994; Caton et al., 1995; North et al., 2004). Although the majority of newly homeless men and women live in family settings prior to becoming homeless (Caton et al., 2005), the toll of psychiatric disability and addictions on family relationships leaves many with limited support over time.

The era of community-based care has seen greater numbers of men and women with severe mental illness experiencing parenthood (Barrow et al., 2014; Caton et al., 1999; David et al., 2011). The fertility rate of people with schizophrenia, for example, far below that of the general population prior to the late 1950s, increased to a level approaching that in the general population following deinstitutionalization (Erlenmeyer-Kimling et al., 1969; Shearer et al., 1968). While parenting holds out the opportunity for a valued life experience, the chronic and relapsing nature of severe mental illness often means separation from children and loss of custody, particularly in the presence of homelessness (Barrow et al., 2014).

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2. The National Survey of Homeless Assistance Providers and Clients (Burt et al., 2001) reported that, among the single adult homeless, 43 percent of men and 36 percent of women were black. In the PATH National Profile Report (SAMHSA, 2014), 37 percent of sheltered homeless people were black/African-American. The proportion of Hispanic background in both studies was 10–12 percent. Higher percentages of homeless minorities are found in areas of the county where blacks and Hispanics make up a larger percentage of the population. In New York City in 2015, 62.1 percent of single adults in shelters were African-American; 23.8 percent were of Hispanic background (www.dhs.nyc.gov).

3. These authors elaborate on possible reasons for greater homelessness among African- Americans, such as globalization and its impact on the labor market, a constriction of the ability of the typical African-American family to offer shelter and alms to extended kin, and the decline in the low-cost housing stock.

THE INTERRELATIONSHIP OF MULTIPLE RISKS FOR HOMELESSNESS

Childhood Adversity

Childhood adversity increases the risk of later homelessness (Roos et al., 2013) and is intricately tied to a cluster of high-risk behaviors in the lives of homeless adults. Common in the early life experiences of homeless adults are extreme poverty, household mobility, inconsistent parenting, and abuse. Out-of-home placement in childhood (Caton et al., 1994; Koegel et al., 1995; Park et al., 2005; Patterson et al., 2015; Susser et al., 1991; Tsai et al., 2011), parental and family instability (Caton et al., 1994), and poor care from a parent (Herman et al., 1997) are well documented in the lives of homeless people, including those with severe mental illness. About one-quarter to one-third of homeless adults experienced foster care placement in childhood (Burt et al., 2001; Park et al., 2005; Patterson et al., 2015; Susser et al., 1991; Zlotnick, 2009; Zlotnick et al., 1999; Zugazaga, 2004). In addition to being predictive of a longer duration of adult homelessness, childhood adversity is associated with a host of psychological, social, and health outcomes in adulthood, including incomplete high school (Patterson et al., 2015), reduced labor force participation (Patterson et al., 2015; Tam et al., 2003), early initiation into the use of alcohol and drugs (Patterson et al., 2014), substance abuse (Rosenberg et al., 2007), poor mental health (Rosenberg et al., 2007), criminal justice involvement and incarceration (Desai et al., 2000; Rosenberg et al., 2007; Saddichha et al., 2014), victimization (Roy et al., 2014) and HIV risk (Caton et al., 2013; Rosenberg et al., 2007).

Substance Abuse

People with severe mental illness are at increased risk for use of tobacco, alcohol, cannabis, and recreational drugs (Hartz et al., 2014), and their rate of substance abuse is greater than that of the general population (Davis et al., 2012; Kessler, 1995). The prevalence of alcohol and drug use comorbidity among people with severe mental illness who are homeless can far exceed that, particularly for those whose homelessness is chronic (Burt et al., 2001). Substance use disorder is the single most important factor that distinguishes homeless people from the never homeless (Caton et al., 2000; Fazel et al., 2008), including those with severe mental illness (Caton et al., 1994; Caton et al., 1995; Drake et al., 1991; Early, 2005; Folsom et al., 2005; Susser et al., 1991; Whaley, 2002). In studies focused exclusively on people with severe mental illness, substance use disorder is greater among homeless men and women compared to a matched control group of people with severe mental illness who had never been homeless (Caton et al., 1995; Caton et al., 1994). Severity of alcohol use disorder and an early age of onset of drug use disorder are associated with chronic homelessness (North et al., 1998).

Violence and Victimization

Most people with severe mental illness are not violent, and violence by people with severe mental illness contributes little to the overall rate of violence in the community. A review of violence among people with severe mental illness did indicate, however, that violence perpetration is more common among people with severe mental illness compared with the general population (Choe et al., 2008). Rates of perpetration were highest among committed inpatients, whose violent acts were likely to have preceded an involuntary hospitalization. During an episode of psychosis, particularly if accompanied by paranoia and command hallucinations, the risk of violence is greater among people with severe mental illness (Insel, 2011). In the presence of substance use disorder and poor adherence to medication treatment, the risk of violence can be increased substantially (Swanson, 1994; Swartz et al., 1998).

Violent victimization is more common among people with severe mental illness than in the general population. Studies of patients with severe mental illness indicate that 25 to 35 percent had been a victim of violence in the past year (Choe et al., 2008; Teplin et al., 2005). Compared to the general population, the one-year rate of victimization among people with mental illness is 11 times higher (Teplin et al., 2005). There is a high incidence of victimization among homeless people associated with their lifestyle and marginality (Lee & Schreck, 2005). Victimization among homeless people with severe mental illness is higher than that found among housed adults with severe mental illness (Roy et al., 2014). Moreover, homeless women are more likely to be victims of violent crimes such as physical abuse and sexual assault (Brunette & Drake, 1997; Cheng & Kelly, 2008; Sullivan et al., 2000).

Criminal Behavior

The presence of large numbers of mentally ill people in prisons and jails has aroused concern that these settings are becoming de facto mental institutions, and that they are unprepared to meet the multiple service needs of this population (McNeil et al., 2005; National Public Radio [NPR] Staff, 2013; Williams, 2015). Others declare that homeless people are unfairly criminalized for attempts to obtain food, shelter, or medical attention and are inappropriately charged by the criminal justice system. A national study of nearly 7,000 jail inmates found that about 15 percent reported an episode of homelessness in the previous year. Compared to the larger, non-homeless group, those who had been homeless were more likely to have been arrested for a property crime. They were also more likely to have had criminal justice involvement in the past for both violent and nonviolent offenses. Other distinguishing characteristics of homeless individuals included mental health and substance abuse problems, less education, and unemployment (Greenberg & Rosenheck, 2008).

Conduct disorder in the early lives of homeless people with severe mental illness increases the risk of later homelessness (Caton et al., 1994; Caton et al., 1995; North et al., 1998) and criminal justice involvement (Desai et al., 2000). A systematic review of 15 studies of criminal behavior and victimization among homeless individuals with severe mental illness revealed that lifetime arrest rates ranged from 62.9 percent to 90 percent, conviction rates ranged from 48 percent to 67 percent, and incarceration rates ranged from 21.1 percent to 80 percent (Roy et al., 2014). A study linking mental health and jail records allowed researchers to compare people with mental illness who experienced incarceration with those who did not. The risk factors for incarceration included having had a previous incarceration, co-occurring substance use disorder, being male, and being homeless (Hawthorne et al., 2012). Another study of predictors of incarceration among urban adults with co-occurring severe mental illness and substance use disorder found that having had a prior incarceration predicted new episodes of incarceration during a three-year study period. A decreased likelihood of incarceration was found among those who had forged friendships with individuals who did not use substances, and those who were engaged in substance abuse treatment (Luciano et al., 2014).

Medical Comorbidities

High exposure to tobacco, alcohol, illicit drugs, violence and victimization, and street and shelter living increase the vulnerability to diseases and conditions that increase the risk of early mortality (Fazel et al., 2014). Excessive mortality results from infectious diseases like tuberculosis (TBC), human immunodeficiency virus (HIV), and hepatitis C (HCV), injuries resulting in traumatic brain injury, suicides, homicides, and accidental overdoses. The age-adjusted death rate for homeless men and women is two to five times higher than the general population's (Baggett et al., 2013; Barrow et al., 1999; Fazel et al., 2014; Hwang, 2000). Mortality among homeless women and men under age 45 is nine to ten times higher than the general population's (Baggett et al., 2013; Cheung & Hwang, 2004). Drug overdoses and HIV/AIDS have been common causes of death in this age group, underscoring the need for treatment of substance use disorder and efforts to prevent and treat HIV/AIDS. The high rate of psychiatric disorders and the risk for suicide underscore the need for improved access to mental health care (Baggett et al., 2013; Cheung & Hwang, 2004).

Infectious Diseases

Tuberculosis incidence is about ten times greater among people who experience homelessness, and treatment in this group is compromised by lack of compliance as well as substance abuse (Bamrah et al., 2013). Testing for HIV requires informed consent, making it more difficult to obtain accurate estimates of HIV prevalence (Caton et al., 2013). A study of homeless patients admitted to a New York City psychiatric inpatient unit found an HIV seroprevalence rate of 6.4 percent, using anonymous discarded blood samples. Seropositivity has been found to be greater among people who were younger and who used injection drugs (Empfield et al., 1993). Infections such as HIV, HBV, and HCV are a threat to homeless people with severe mental illness, particularly if they are intravenous drug users or engage in unprotected sex (Caton et al., 2013; Rahav et al., 1998). Co-infection of HIV and TBC among homeless people with mental illness often occurs (Haddad et al., 2005; Saez et al., 1996). A study of people with severe mental illness and substance use comorbidity found that about 6 percent were HIV-positive, and slightly under half were positive for either HBV or HCV (Klinkenberg et al., 2003).

CASE NARRATIVES

Susan M. Barrow[4]

The interrelationship of risks for homelessness among people with mental illness is reflected in their complex life trajectories. While any given

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[4] A qualitative pilot study of "Pathways to Shelter" was funded by the Columbia University Center for Homelessness Prevention Studies to inform efforts to develop

episode of homelessness may have a particular precipitant, the many factors that destabilize lives and conduce to homelessness become visible over the course of time. In an Institutional Review Board approved pilot study of pathways into men's and women's shelters for unaccompanied adults in New York City, narrative interviews revealed both the specific event or circumstance—an eviction, a fire, a falling out with relatives—that brought individuals into shelter, as well as the larger life contexts in which such events were embedded. The three abbreviated narratives that follow offer specific examples of how abstractions like homelessness, mental illness, childhood adversity, medical comorbidities, substance abuse, and family disruptions intersect in the lived experience of individuals. Pseudonyms are used to protect participants' privacy.

Jeanette

Jeanette, a 46-year-old African-American woman, arrived at the women's shelter after a fire destroyed her apartment building. This was not her first shelter stay. Within the past ten years, she had twice before stayed in shelters as she struggled with overcrowded and dangerous housing, several chronic health conditions, and schizophrenia.

Jeanette grew up in the Bronx with her parents and seven younger siblings, but says, "I started living with my grandmother [next door] when I was 12 years old because I had seizures and my mother couldn't take it." While the seizures have continued, Jeanette now also contends with asthma, type 2 diabetes, hypertension, and arthritis. Since coming to the shelter, she has experienced several panic attacks.

Jeanette has been married for 28 years. Her husband moved in with her at her grandmother's apartment. Over the next 20 years they raised two children there, while he worked in construction and she had periodic jobs in retail and as a home health aide. The two-bedroom apartment was crowded, accommodating Jeanette's grandmother, the couple, their two children, and eventually her daughter's first child. When Jeanette's

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preventive interventions to avert homelessness among single adults. Consecutive samples of 40 adults (24 men and 16 women) who resided in upper Manhattan prior to entering New York City single-adult assessment shelters consented to participate in the study. In-depth interviews lasting 90 minutes on average elicited detailed narratives of family, residential, employment, health, and mental health histories, as well as demographic information, current mental health symptoms, experiences in shelters, and expectations for the future. Diagnoses of serious mental disorders (bipolar disorder, schizophrenia, major depression) were reported by 23% of participants. The portraits presented here were drawn from this group and were selected to exemplify how factors identified in epidemiological studies play out in individual lives.

grandmother died, the family lost the apartment and entered a family shelter for a few weeks, then moved to an apartment in upper Manhattan where they remained for about six years. The building was a magnet for squatters and drug dealers, and was infested with rats and other vermin. Once Jeanette was robbed at knifepoint. There were winters without heat, and months with no elevators or electricity. Jeanette's daughter became pregnant with her second child and moved with her children to an apartment in the Bronx, but Jeanette, her husband, and her son remained.

During this time, Jeanette began to hear voices, and her husband's aunt encouraged her to go to a psychiatric emergency room. She was admitted to the hospital and was diagnosed with schizophrenia. After discharge two weeks later, she returned to the apartment, where conditions continued to deteriorate. She began to withhold her rent and took her landlord to court, but she lost the case and was evicted. Her daughter found the family an apartment in the Bronx near her own, but soon after moving there, Jeanette's son was incarcerated, and her daughter decided to move her own family down south. Jeanette and her husband drove to South Carolina with a U-Haul and stayed with their daughter for several weeks before driving back to New York. Upon returning, they learned their building had burned down: "Somebody told me that [the landlord] had poured gasoline all over her apartment and all over her crippled daughter, a little girl that couldn't do for herself. She went across the street, just looking at her daughter burn up. They arrested her for murder."

Jeanette went to stay at the women's shelter while her husband went to a men's shelter. The fire was traumatic and destabilizing for Jeanette: "Right after I came here, I didn't even stay one day and I ended up in the [psychiatric] hospital for a week. When I was released from the hospital, I came straight back here."

Her husband, who remains at the men's shelter, visits her daily after work. Since returning to the shelter, Jeanette has been hearing voices again: "When I had my apartment [in the Bronx], I didn't hear them as much. Now I hear them a lot in here. During the build-up to sleep, that's when they want to talk to me."

Sometimes the voices are benign, telling her to check on whether another resident is okay; but often the shelter dormitory room stinks, and the voices tell her to hit or throw a chair at the woman who refuses to bathe. She describes herself as being unable to concentrate, feeling like a failure, and believes she would be better off dead: "[I feel] hopeless in not finding a place to live. I go to all the real estate [offices] and they turn me down." She thinks frequently about cutting her wrists—most recently just before our interview, following a verbal altercation with a shelter staff member.

Yet she maintains hope that the shelter can help her find an apartment in a quiet neighborhood in the Bronx.

Luis

Luis, who identifies himself as Puerto Rican, celebrated his 22nd birthday at a men's shelter, two weeks after his eviction from a supported housing program. The shelter and housing program are the latest of the institutional and quasi-institutional settings where he has resided his entire life.

Luis was placed in foster care at birth, while his mother struggled with drug addiction and his father was in and out of prison. He remained in the child welfare system until he was 19, moving through multiple placements before age five, when his mother's parental rights were terminated: a six-year stint with one foster family (age 5–11); a series of group home placements, occasionally interrupted by child psychiatric hospitalizations (age 11–17); and two transitional housing programs for youth aging out of foster care (age 17–19). Evicted from transitional housing at age 19, Luis was diagnosed with bipolar disorder and spent the next three years in the mental health system: two and a half years at an adult psychiatric center as an inpatient, a few months in an adult care facility on the same premises, and three months in a supported housing program where he shared an apartment with another program participant. When he was evicted for using and selling drugs and refusing to meet with his case manager, he entered the city's homeless shelter system.

Despite his institutional trajectory, Luis stayed in contact with family members. Periodic "visitation" with his mother and siblings stopped when he was six, but other relatives kept in touch: "My whole family has been supportive in their own different ways. My grandmother, she has been in contact with me growing up, my uncle keeps a lock on me since birth . . . my aunt lives in the same area as my grandma, my other aunt is in the same building, and my older sister is in Florida right now. My other siblings, I really want to find them but don't have any means of knowing where they are at."

As a birthday surprise, his aunt arranged a reunion with his mother, but it ended badly:

> You can't patch things up within a week, not [after] the past 14 years or so. My mother's in a shelter, like a shelter hotel. It was hard seeing her again and we got into a little altercation. I have her counselor's number but I don't speak directly with her. It might be awhile. . . . I gotta fix my life before I can fix her life. Plus

> she is HIV positive. She's getting a bit better but she is not really taking her medication. So when I was with her those couple of days, I was telling her, "Ma, I love you and everything, but you got to take your medicine." And she was like trying to sell her medicines and other stuff so she can make me happy. And I'm like, "No, the only way that you are going to make me happy is to see you [alive] the next time I come." I'm trying to convince her to take care of herself and that is very hard for me, me being 22 and her being 46.

Luis enjoyed high school, had a good academic record, and held part-time and summer jobs since age 14. He started working on an associate's degree in business management but was derailed by knee surgery resulting from a sports injury from his high school years.

With mental health system experiences in inpatient, outpatient, clubhouse, and supportive housing facilities, Luis says that he has had "about 20 psychiatrists, 20 psychologists and about 30 therapists" in his life, but he is wary of mental health professionals. He describes his extended psychiatric hospitalization as "like incarceration. It was like no windows to be open, supervision wherever you go, and you had to sneak cigarettes." Some groups were good, if he liked the group leader. But as a 19-year-old among much older adults, "I was basically tangled up with people of different ages who had different issues." His subsequent outpatient treatment in a different unit at the same facility "was a lot better because I can go outside," and outpatient staff assisted with money management and career planning. After years on and off psychiatric medications, his doctor recently discontinued his medication because of weight gain and skyrocketing cholesterol levels.

Luis described the shelter environment as stressful but hopes it will lead to stable housing with "a sense of comfort, familiarity, good qualities of the neighborhood, in a clean apartment with my girlfriend."

Ardella

Ardella is a 41-year-old African-American woman who came to the shelter from her sister's home where she had stayed for a month. She had recently graduated from a drug treatment program and feared that her sister's drinking would precipitate her own drug relapse. It had been 20 years since Ardella had housing of her own, when she shared an apartment with her sister, her brother, and the first three of the nine children she ultimately had. When her siblings fell behind on their share of the rent, the family was evicted, and Ardella and her children moved in with her grandmother.

While she remained there for 12 years, it was an unsettled period: she gave birth to her fourth daughter, ended her relationship with a boyfriend who tried to kill her, and lost custody of all four children when her sister reported her to child welfare for using drugs. Three more children were born to her there, but two were taken at birth by child welfare authorities. When her grandmother died, she and her seventh child, a daughter, moved in with that child's father. When her eighth child was born with drugs in her system, Ardella gave the two girls to their father and entered a women's shelter for the first time. When she became pregnant with her only son, she and his father moved to a family shelter, but her son was removed from her custody soon after birth. She left the shelter and stayed on the streets and with friends until she was arrested. Charged with felony drug possession, she accepted a plea bargain mandating her to the drug treatment program, and after graduating 14 months later, she lived with her sister until entering the shelter.

Ardella submitted an application for public housing almost ten years ago when she was living with her grandmother. By the time she was called for an interview, she was in the drug treatment program, and her application for housing was denied because of the felony charge, which would stay on her record until she completed treatment. She has now applied for a new hearing and hopes she will finally get her own housing.

Ardella keeps in contact with her brother, who is in prison out of state, and speaks with her sister every few days. She is in touch with four of her nine children—her two oldest daughters who share an apartment of their own, and her two youngest daughters, whose father has promised to return them to her once she has an apartment of her own. She has lost track of two daughters, but her older daughter was able to trace the other two:

> I know where they are, but I'm too scared to go there right now. I want to go when I get my apartment so I can let them know the doors are open wide if you feel like you want to come home. But I just gotta face what they going to say, you know? "Why wasn't you coming to see me?" and all this stuff. In my heart, I don't think they hate me [but] whatever happens, happens. If [they] don't want to come home, well, it's something I got to deal with.

She talks about seeking custody of her son, but acknowledges that success is improbable:

> When I was in the program I went to get a birth certificate for him, and the birth certificate place told me they changed his name. I go through this emotion every day, I'm learning how to deal with it, because there's really nothing I can

> do about it. And I kept my head up strong. I didn't go use or anything. I just kept moving. And I just be like, well, it is what it is. Something I gotta deal with, that's all, for the rest of my life. If my son want to see me, he will find me, just like my other daughters have found me.

Born with a congenital heart problem, Ardella has had three heart attacks and a stroke. She has had open-heart surgery twice, cervical cancer followed by a hysterectomy, and asthma. Five years ago, after losing custody of her son, she attempted suicide and was diagnosed with bipolar disorder. She was hospitalized for three months and now takes psychotropic medication, along with multiple medications for her other health problems. Ardella expressed hope that she can eventually obtain her own housing, reunify with her youngest daughters, and perhaps marry the boyfriend she's been seeing for the last eight months.

Jeanette, Luis, and Ardella experienced years and even decades of severe disruptions in housing, health, mental health, and family life. Their stories offer a small sample of the multiple ways in which such disruptions co-occur and compound each other—not only in these three lives, but in those of their parents, siblings, partners, and children. Creating the conditions for fulfilling their modest hopes for more routine, stable lives in decent housing and quiet neighborhoods remains an urgent challenge.

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CHAPTER 4

Overcoming the Problem of Disengagement from Treatment

Advances in evidence-based mental health treatment have expanded opportunities for people with serious mental illness to avoid unnecessary suffering and disability and establish satisfying lives in the community (Dixon & Schwarz, 2014). Too many, however, fail to engage in mental health treatment and have been left behind (SAMHSA, 2014). The most severe forms of mental illness and substance abuse, if left untreated, can interfere with good judgment, the ability to hold down a job, family and social relationships, and caring for one's basic needs—any or all of which can play a role in the onset of homelessness. It is unfortunate that the most disabled of the mentally ill sometimes have the weakest connections to the mental health service system, and some that are visibly ill never seek any form of treatment.

Disengagement, or dropping out of contact with the service system before recovery is complete,[1] can lead to devastating consequences, such as a recurrence of symptoms, re-hospitalization, violent and self-destructive behavior (Dixon et al., 2009; Kreyenbuhl et al., 2009), and homelessness (Belcher et al., 1991; Caton et al., 1995; Herman et al., 1998). Studies conducted in the post-deinstitutionalization era indicate that fewer than half of people with severe mental illness in the United States who might benefit

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[1] O'Brien et al. (2009) discuss the lack of common definitions of "engagement" and "disengagement" that have been used in studies in the area to describe "the complex relationship between people with mental health problems and the services providing for them" (p. 559).

from mental health treatment are involved in care (Kreyenbuhl et al., 2009; O'Brien et al., 2009). The figure is at least as high or higher among people with severe mental illness who are homeless (Mowbray et al., 1993; Mowbray et al., 2009). The lack of a stable connection to the service system, common among shelter and street dwelling people, leaves them to cope on their own with the vicissitudes of the homeless condition which often include violence, victimization, and contact with emergency services, hospitals, and the criminal justice system (Hopper et al., 1997; O'Brien et al., 2009). Re-engagement of high-need individuals with severe mental illness in needed services is an ongoing challenge (Smith et al., 2014). There is little doubt that an inadequate and fragmented mental health service system is a most unwelcoming environment for the distressed and vulnerable individuals who need effective evidence-based care the most. In the decades since the federal government ceased funding community mental health centers, the commitment of states to funding mental health and substance abuse treatment services has been uneven. In the competition for public dollars, behavioral health services have been fair game for budget reductions and service cuts in times of financial stress (Aron et al., 2009; Morrissey, 2016). While efforts at the state level to address problems in the service system involve factors such as increased financing, workforce training, and greater organizational commitment to the values of advancing recovery and individual empowerment, progress has been slow (Drake & Latimer, 2012; Drake & Essock, 2009; Glied & Frank, 2009). It is hoped that the Affordable Care Act and mental health parity will increase opportunities at both the individual and systems levels for greater access to state of the art mental health care.

WHY PEOPLE REJECT MENTAL HEALTH CARE

Lack of Insight

When illness of any nature strikes, ignoring the symptoms, diminishing their significance, or failing to seek treatment is all too common (Covino et al., 2011; Santos et al., 2006; Vos & deHaes, 2007). The self-recognition of symptoms can be challenging when the abnormalities involve emotional states, behavior, cognition, or perception. Clinicians have observed that people who suffer from severe mental illness are sometimes unaware of the significance of the symptoms they are experiencing or their need for treatment (Amador, 1993; Amador & David, 1998) perhaps due in part to low levels of mental health literacy (Thornicroft et al., 2007). Providers often cite lack of insight (difficulty recognizing one's own symptoms and attributing the symptoms to mental illness) or "sealing over" (minimizing the importance of the symptoms or their impact) (Tait et al., 2003) as an important reason why people with severe mental illness are not compliant with treatment (Agarwal et al., 1998; Kemp & David, 1996; Olfson et al., 2000; Smith et al., 2013).

Self-Declared Reasons for Rejecting Treatment

Reasons given by individuals for not seeking mental health care are instructive. In the National Comorbidity Survey (Kessler et al., 2001), a survey of a nationally representative household sample,[2] fewer than 40 percent of people with a diagnosis of severe mental illness received stable treatment. The majority of those who received no treatment felt that they did not have an emotional problem requiring treatment. Among people who recognized their need for treatment, the most common reason for failing to seek treatment or for dropping out of treatment was the desire to solve the problem on their own (Kessler et al., 2001, p. 987). Situational and financial barriers and the view that treatment would not be effective were also reported as reasons for not seeking treatment.

Other reports of reasons for not seeking or continuing with mental health care include a fear of loss of control from the effects of psychiatric medication that might interfere with a desire to be a capable and independent person (Priebe et al., 2005), dissatisfaction with treatment, and a feeling that treatment would be unlikely to help (Rossi et al., 2008). Some individuals fear the mental health system as a consequence of prior experiences of mistreatment or coercion (O'Brien et al., 2009; Rossi et al., 2008; Watts & Priebe, 2002). Complaints of not being listened to and not being able to actively participate in decision-making have also been reported as reasons for dropping out of treatment (Priebe et al., 2005). Kreyenbuhl et al. (2009) reported a host of practical reasons for disengaging from treatment, such as a move to a new location, the high cost of transportation, or merely forgetting to keep an appointment.

The Stigma of Mental Illness

A nationwide survey to characterize public perceptions of mental illness found that although the majority of the public can accurately identify

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[2] Homeless people were not included in this study.

psychotic disorder and accept that multiple biological, genetic, and environmental stressors are involved in its etiology, there is a strong stereotype that mentally ill people are dangerous and to be avoided (Link et al., 1999). Dangerousness is most often ascribed to people suffering from psychotic disorders (Henderson et al., 2013). Negative attitudes toward mental illness that are shared by health care professionals contribute to the reluctance to seek help and the receipt of less adequate mental health care. (Thornicroft et al., 2007).

The stigma of mental illness can be a strong deterrent to seeking needed mental health care (Anglin et al., 2006; Link et al., 2001; Pattyn et al., 2014). A three-year ethnographic study of homeless women in inner-city Chicago is instructive. The study involved interviews with and observations of women who frequented a drop-in center that offered nonclinical services such as laundry facilities, a mail drop, and a daily meal. Although mental health services and housing opportunities were available, women who were homeless and psychiatrically ill often refused offers of help, including diagnosis-related supportive housing. The street culture in which the women lived exerted an overpowering influence. Being "crazy" signified weakness and vulnerability to victimization. When the women claimed that they were not crazy, they affirmed their ability to be strong, protect themselves, and survive in an environment fraught with danger and extreme challenges. Had the association of housing and services with a psychiatric diagnosis been downplayed, more of the homeless mentally ill women might have accepted offers of help (Luhrmann, 2008).

Characteristics of People Who Refuse Treatment

Reviews of service disengagement suggest that individuals who drop out of treatment may have greater needs for help and are more socially and psychologically impaired than those who remain connected to services (Killaspy et al., 2000; O'Brien et al., 2009; Owen et al., 1996). Individuals with severe mental illness and concurrent substance use disorder have high rates of disengagement, as do those with greater levels of psychopathology (Kreyenbuhl et al., 2009; Nose et al., 2003; O'Brien et al., 2009). People who refuse treatment are more likely to be young, male, of ethnic minority status (Kreyenbuhl et al., 2009; O'Brien et al., 2009), socially isolated, poorly educated, and unemployed. Disengagement from services is greater among those who have a forensic history, perhaps reflecting antisocial traits underlying both criminality and disengagement (O'Brien et al., 2009).

APPROACHES TO SERVICE ENGAGEMENT

A solid connection to mental health services has been linked to housing stability among people with severe mental illness, and is an objective at the forefront of public psychiatry. When a person with severe mental disability fails to adhere to treatment and reaches a crisis point that comes to the attention of health services or the criminal justice system (Swanson & Swartz, 2014), a variety of approaches to increase engagement in services have been developed, both coercive or "leveraged," and voluntary.

Leveraging Entitlements and Housing

There are some situations in which individuals are compelled to relinquish liberty in order to obtain entitlements or housing. In cases of severe disability, concurrent substance use, homelessness, or a history of the inability to manage money, the Social Security Administration can appoint a representative payee to receive the entitlement on behalf of an individual to ensure that basic needs, such as rent and food, are covered. It is estimated that about 700,000 Social Security beneficiaries with psychiatric disabilities have been assigned a representative payee (Rosen et al., 2007). Typically, representative payees are family members, mental health agencies, or housing providers (Dixon et al., 1999; Monahan et al., 2001; Rosen et al., 2007). In some cases, disbursement of funds is linked to sobriety and adherence to mental health treatment (Monahan et al., 2001; Ries & Dyck, 1997).

Only a handful of studies have explored the effect of a representative payee on clinical outcomes. Rosen et al. (2007) observed that use of psychiatric services was greater following payee assignment, but there was no evidence that substance use declined. Rosenheck et al. (1997) found that people who were homeless and suffering from both mental illness and substance abuse experienced fewer days homeless after assignment to a representative payee. The investigation of client satisfaction with representative payee programs is limited. Dixon et al. (1999), however, observed that while client satisfaction was initially low, it grew more favorable over time.

Schutt and Goldfinger (1996) have reported that of shelter-resident mentally ill people in Boston, 92 percent indicated that they wanted to obtain permanent housing even if it meant that they would be required to take psychotropic medication. Although there is a growing sentiment following the Olmstead decision (1999) that housing should be de-coupled from an obligation to participate in mental health services, in some cases medication compliance is tied to the ability of an individual to obtain and retain supportive housing.

Program-based supportive housing programs that have on-site services sometimes require treatment adherence as a condition of acceptance and tenure. Typically, “housing first” programs do not demand that a resident engage in treatment (Tsemberis et al., 2004), although periodic visits by a treatment team are necessary. Currently, grantee agencies in receipt of Shelter Plus Care program funds from the U.S. Department of Housing and Urban Development are required to make supportive services available for the duration of the rental assistance, and grantee agencies may demand that a tenant take part in supportive services such as case management provided through the program as a condition of acceptance and continued occupancy. The grantee agency cannot require that a tenant participate in disability related services, or require that those whose disability is related to mental health participate in mental health services (hudexchange.info, 9/2/14).

Involuntary Inpatient Treatment

There are times when a person with severe mental illness may be compelled to seek mental health treatment against his or her will. State commitment laws vary (see mentalillnesspolicy.org/studies/state-standards-involuntary-treatment.html), but the criteria for involuntary commitment are markedly similar across state lines. In a court hearing, the laws require that it must be determined that an individual is mentally ill, and as a result of the illness the individual poses a real and present threat to harm of self or others. Because of mental illness, the individual is not able to make a rational and informed decision on whether treatment is needed. Moreover, if not treated, the individual will continue to suffer from mental distress and the inability to function independently.

The outcome of involuntary hospital commitment has been reported in two systematic reviews and a multi-site study involving a large sample. In the review conducted by Katsakou and Priebe (2006), most studies of involuntary psychiatric hospital admissions reported that the majority of patients showed marked clinical improvement, and patients with greater clinical improvement had more positive assessments of the value of the hospitalization experience at follow-up. Importantly, a substantial number of involuntary patients did not feel that their hospital admission was either justified or helpful.

In a systematic review of studies of outcome diversity among involuntary and voluntary hospital admissions, Kallert et al. (2008) observed that most studies reported that involuntary patients had greater lengths of stay, a higher readmission risk, greater risk for suicide, lower levels of social functioning, greater dissatisfaction with treatment, and greater questioning of the need for hospitalization.

In a large European multi-site study of legally coerced patients and patients admitted voluntarily who felt coerced, Kallert et al. (2011) noted that symptom levels in both groups markedly improved over a three month follow-up period. Diagnosis was not a factor in symptom improvement. Greater symptoms at baseline, being unemployed, living alone, having a history of repeated hospitalizations, being a voluntary patient who felt coerced, and less satisfaction with treatment were associated with less symptom improvement. The limited symptom improvement found among coerced patients is possibly accounted for by the severity of their underlying disorders.

Assisted Outpatient Treatment

Assisted outpatient treatment (AOT) is the extension of involuntary commitment to an outpatient setting. AOT is a civil legal proceeding in which a judge can order a person with mental illness who meets specified criteria to comply with a court-ordered treatment plan in the community (Swartz et al., 2010). In the United States, psychiatrists Roger Peele and Armando Saenz of St. Elizabeth's Hospital in Washington, D.C. first used AOT in 1972 (SAMHSA, 2015). In the years following deinstitutionalization, the lack of available and appropriate mental health services for people with severe mental illness, compounded by the resistance to treatment of severely disabled individuals, often resulted in preventable hospitalization episodes and overuse of crisis mental health services. Disturbed or threatening behavior by community-resident people with mental illness brought them in contact with the criminal justice system. The new AOT procedure promised to be a remedy to the problems engendered by untreated mental illness, and as knowledge of it grew states enacted laws authorizing its practice. By 2015, 45 states had AOT laws (the exceptions are Connecticut, Maryland, Massachusetts, New Mexico, and Tennessee). In spite of the widespread availability of AOT laws, there is considerable variability among states in their implementation and use (Swartz & Monahan, 2001). In most cases AOT cannot mandate a specific treatment. Its function is to bring an individual into contact with professionals who can assess an individual's state of mental health, recommend appropriate treatment, and facilitate a return to the hospital when warranted (Goldman, 2014).

The practice of AOT remains highly controversial (Geller, 2006), and it has stimulated a lively and polarizing debate as the expansion of AOT has been proposed in a bill, Helping Families in Mental Health Crisis Act, recently presented to the United States Congress (Carey, 2014). Proponents of AOT assert that the pressure exerted on the individual with mental illness to comply with treatment or face greater confinement is beneficial and necessary. Moreover, the practice compels the mental health service system to provide the supportive community services needed to successfully implement the policy (Swanson et al., 2010). Opponents of AOT, critical of any form of coercive treatment that impinges on civil liberties, include clinicians as well as patients and mental heath law advocates (Swartz & Monahan, 2001). Testimonials of patients who have been the recipients of AOT are both positive and negative (Frese, 1997). For some, forced treatment was a turning point in the ability to deal successfully with a chronic illness, while for others, the notion of forced medication or electroconvulsive treatment aroused strong objections. Although there are numerous case reports and surveys on the topic (Geller, 2006), only a handful of studies with reasonably strong design and methods have been conducted, yielding limited and inconclusive findings.

The North Carolina Controlled Trial

One of the first randomized controlled trials of outpatient commitment was carried out in North Carolina. The study involved 331 involuntary hospitalized patients who were randomly assigned to undergo outpatient commitment or be discharged directly to the community. Each group received case management services and outpatient treatment. Patients in the outpatient commitment group received an initial 90-day commitment order that could be renewed for an additional 180 days. Patients in the control group were ineligible for outpatient commitment for a one-year period. Data consisted of patient and informant reports, and was drawn from hospital, outpatient, and arrest records. When the duration of outpatient commitment was not considered, there was no difference in outcome in the outpatient commitment group and the control group. However, patients who received a longer duration of outpatient commitment and who received intensive outpatient treatment experienced improved outcomes as evidenced by fewer hospital admissions, fewer days of hospitalization, and greater compliance with treatment. They were also less likely to be violent or victimized. Arrests were fewer among patients with extended outpatient commitment who had histories of multiple hospitalizations and numerous arrests (Swartz et al., 2001). Importantly, individuals in the assisted outpatient treatment group who were committed for a longer period of time expressed greater perceived coercion. Greater self-reported coercion was also found among those who were African American, single, and those with concurrent substance use disorder, severe symptoms, and poor insight (Swartz et al., 2001).

The New York City-Bellevue Controlled Trial

A second random assignment study of outpatient commitment involved a pilot program established in 1994 at New York City's Bellevue Hospital. Seventy-eight individuals received court-ordered treatment and an enhanced services package, while 64 control subjects received only the enhanced services package. At 11 months post hospital discharge, no significant differences in outcome were found between the two groups, as evidenced by hospitalizations, arrests, quality of life, symptomatology, treatment compliance, and perceived level of coercion (Steadman et al., 2001).

Non-Experimental Studies of New York's Kendra's Law

A series of three non-experimental studies of outpatient commitment were carried out in New York State, involving a statewide implementation of Kendra's Law (New York State Mental Health Law 9.60, August, 1999).[3]

The New York State Office of Mental Health conducted a descriptive study of the outcome of Assisted Outpatient Treatment for 3,766 individuals enrolled in the program. Compared to the period prior to receipt of assisted outpatient treatment, at six months after termination of assisted outpatient treatment, patients experienced an 87 percent decline in incarceration, an 83 percent decline in arrests, a 77 percent decline in psychiatric hospitalizations, and a 74 percent decline in homelessness. Harmful behaviors, social functioning, and self care also improved (NYS OMH, 2015).

A legislatively supported second study of the outcome of Kendra's Law was carried out using AOT administrative data from the New York State Office of Mental Health and Medicaid claims over an eight-year period from the time the law was passed in 1999 to 2007. Findings from this

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[3] The law was named for Kendra Webdale, who was pushed in front of a New York City subway train by a man with a history of mental illness and multiple hospitalizations.

study of 3,576 individuals who received AOT revealed a nearly 25 percent reduction in psychiatric hospital admissions during the initial six-month period of the court order compared with the period prior to the court order, and when the court order was renewed for an additional six months, the hospitalization rate was further reduced. Reductions in the number of days hospitalized were also observed. In addition, improvements in the receipt of psychotropic medications, case management services, and engagement in outpatient care were found (Swartz et al., 2010). Improved rates of receipt of medication and reduced hospitalizations were more likely to be sustained post AOT when the intervention was kept in place longer than the initial six-month duration of the program (vanDorn et al., 2010).

A third New York State study compared the outcome of 76 individuals mandated to AOT with 108 recent hospital discharges without AOT who were attending the same outpatient programs as those with AOT. The study employed propensity score matching and generalized estimating equations to maximize causal inference in the absence of experimental design. Findings revealed that suicide risk and violence perpetration were lower in the AOT group, and the AOT group experienced improved functioning. No differences in psychotic symptoms or quality of life were observed in the two groups, and the AOT group was somewhat less likely to report feelings of stigma and perceived coercion compared to the outpatient only group (Phelan et al., 2010).

The British Controlled Trial

Another experimental study of compulsory community treatment was conducted in the United Kingdom to test “Community Treatment Orders” (CTO), which became available in 2008. The study contrasted compulsory treatment orders with Section 17 Leave, a conditional release policy that was not compulsory. All eligible patients had been admitted to hospital as involuntary patients and were determined by their clinicians to be appropriate for supervised outpatient care. The study tested whether CTOs reduced admissions in comparison to patients with conditional release (Section 17 Leave) when both groups were exposed to equivalent levels of community treatment but different lengths of compulsory supervision. The 336 individuals who consented to the study were randomly assigned to either CTO or conditional release. At the 12-month follow-up point, the number of patients readmitted to hospital did not differ between the two groups. The authors concluded that in a mental health system with well-coordinated community services, mandatory community treatment does not reduce readmissions and does not warrant its significant limitation of individual liberty (Burns et al., 2013).

The Cochrane Review

A recent Cochrane Review of involuntary outpatient treatment (Kisely & Campbell, 2015) considered the relevant randomized controlled trials (NC and Bellevue studies in the USA; British study) involving at least 12 months of community follow-up. Rating the quality of the evidence to be low to medium grade, the results of the review revealed that overall, compulsory community treatment was no more likely to result in improved use of services, social or mental functioning, or quality of life than usual voluntary outpatient care. However, individuals in receipt of compulsory care were less likely to be the victims of crime, whether violent or non-violent. With the exception of feelings of coercion, compulsory community treatment was not associated with negative outcomes. The review concluded that because of the methodological limitations (limited quality of evidence and relatively small samples) of the existing randomized controlled trials, further research on the effects of different types of compulsory community treatment is warranted.

VOLUNTARY APPROACHES TO TREATMENT ENGAGEMENT

The Recovery Movement in mental health care has yielded new approaches to treatment engagement inspired by rehabilitation models that, in contrast to the medical model, go beyond symptom control to assist individuals to establish satisfying lives in the community (Corrigan et al., 2008; Frese et al., 2009; President's New Freedom Commission on Mental Health, 2003; Salyers & Tsemberis, 2007). Shared decision-making (Deegan & Drake, 2006; Drake & Deegan, 2009), illness management and recovery (McGuire et al., 2014), and peer support services (Chinman et al., 2014) are based on the notion that mental health treatment should be collaborative, respectful of an individual's perspective and life goals, and encourage empowerment and independence. Shared decision-making is at the heart of voluntary approaches to engagement in treatment.

Shared Decision-Making

Shedding a paternalistic approach to the clinician-patient relationship, shared decision- making changes the role of the clinician into a collaborator who works in partnership with the patient to share information, clarify preferences, and provide expertise concerning the patient's care and treatment (Adams et al., 2007; Joosten et al., 2008). Shared decision-making has achieved considerable currency across medicine in general (Joosten et al., 2008), bolstered by the view that placing the patient at the center of care is a mechanism to improving its quality. The export of shared decision-making into the behavioral health arena has developed more slowly (Hamann & Heres, 2014). Despite the fact that shared decision-making is viewed positively by individuals with severe mental illness (Adams et al., 2007; Park et al., 2014) and is supported by clinicians for ethical and practical reasons (Drake & Deegan, 2009; Legare et al., 2014), it has not been widely implemented or studied in clinical settings (Beitinger et al., 2014; Joosten et al., 2008). It has been contended that shared decision-making is most relevant when there are several treatments that are possible (Legare et al., 2014).

A challenge to the implementation of shared decision-making in behavioral health care occurs when a patient is experiencing a psychotic break or expresses suicide intent. It has been suggested that shared decision-making be modified in "life or death" decisions, when a patient lacks insight, or is resistant to treatment (Hamann & Heres, 2014). Advocates for shared decision making argue that decisional incapacity is rare even in the presence of psychosis (Deegan, 2014), and it is noted that legal statutes to guide proxy decisions when decisional capacity is impaired already exist, making "paternalistic" decisions in crisis situations unnecessary. Joosten et al. (2008) argue that shared decision-making is particularly suitable for long-term decisions, such as in chronic illnesses that involve multiple treatment sessions, enabling a focus on treatment decisions that impact on a person's life style and personal preferences, including medication management (Deegan & Drake, 2006).

Voluntary and Involuntary Treatment: Future Directions

The relevance of disengagement from treatment for current policy and practice decisions demands that future research, both experimental and descriptive, on leveraged entitlements and housing, shared decision-making, conditional release, and legal mechanisms such as compulsory community treatment, be carried out to determine for whom and under what conditions a specific remedy for addressing treatment engagement is most appropriate (Goldman, 2014; Morrissey et al., 2014). In the meantime, issues such as decisional capacity and dangerousness will undoubtedly weigh heavily in clinical decision-making in real-world service settings.

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CHAPTER 5

Mental Health Services Take to the Streets

The challenge of reaching out to the homeless mentally ill initiated a period of creative development in mental health services delivery. Early in the post-deinstitutionalization era, the difficulty of engaging a disaffiliated and hard-to-reach population prompted clinicians to "take to the streets" (Cohen, 1990) and relate to homeless people where they could be found, whether on the streets or in transportation depots or abandoned buildings (Cohen, 1990; Cohen & Marcos, 1992). "Outreach" and "crisis intervention" became the established terms for new mechanisms to deal with the low rates of attendance and retention in outpatient mental health services. Over time, health and mental health services have been provided in shelters, community residences, and apartments to meet the needs of severely mentally ill people wherever they are living in the community. This chapter will describe and assess the evidence for the various approaches that have been developed or adapted to assist homeless mentally ill people to achieve stable residence in the community, including interventions based on case management (deVet et al., 2013), peer recovery support (Reif et al., 2014), critical time intervention (CTI; Susser et al., 1997), assertive community treatment (ACT; Bond et al., 2001), integrated treatment for people with dual disorders (Drake et al., 2004), and interventions to move individuals toward recovery and use of mainstream services (Rosenheck & Mares, 2007).

THE "EVIDENCE-BASED" STANDARD AND THE QUALITY OF AVAILABLE EVIDENCE

Homeless people with severe mental illness are often besieged with an array of problems such as poor physical health, substance abuse, long-term poverty, social isolation, and bruising histories of past trauma and criminal justice involvement (Rosenheck, 2000). Consequently, programs designed to meet the needs of this population must provide treatment for health, mental health, substance abuse, and rehabilitation services, in addition to addressing housing and income maintenance issues. In communities nationwide, program strategies have been implemented to serve homeless people with mental illness. Some program models have been rigorously evaluated experimentally, while others have been studied using less sophisticated methods. Programs have been scaled up despite the paucity of evidence for their effectiveness, and some new services for the homeless mentally ill are adaptations or modifications of programs initially developed for people with severe mental illness who are stably housed (Hwang et al., 2005).

In twenty-first-century health care, objective assessment of the effectiveness of a program or intervention has become an essential element in determining its value. "Evidence-based care" is the term used to classify research on service outcomes based on the amount and quality of data indicating that an intervention is effective (Anthony et al., 2004; Drake et al., 2003; Sackett et al., 2000). A "gold standard" for classifying an intervention as "evidence-based" is when the available research on the outcome of an intervention consists of large samples, multiple randomized controlled trials, use of well-established behavioral assessments, adequate controls, and unequivocal findings. In fact, much of the recently published work on service innovation targeted at people who are homeless and severely mentally ill falls short of this standard, yet the work, which has emerged from experiences in real-world service settings in response to sorely felt unmet needs, is unquestionably relevant. Moreover, studies of service programs, whether descriptive or experimental, are rarely replicated in exactly the same form, challenging our ability to compare outcomes even when the programs under study are conceptually similar. A focus on the "best available evidence" of the effectiveness of services is the most practical approach to weighing the strengths and weaknesses of the current state of the science.

Outreach

Outreach is an activity that lacks a universal definition, and there is no established evidence base to guide its practice. Typically, outreach programs work with individuals in non-traditional settings such as street locations, transportation depots, crisis shelters, or food programs (Morse et al., 1996), as an alternative to usual clinic-based care. Although outreach has been termed a fundamental element in a thoroughly developed plan to assist homeless people with mental illness, in practice, it tends not to be a stand-alone approach but is incorporated into case management, multidisciplinary teams, and crisis intervention as an essential first step. Outreach involves the clinical craft of establishing and maintaining rapport and trust (Morse et al., 1996; Ng & McQuistion, 2004) in order to engage the individual in a collaborative process that will eventually lead to the linkage with housing and support services (Burt et al., 2004). Relationship building is a key element in outreach, and it is not uncommon for outreach teams to secure food, clothing, and shelter for the individual in the process of establishing a productive relationship. Street outreach teams employ various approaches to engage people with mental illness in a dialogue on eventual involvement in services (Tsemberis & Elfenbein, 1999). Increasingly, outreach alone is considered to have limited success, unless it is combined with access to housing (Burt et al., 2004).

The "Choices Center" program for street-dwelling homeless people is illustrative (Shern et al., 2000). Conceptualized as a psychiatric rehabilitation program consisting of outreach, engagement, and the opportunity to participate in a low-demand day setting, the Choices Center offered food, showers, socialization, and health and mental health care. Overnight respite was available in a church-based shelter or a supervised room at the local YMCA. Choices Center staff provided planning for community housing. A randomized controlled trial compared the Choices Center group to a standard services group in which individuals had access to a range of services including outreach, case management, drop-in centers, health and mental health services, and homeless shelters. Findings revealed that people in the Choices Center program spent less time on the streets and more time in community housing, had less difficulty in meeting their basic needs, experienced greater reductions in psychiatric symptoms, and voiced greater life satisfaction. The Choices Center demonstrated the value of a comprehensive approach to homelessness that began with street outreach and was carried through until the person was successfully housed and off the streets.

Discharge Planning

Chronically homeless people often cycle between institutions and life on the streets or in crisis shelters. Another element in a comprehensive approach to care for this population is effective planning for community services when they are discharged from treatment facilities, hospitals, and jails. Planning for discharge is a process that is initiated as part of institutional care. Successful implementation, however, requires the collaboration of the community service agencies that will assume responsibility for care following institutional release. The small number of controlled studies to date (Forchuk et al., 2005; Naji et al., 1999) concern discharge from psychiatric hospitals. Findings suggest that discharge planning interventions are effective in reducing hospital readmissions and in improving adherence to outpatient aftercare treatment (Steffen et al., 2009). Like the concept of outreach, planning for the next steps in an individual's progress toward clinical stability and recovery has become a part of standard practice in service programs for the homeless mentally ill.

Case Management

From the emergence of contemporary homelessness, case management has been an enduring strategy for providing individualized care to people with severe mental illness in community settings. The various models of case management all possess similar functions—outreach, assessment, planning, linkage, monitoring, and advocacy (deVet et al., 2013; Intagliata, 1982).

Major differences can be found, however, in the definition, practice, and outcomes of case management models. Systematic reviews of case management have dealt with severe mental illness in general (Dieterich et al., 2010; Mueser et al., 1998) and a select number that concern the homeless mentally ill (Coldwell & Bender, 2007; deVet et al., 2013; Nelson et al., 2007). Individual studies have produced a range of findings with uneven results. Systematic reviews, however, provide the best available evidence of the efficacy of case management models. Findings from these studies suggest the importance of matching a case management model with an individual's unique clinical and social needs at various times in the process of recovery.

Standard or "Broker" Case Management

Standard or "broker" case management was one of the first models of case management to be developed (Mueser et al., 1998). The overall goal in the standard model is to connect the individual to needed services and coordinate service implementation among the various providers. The case manager does not act as a clinician and does not typically conduct outreach activities. Some are actually based in clinics. The average caseload is about 35 individuals, and the services are time-limited. In the standard-broker model, case managers are typically not required to have a degree in a clinical discipline. Studies of the outcome of standard case management versus usual care for homeless individuals have revealed mixed outcomes in many areas of functioning. Compared to usual community care, standard case management for homeless substance users has led to improvements in housing stability, reduced use of substances, and a lessening of barriers to employment resulting from substance abuse (deVet et al., 2013). A meta-analysis focused on case management for homeless people with severe mental illness, in which the effectiveness of standard case management was compared to the more intensive and clinically-oriented assertive community treatment, yielded no differences in hospitalization outcomes. Individuals treated with assertive community treatment, however, experienced greater improvement is psychiatric symptoms and a greater reduction of homelessness compared to those treated with standard case management (Coldwell & Bender, 2007).

Intensive Case Management

The need to provide direct clinical services to people with chronic mental illness underlies the “clinical” or “intensive” model of case management (Harris & Bergman, 1987; Lamb, 1980). The expanded activities characteristic of this model go beyond the activities of the standard model to incorporate a more comprehensive process of engagement, assessment, and planning. Intensive case managers mobilize their clinical skills to collaborate with physicians and hospital personnel, consult with and educate the patient and family about illness and treatment, counsel and train individuals in community living skills, conduct crisis intervention, and monitor a client’s progress (Mueser et al., 1998). Intensive case managers hold clinical degrees in a mental health discipline, and their caseloads consist of homeless persons with the greatest service needs. Caseloads average about 15 clients, and services are not time-limited. A systematic review of the outcome of intensive case management versus usual care in studies of homeless individuals with drug and alcohol problems revealed mixed outcomes and few differences in the two treatment groups, explained in part by widespread non-compliance with services offered (deVet et al., 2013). In contrast, a review of research on the effectiveness of housing and case management support revealed that, when combined with housing, intensive case management yielded significant reductions in homelessness and hospitalizations compared to the usual services that are offered to homeless people with severe mental illness. Moreover, compared to usual care, intensive case management combined with housing increased people's contact with family and improved their overall life satisfaction. Intensive case management without housing did not produce the same positive effects (Nelson et al., 2007), underscoring the importance of access to housing in improving the lives of homeless people.

Assertive Community Treatment

Assertive community treatment is the most widely investigated case management intervention for homeless people with severe mental illness, and it is the approach with the greatest evidence for its efficacy. In seeking an alternative to mental hospital treatment, the Program for Assertive Community Treatment, developed by Stein and Test (1980) in the 1970s is the most service-enriched case management intervention and was designed specifically for high-need individuals with severe and chronic psychosis. Assertive community treatment employs a multidisciplinary team approach, with teams typically including a psychiatrist, a nurse, one or more case managers, and on occasion, a social worker, forensic specialist, or housing specialist. The work is conducted in situ in the community. The team shares a caseload of 10 to 15 patients, and services are available around the clock. Assertive community treatment is typically continued as long as services are needed (deVet et al., 2013; Mueser et al., 1998).

In the published literature, the term "intensive case management" is sometimes used interchangeably with "assertive community treatment" when it adheres to the principles of the assertive community treatment model. In a systematic review of intensive case management for severe mental illness that included studies of assertive community treatment and homeless subjects, intensive case management was found to be superior to usual care in reducing hospitalization, increasing retention in treatment, and improving social functioning. Compared to standard case management, however, outcomes of intensive case management were not significantly different in areas such as service use, social functioning, psychopathology, client satisfaction, or quality of life (Dieterich et al., 2010). In the systematic review conducted by deVet et al. (2013), assertive community treatment for homeless people with severe mental illness, which included those with substance use comorbidity, achieved superior outcomes on housing stability compared to various types of usual care or standard case management. In the meta-analysis by Coldwell and Bender (2007) of randomized trials focused exclusively on homeless people with severe mental illness, assertive community treatment was superior to standard case management in reducing homelessness and improving psychiatric symptomatology. Hospitalization outcomes, however, did not differ in the two treatment groups. Finally, the review by Nelson et al. (2007) on the effect of housing and support from assertive case management or intensive case management for the homeless mentally ill revealed that the best outcomes for housing stability were produced by programs that combined housing and support, followed by assertive community treatment alone. Again, findings underscore the importance of housing in bringing about a solution to homelessness.

Cost-Effectiveness of Assertive Case Management for Homeless Mentally Ill

Two cost-effectiveness studies of case management models for the homeless mentally ill have compared assertive community treatment to usual care (Lehman et al., 1999) and standard case management (Wolff et al., 1997). Both studies concluded that assertive community treatment is a cost-effective approach to managing the severely mentally ill at risk of homelessness. Compared to standard case management, people in receipt of assertive community treatment had greater program involvement, improvement in psychiatric symptoms, and greater satisfaction, at no greater cost (Wolff et al., 1997). The dollar cost of implementing assertive case management's team approach and lower staff-to-client ratio is greater, and typically the direct treatment costs exceed those of usual care or brokered case management approaches. The net effect of providing a more enriched service intervention in the community is a reduction in costly inpatient mental health care.

Critical Time Intervention

Prompted by the realization that the rate of return to homelessness following discharge from a shelter was unacceptably high (Caton et al., 1990), "critical time intervention" was designed to assist the individual in the transition from the homeless shelter to community housing, with the goal of increasing residential stability. Like intensive case management, critical time intervention is service-enriched, but it is limited to a time period of about nine months. With a caseload of 10 to 15 individuals, the bachelor's degree or master's-level case manager provides continuity to bridge the gap between shelter-based care and community services and seeks to strengthen the individual’s ties to new community services, family members, and friends. In addition, the case manager provides support to the individual in the process of transition (Susser et al., 1997). The nine-month duration of the intervention is divided into three phases in which the case manager makes home visits, meets with caregivers or others in the new community environment, negotiates ground rules for relationships, and marks the occasion when care is transferred from the shelter to the community. A mental health clinician provides supervision to the case manager throughout the intervention.

Two randomized controlled trials of the efficacy of critical time intervention in treating people with severe mental illness who have been homeless have been conducted: a sample of homeless mentally ill men after discharge from a shelter (Susser et al., 1997), and a sample of formerly homeless men and women after discharge from a psychiatric hospital (Herman et al., 2011). In both studies, homelessness in the critical time intervention groups was significantly less during the follow-up period compared to the usual-care control groups. In the shelter study, individuals in the critical time intervention group also experienced fewer negative symptoms (Herman et al., 2000), while in the psychiatric hospital study, rehospitalization was less in the critical time intervention group (Tomita & Herman, 2012). A study of the cost-effectiveness of critical time intervention compared to usual care was carried out in which costs were defined by acute care and outpatient services, housing and shelter costs, criminal justice services, and transfer income (Jones et al., 2003). Over the 18-month study period, costs incurred by the critical time intervention group were $52,374 compared to $51,649 for the usual-care group. During the same time period, the critical time intervention group experienced 32 nights homeless compared to 90 nights for the usual-care group. The cost-effectiveness of critical time intervention is supported by the superior housing outcome for approximately the same total cost.

Adaptations of Case Management: Integrated Dual-Diagnosis Treatment

Substance abuse is widely prevalent among people with severe mental illness (Buckley et al., 2009; Caton et al., 2007) and is associated with a host of negative outcomes, including relapse, rehospitalization, violence risk, health problems, incarceration (Morse et al., 2006), and high treatment costs (Dickey & Azeni, 1996). Importantly, substance abuse is a major factor in chronic homelessness (Caton et al., 2007). As an alternative to separate programs to treat mental illness and substance abuse, the services are combined in integrated dual-diagnosis treatment (Drake et al., 2004; Drake et al., 1997). Integrated treatment has been incorporated into case management models. A random assignment study compared the clinical and social efficacy and cost of integrated assertive community treatment, assertive community treatment alone, and standard care for homeless people with severe mental illness and substance use comorbidity. Over the two-year follow-up period, people in the integrated assertive community treatment program and the assertive community treatment program expressed greater satisfaction with treatment and reported more days in stable housing compared to those in the standard control condition. There were no differences in the groups on psychiatric symptoms or substance use. Average costs of integrated assertive community treatment did not differ from those of usual care, and costs were less than those for assertive community treatment alone (Morse et al., 2006). A study of the delivery of integrated treatment with assertive community treatment and standard case management for homeless or unstably housed individuals revealed that participants in both treatment conditions improved in many areas, including substance abuse. The few differences in the two models suggest that integrated community treatment can be delivered effectively with either assertive community treatment or standard case management (Essock et al., 2006).

"Peer Support": The Consumer as a Member of the Mental Health Team

The belief that people with mental illness could support one another predates the deinstitutionalization era. In the late 1940s, six people treated at Rockland State Hospital in New York met as patients and began to share stories and participate together in hospital activities. After leaving the hospital, they continued their relationships, naming their group "We Are Not Alone," believing they could offer one another support in achieving recovery and meeting life's challenges. Their typical meeting place was on the steps of the New York Public Library until 1948, when, with the help of supporters, they were able to purchase a building in Manhattan's Hell's Kitchen area. The Fountain House "clubhouse" was founded with the goal of supporting recovery and changing the social perception of mental illness (www.fountainhouse.org/about/history).

"Peers" or "consumers" have been widely employed in outreach and case management programs for homeless people. To date, however, there has not been a single controlled trial of care provided by peers that has dealt with a sample of people with mental illness who were homeless at baseline. Peers with histories of living successfully with serious mental illness have, however, achieved a prominent place in contemporary mental health service programming in general. Perhaps because they have experience with mental illness and have achieved a measure of recovery through treatment, they are uniquely able to provide support and empathy to individuals coming to terms with similar challenges (Chinman et al., 2014; SAMHSA, 2011). Peers can assist in the development of coping and problem-solving strategies that can lead to successful self-management of a person's vulnerabilities, encourage engagement in treatment, and help the individual access housing and support in the community (Chinman et al., 2014). Peer roles have been added to standard care, case management, and assertive community treatment teams, and peers have been placed in existing case manager positions where they function in typical case management roles. They have also been trained to deliver specified program curricula, such as the Wellness Recovery Action Plan (Copeland, 1997). Peer support training and certification programs have been developed in many locations to facilitate reimbursement through Medicaid.

In an assessment of the evidence for the efficacy of peer support for people with serious mental illness, Chinman et al. (2014) noted that many studies had methodological limitations and that outcomes were mixed for adding peer support to existing services and peers in existing roles. Of the six randomized controlled trials of peers added to existing services, Sledge et al. (2011) reported that patients with multiple hospitalizations who had access to usual care plus a peer mentor had fewer hospitalizations and hospital days than patients in a usual-care control group. Two other randomized controlled trials found that patients assigned to assertive community treatment teams with peers had better short-term treatment engagement (Sells et al., 2006), lower rates of non-attendance at appointments, and greater participation in structured activities compared to patients assigned to assertive treatment teams without peers (Craig et al., 2004). The additional three randomized controlled trials produced no advantages for peer support added to existing programs (Chinman et al., 2014). In the studies of peers in existing roles, outcome of assertive community treatment staffed by peers compared to assertive community treatment without peers revealed no differences in homelessness or arrests, but greater hospitalizations and emergency department visits were observed in the standard assertive treatment group (Chinman et al., 2014). A Cochrane systematic review (Pitt et al., 2013) of 11 randomized controlled trials of consumer providers of care for adult mental health clients reported no adverse outcomes. The authors concluded that the involvement of consumer providers in mental health teams produces no better or worse psychosocial or symptomatic outcomes than those achieved by mental health professionals in similar case management roles.

ENGAGING HOMELESS PEOPLE WITH MENTAL ILLNESS IN NEEDED CARE: NEXT STEPS

Using Costly Services Efficiently

Rosenheck (2000) has observed that while specialized interventions for the mentally ill homeless have improved outcomes, they are also associated with the increased use of many types of health and support services, resulting in increased costs. Whether or not the body politic will support the increased cost of providing effective and more humane care to people with mental disabilities, there are steps that can be taken to ensure that the available service options are used most efficiently. Toward that end, Clark and Rich (2003) suggest that the effectiveness and cost of services for homeless people could be improved by matching the intensity of services to the individual's severity of psychiatric impairment and substance use, rather than by "treating mentally ill homeless people as a homogeneous group" (Clark & Rich, 2003, p. 78). Tsai and Rosenheck (2012) carried out a pilot project for a group-based peer support intervention for homeless veterans as an adjunct to supported housing that would lower the direct service costs compared to the cost of multidisciplinary teams. Further study of this approach could reveal whether group-based peer support is as effective as individual peer support for homeless people with severe mental illness.

Integrating Health and Mental Health Treatment

It is well known that homeless people with severe mental illness have behavioral risk factors such as alcohol and drug use, tobacco use, and obesity. Often they have sought health care through hospital emergency departments and inpatient services for lack of access to primary care (Kushel et al., 2001). The Medicaid expansion provision of the Affordable Care Act (ACA/Obamacare) offers new opportunities for health insurance coverage for homeless people. A stable funding source can enable greater access to general medical care for people with severe mental illness by integrating primary care and behavioral health services (Druss et al., 2001; Pollard et al., 2014; Smith et al., 2013). Services integration could also have the effect of reducing mental health stigma (Shim & Rust, 2013), encouraging greater numbers of people suffering from mental illness to seek treatment. If service innovation following the implementation of the ACA develops, systems integration approaches developed through the ACA, such as health homes, could be enhanced by efforts to support and empower individuals with severe mental illness to successfully navigate the health care system and embrace "self-management" of their health conditions (Kelly et al., 2014).

Moving Toward Recovery

The achievement of stable community housing sets the stage for people with severe mental illness to move toward recovery and resume ambitions that were cast aside by illness and misfortune. Clubhouses modeled after Fountain House in New York City (www.iccd.org) and consumer-operated "drop-in" or recovery centers (Mowbray et al., 2009; Whitley & Siantz, 2012) offer people with mental disability the opportunity to help each other achieve greater involvement in employment, education, wellness management, and personal enrichment activities. Recovery centers are very recent, and outcomes for participants have yet to be investigated. Clubhouses offer individuals the opportunity to work in various aspects of clubhouse operation, or they can be placed in competitive jobs arranged through the clubhouse.

Supported employment is an evidence-based approach to assist adults with severe mental illness or co-occurring mental illness and substance use disorders in obtaining and maintaining competitive employment (Drake et al., 2012; Kinoshita et al., 2013; Marshall et al., 2014). Based on findings from studies of supported employment, Macias et al. (2006) conducted a randomized controlled trial of vocationally integrated assertive community treatment compared to a certified clubhouse in the delivery of supported employment services. Employment outcomes of both the vocationally integrated assertive community treatment and the clubhouse model were similar to those achieved by established supported employment teams. Findings demonstrate that supported employment can be scaled up in connection with existing treatment and rehabilitative programs, broadening the opportunities for people with mental illness to pursue ambitions beyond the achievement of stable living in the community.

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CHAPTER 6

From the Streets to Homes

Having a decent and safe place to live in is a basic human need, and adequate housing is an essential element in the recovery of people with psychiatric disabilities (Corrigan et al., 2008; Padgett, 2007). In spite of nearly universal agreement on the need for housing solutions to homelessness, the presence of people without homes wandering the streets of cities and towns across the United States has been unremitting in the era of community treatment.

The persistent poverty found among homeless people with psychiatric disabilities and the limitations of their public entitlements make it impossible to support the cost of even the most modest community dwelling. In 2016, the average monthly entitlement income for Supplemental Security Income (SSI) recipients was $733 (Social Security Administration, 2016), an amount far below the federal poverty level (Martone, 2014). Lacking a stable residence, people with severe mental illness are more likely to cycle in and out of homeless shelters, jails, emergency departments, and psychiatric inpatient facilities. This chapter will describe how homelessness spurred the development of an array of specialized housing for people with severe mental illness by innovative providers, nonprofit organizations, and governmental agencies, innovations that consider the limited resources of disabled individuals and their need for long-term access to treatment and support services.

LOW-COST HOUSING OPTIONS IN THE WAKE OF DEINSTITUTIONALIZATION

In the early days of deinstitutionalization, patients who had close ties with their families often returned to family living settings after they were discharged. For others, long-term institutionalization had frayed their relationships with their family and kin, and many could not count on their families for housing or sustenance when they returned to the community. Some were inappropriately placed in nursing homes (Melick & Eysaman, 1978). Others were priced out of the rental housing market and often confronted with discrimination. In some cities, the options for discharged patients on public entitlements consisted mostly of for-profit board and care homes, group homes, or large, multi-bed, proprietary adult homes, business enterprises requiring considerable capital investment and concerned about costs and profits. Staff were typically untrained and lacking in therapeutic skills. Reports of inadequate care and exploitation in these settings were common (Caton et al., 1990; Segal & Aviram, 1978; VanPutten & Spar, 1979), and they were often located in rundown and unsafe neighborhoods that exposed their tenants to violence and drug use. By the mid-1970s, the need of the severely mentally ill for adequate housing was recognized in federal mental health policy. A 1975 amendment to the Community Mental Health Centers Act (Title III, Public Law 94-63) included the community residence as one of the essential services of a community mental health center, but no such facilities were ever developed.[1]

By the late 1970s, the sight of people seeking shelter in transportation depots, in church doorways, under bridges, in public parks, and on the heating grates of modern office buildings became commonplace in urban centers across America. Some cities had shelters or missions operated by private or nonprofit agencies, but they could serve only a small, select portion of those in need. The success of advocates in Washington, D.C., in obtaining an unused federal building to shelter the homeless, and in winning the legal right to shelter in New York City, presaged the provision of federal funding for emergency shelter services in the McKinney-Vento Homeless Assistance Act of 1987 (see Chapter 2).

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[1] Community mental health centers were never fully funded or implemented nationwide. Mental health center funding was folded into block grants to the states by the Reagan administration.

Emergency Shelters

Shelters provide people with a place to sleep when they are without a usual place of nighttime abode and are seeking a respite from the elements. In the homeless service system, shelters offer a temporary reprieve for those who may be able to return to stable housing in a matter of days, and they are a first step in the continuum of care for those whose path to permanent housing may be long term.

Shelters vary considerably in size, admission criteria (some adult shelters are single-gender), length of stay (there are no time limits on length of stay in New York City shelters, but in some locales the length of stay is limited to 90 days or fewer), the types of accommodations, and services provided. Shelters typically offer three meals a day and shower and laundry facilities. In some cities, there are specialized shelters for people with mental illness that have on-site services for health, mental health, substance abuse treatment, employment training, and case management. Shelters typically have curfews, prohibit the possession of weapons, and forbid abusive or assaultive behavior. Some do not allow the use or possession of drugs and alcohol. Some may require that shelter guests help with menial chores.

In response to criticisms of 30 years ago that shelters were overcrowded, oppressive (Lipton & Sabatini, 1984), dangerous (Hopper et al., 1982), and similar to the worst of the nineteenth-century almshouses (Lipton & Sabatini, 1984, p. 161), emergency shelter programs in receipt of public funding must meet specific health, safety, and quality standards. Despite such measures, some street-dwelling homeless people eschew shelters, voicing complaints reminiscent of those heard in the 1980s. In terms of cost, shelters are an adequate response to an immediate housing crisis for most individuals, but they are an expensive long-term solution compared to permanent housing (Spellman et al., 2010).

New York City's Aberdeen Hotel and the Origins of "Supportive Housing"

In metropolitan areas like New York City, patients discharged from state mental institutions gravitated to commercial single-room occupancy (SRO) hotels, where rent costs were low, lease agreements were not required, and landlords accepted the daily or weekly rent paid by welfare. Most such settings offered a small room, with a shared bathroom, and some had no access to a kitchen. Often located in semi-commercial neighborhoods, by the 1970s, many were rundown and living conditions were substandard (shnny.org/learn-more/history-of-supportive-housing/). In these settings, patients often lived side by side with a criminal element and active substance users.

In the early 1970s, Fathers John Felice and John McVean, Franciscan priests affiliated with a parish in Manhattan's West Thirties, became aware that people discharged from state mental institutions were living at a neighborhood SRO, the Aberdeen Hotel. Concern for the unmet needs of the hotel residents led the priests to obtain two rooms from the hotel management so that mental health services could be provided on-site by a New York State aftercare clinic and the Department of Psychiatry at Bellevue Hospital. A kitchen was also set up to serve hot meals to the hotel residents.

By the mid-1970s, the stock of SRO housing was in decline. Federal urban renewal programs and local tax abatements to spur gentrification in declining neighborhoods created a strong incentive for landlords to upgrade to commercial hotels or market-rate apartments. Consequently, the services at the Aberdeen Hotel were threatened when, in 1979, a new owner of the hotel planned to renovate and upgrade the facility into a moderately priced tourist hotel.

Committed to continuing their work with the discharged mentally ill, the priests set about trying to lease or buy a hotel for this purpose. With funds belonging to the Franciscan Order and interest-free loans, they were able to purchase a hotel on East 24th Street. The St. Francis Residence opened in 1980 and was the first of its kind to provide permanent housing and supportive services to homeless people with severe mental illness. The success of this first endeavor let to the development of two additional St. Francis Residences, and the model created by Frs. Felice and McVean has inspired the development of supportive housing worldwide (www.stfrancisfriends.org).

The Evolution of Supported Housing

In New York City, Ellen Baxter, a founder of the Coalition for the Homeless, and Tony Hannigan, a developer of housing and services for the severely mentally ill, channeled their concern for the housing needs of the homeless mentally ill by spearheading the advance of the model of supportive housing developed by Frs. Felice and McVean. Advocating for a permanent supportive housing model that would provide services, allow the tenant to hold the lease, and have an integrated tenancy made up of formerly homeless people with mental illness and people from the local community, an initial effort reflecting this approach was the nonprofit Broadway Housing. This model has been widely replicated and is well represented in the 30,000 supportive housing units now available in New York City.[2]

Capitation funding for supportive housing from state and local governments, such as New York/New York Housing, has fueled the expansion of new multi-unit buildings, but this type of support is relatively uncommon. The creation of new single-site supportive housing has required developers to piece together funding from foundations, private donations, interest-free loans, low-income housing tax credits, and various public agencies. The Corporation for Supportive Housing, founded by Julie Sandorf in 1991, has played an important role in enabling communities to invest in housing for homeless people with mental disabilities. A certified community-development financial institution, the Corporation for Supportive Housing offers loan products and technical assistance to developers to leverage financing and advise communities on the issues involved in implementing solutions to homelessness. Staff trainings on best practices are offered to providers to assist tenants to participate in mainstream society. Originating in New York City, the Corporation for Supportive Housing has expanded nationwide (www.csh.org).

Supportive housing has been widely implemented in homeless services and mental health service systems nationwide. Federal funding for housing assistance through the McKinney-Vento Homeless Assistance Act has facilitated the expansion and formalization of supportive housing. In the 1990s, the Department of Housing and Urban Development's funding initiatives supported service-enriched transitional housing, including safe havens as places of respite, treatment engagement, and rehabilitation, to achieve readiness for more long-lasting housing placement. Safe havens were created for people who are chronically homeless and service-resistant. Often involving the collaboration of a mental health service agency, programs are limited to about 25 residents, and are typically guided by a housing-first or low-demand perspective. Behavioral health programs are offered, such as 12-Step meetings, training in daily living skills, medication maintenance, and case management, but residents are not required to participate. Safe havens are staffed around the clock (O'Hara & Housing and Urban Development, 1997). In the most recent Federal homelessness initiative, however, transitional housing has been eclipsed by the emphasis on permanent supportive housing and rapid rehousing (USICH, 2015).

[2] Personal communication, Tony Hannigan, 2015.

The two most common models of supportive housing are the single-site model (also termed “purpose-built” or “site-based”) in which all or most of the units in a facility (apartment building or SRO hotel) are dedicated to formerly homeless people with mental illness, and treatment and support services are provided onsite; and the scatter-site model in which the target population is able to access rent-subsidized apartment units in the competitive housing market, with services provided by a mobile team or offsite case managers. Some apartment buildings have “unit set-asides” for a specified number of people with disabilities. There is a third, hybrid model in which a single site mixes supportive housing for formerly homeless people with mental illness with rental housing for people with HIV/AIDS, substance use disorder, or low-wage workers from the community at large. The housing programs created by developers of integrated housing provide a relatively secure community to a diverse group of residents who have all met the required admission standards (Hopper & Barrow, 2003).

Because these program models serve a population suffering from severe mental illness or multiple comorbidities, a range of services is provided directly or by referral to meet a variety of needs (Caton et al., 2007). For example, services delivered onsite can include assistance in establishing a household, health and mental health treatment, substance abuse treatment, peer support, money management, and connections to educational and employment opportunities. State and local mental health authorities have often funded mental health and substance abuse treatment services, but in the Affordable Care Act’s Medicaid expansion, treatment costs in supportive housing will be a covered expense. Tenants typically pay 30 percent of their income in rent, with the remainder of rent funded with federal housing vouchers, state or local subsidies, or charitable contributions to housing nonprofits. Section 8 housing supports some scatter-site apartments, and multiple Section 8 vouchers are sometimes bundled and allocated to a single-site permanent supportive housing program. About one-fourth of permanent supportive housing units nationwide are funded through the Department of Housing and Urban Development’s Continuum of Care program.[3]

HOW SUPPORTIVE HOUSING MODELS DIFFER

Despite having similarities, there are many differences, both subtle and obvious, in how supportive housing programs across the country are

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[3] Personal communication, Richard Cho, October 29, 2015.

defined and operationalized. Areas in which they differ are fourfold: housing first or housing readiness, whether the housing environment is "high demand" or "low demand," the intensity of supportive services, and whether the duration of housing is temporary or permanent.

Admission Criteria: Housing First or Housing Readiness

In the decade following the funding of the McKinney-Vento Homeless Assistance Act, it was common practice to encourage people with psychiatric disabilities to progress from homelessness to permanent housing through a series of step-by-step residential programs, from transitional housing to various types of supervised community residences and apartments, until they had demonstrated several months of sobriety, had mastered basic living skills and personal self-care, and were motivated to adhere to mental health treatment (Caton et al., 2007). Unfortunately, a limitation of this approach is that many chronically homeless people were not able or willing to meet these demands (Barrow et al., 2004; Kertesz et al., 2006). Alternatively, the housing-first approach places people directly into permanent housing without preconditions or the stipulation that they be engaged in mental health treatment prior to receipt of housing (Tsemberis, 1999). The housing-first approach has grown in popularity and has influenced the operation of both single-site and scatter-site permanent supportive housing programs (Burt & Anderson, 2005; Clifasefi et al., 2013). There remains, however, considerable variability in the admission criteria and procedures for many supportive housing programs.

The Terms and Conditions for Treatment and Services

Supportive housing programs vary widely in the extent to which they require participation in mental health treatment and rehabilitation. A "low-demand" approach is characteristic of many housing-first programs in which services are based on client choice and there are few requirements other than the usual demands of tenancy (paying rent, not destroying property) and the need to prohibit illegal activities or unsafe behavior. Some low-demand programs may tailor requirements to an individual's need for a representative payee to manage entitlement income, and a periodic visit from a case manager or community treatment team. A low-demand approach is typical of safe havens and some permanent supportive-housing programs. In contrast, a "high-demand" approach usually requires client participation in several programs, often including medication management and substance abuse treatment, as the individual progresses on a path out of shelter or street living through transitional placements to permanent supportive housing. Moreover, there are supportive housing placements that provide onsite support services 24 hours a day, seven days a week.

Service Enrichment

In some permanent supportive housing settings, housing is not contingent upon service participation, and an individual can choose from a variety of service programs based on need and personal preference. There is, however, considerable variability in the nature and staffing of services in supportive housing programs. Transitional housing programs tend to have greater structure and have requirements for participation in work programs, treatment, and housing searches. Some single-site housing programs have onsite recreational and self-improvement activities, as well as onsite clinical staff to prescribe and dispense medication treatment or deliver primary care services. Some even provide two or three meals a day. In scatter-site apartment units, there may be periodic visits from a mobile mental health team or case manager to provide psychiatric treatment or arrange for access to clinic-based or offsite rehabilitation services.

Permanence of Tenancy

Transitional housing programs including safe havens are time-limited, but tenure is not rigid, and some individuals remain for months or longer until they are able to move on to permanent housing. Tenants may be required to move to more independent housing as their needs for intensive services and structure are reduced. In many permanent supportive housing programs, the residents have full rights of tenancy, with a lease (or a sublease) in their name and with the same terms and conditions as would be found in a typical lease. Housing is permanent as long as the individual is able to maintain the requirements of successful tenancy. However, in some programs, housing may be terminated for the individual's failure to adhere to treatment goals, for illegal activity, or persistent disruptive behavior. Sometimes house rules are no different from those found in housing for people without mental illness, but supportive housing programs are known to have curfews and house rules banning smoking, alcohol, and drug use. Rule violations can be a cause for sanctions.

EXAMPLES OF SUPPORTIVE HOUSING MODELS

There is considerable variability in the housing that has been developed for psychiatrically disabled people nationwide. The following paragraphs describe housing programs designed for individuals with different levels of service needs.

"New York/New York" Transitional Housing

In 1990, New York City and New York State embarked on a joint program to fund the development of supported housing for homeless people with mental illness. The success of the program in reducing the number of mentally ill homeless people on the streets and in shelters led to its expansion in 1998 and 2005. The transitional housing models funded through the "New York/New York Housing" program are illustrative. Two transitional models are described here (NYS OMH, 2015).

"Apartment treatment housing" is transitional housing that provides enriched support and skills training to individuals in scatter-site rental apartment units. One to three individuals typically occupy an apartment, bedrooms may be private or shared, and the apartment residents are responsible for meal preparation. Licensed by the state, this model offers rehabilitative and support services designed to encourage use of community programs and the forging of connections with family and friends. Services are provided onsite with the goal of preparing the individual for greater independence and permanent community housing.

"Licensed supportive housing" is transitional "extended stay" housing in a community residence that resembles a typical apartment building. Individuals have studio apartments or private bedrooms in suites, and residents are responsible for meal preparation. Supportive services are onsite and are available at all hours. Although this is classified as transitional housing, the average stay is about four years.

Permanent Supportive Housing

A variety of permanent supportive housing programs have been developed nationwide. Examples of single-site housing, integrated housing, and scatter-site housing are described next.

Single-Site Housing: Kelly Cullen Community, San Francisco, California

San Francisco's former Central YMCA, located in the Tenderloin district, has been transformed into supportive housing and a health clinic for homeless people and community residents. Constructed in the early twentieth century, the landmark building had become unusable because of the need for significant infrastructure upgrades. The YMCA relinquished the building to the Tenderloin Neighborhood Development Corporation, a nonprofit housing developer. The five-year $91 million project, developed with federal, state, and tax credit equity funding, produced Kelly Cullen's 174 permanent supportive housing units, each with a kitchenette, bathroom, and storage space. The Kelly Cullen Community also has common spaces for a kitchen, laundry room, and landscaped roof. The San Francisco Department of Public Health occupies the building's first floor and provides medical, psychological, and social services to Kelly Cullen residents and members of the local community. A multi-agency team of social workers and nurses is onsite, as well as staff who help tenants manage money and coordinate rent payments (http://huduser.gov/portal/casestudies/study_04062015_1.html).

Single-Site Integrated Housing: The Times Square, New York City

The benefits of integrating individuals with severe mental illness into mixed-use affordable housing include the potential to reduce stigma, lessen community resistance ("Not In My Back Yard" or NIMBY), and increase opportunities for recovery. The Times Square's 652 units make it the largest permanent supportive housing residence in the nation. It is one of the first to serve a mixed population of low-income and formerly homeless adults, people with serious mental illness, and people living with HIV/AIDS. People who work in low-wage jobs in Manhattan's theater district often seek residence in the Times Square, along with the special populations the facility was designed to serve. A former "grand hotel" that is listed on the National Register of Historic Places, the hotel had become crime-ridden and was in considerable disrepair when it was purchased by the New York City nonprofit Common Ground in 1991. After a $50 million renovation, the Times Square was able to offer studio apartments to its residents, along with enriched onsite services. The Times Square has a computer lab, a library, an art studio, a medical clinic, rehearsal space, 24-hour laundry facilities, and 24-hour security. Case management, recreational activities, and self-sufficiency workshops are also provided. The building's large lobby is used to display the work of resident artists, and the community room on the top floor with its dramatic city views is used for tenant events and is available for rent to the general public (www.breakingground.org).

Scatter-Site Apartment Housing: Pathways to Housing, Rural Vermont

Based on the belief that housing is a human right, and valuing consumer choice, Pathways to Housing employs a housing-first approach to assist homeless individuals with severe psychiatric disability and addictions to locate safe and affordable market-rate housing. Housing is provided with no preconditions and is independent from services. Service engagement is guided by client choice. Pathways staff have ongoing relationships with 85 landlords who can provide affordable apartments in seven rural communities. Staff are available to residents to help with property maintenance, navigate landlord relationships, and deal with other issues related to tenancy. Case management teams work in specific geographic areas to maximize efficiency, and the use of technology facilitates responsiveness when travel may be difficult. Tele-health consultation supplements in-person visits for mental health, medical, and substance abuse problems (Stefancic et al., 2013). Regional multidisciplinary specialists foster connections to educational and employment opportunities to facilitate community engagement. Individuals hold the lease to the housing unit and pay 30 percent of their income toward rent and utilities. Sources of funding for Pathways include the Vermont Department of Mental Health, the Vermont Department of Corrections, and the United Way (pathwaysvermont.org).

THE PROCESS OF OBTAINING HOUSING

Admission to service-enriched housing programs is not available to everyone who is homeless and mentally ill. Importantly, there are strict eligibility criteria for access. An individual must have a DSM diagnosis (*Diagnostic and Statistical Manual of Mental Disorders*) determined by a psychiatrist that is consistent with severe mental illness (psychotic disorder, major depressive disorder, or obsessive compulsive disorder), rendering the individual eligible for Social Security disability benefits. Sometimes public or private funding sources target a subgroup of homeless people with specific characteristics. For example, housing programs in receipt of Housing and Urban Development (HUD) funding for chronic homelessness require that an individual meet the Federal definition of chronic homelessness: disabled, having been homeless continuously for one year, or has had four or more homeless episodes in three years (HUD, 2015). Other programs have looser restrictions on the duration of homelessness needed to qualify for supportive housing. Despite the substantial progress that has been made in providing housing for homeless people, some are left out. The underserved include newly homeless people with severe mental illness, homeless youth with new-onset psychiatric disorder, and homeless people with addictions who do not meet the eligibility criteria for severe mental illness.

Mental health providers typically introduce individuals to supportive housing opportunities, but a formal application is required that includes the documentation of a psychiatric disability and receipt of a disability income to cover a portion of the rent payment. Proprietors of nonprofit housing programs set terms and conditions for admission and tenure, and they are not required to accept everyone who applies. Some will accept only those who are "clean and sober" and connected to a mental health treatment program. In some cases, a proprietor will request to be made the applicant's representative payee for receipt of disability benefits in order to guarantee rent payments.

In a tight low-cost housing environment, homeless people with severe mental illness must compete with other low-income groups in the search for a market-rate apartment. They rely on providers of the "housing as housing" and housing-first approaches to assist them in gaining access to entitlements and subsidies, in the search for an available apartment, in guaranteeing rent payments, and vouching for their ability to be good neighbors (Hopper & Barrow, 2003). Often providers have established relationships with landlords and are able to intervene in disputes or behavioral problems that could put the person at risk for eviction. There is very little information on the process of housing search for this population, how quickly apartments are obtained, whether they comply with the individual's housing preferences, or the characteristics of the neighborhood.

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CHAPTER 7

Challenges to Bringing Housing to Scale

Housing's importance in ending homelessness and aiding the recovery of people with severe mental illness is unquestioned. Having a home is conducive to meaningful treatment engagement and is an antidote to the stressful and chaotic existence of life on the streets. Studies of case management with and without a housing component underscore the role of housing in facilitating both housing stability and treatment retention, and in demonstrating that a dual housing and treatment approach is superior to treatment alone, particularly for those whose housing stability has been fragile (Nelson et al., 2007; Rosenheck et al., 2003).

PERMANENT SUPPORTIVE HOUSING

In a nutshell, permanent supportive housing is subsidized housing with treatment and support services. There is no agreed-upon standard model for housing homeless people with severe mental illness to guide both policy and practice (Bentson, 2015). Among providers of mental health and housing services, there are markedly different conceptual approaches on how best to house and treat this population (McHugo et al., 2004; Newman & Goldman, 2009; Torrey, 2014; Tsemberis, 1999). The Substance Abuse and Mental Health Services Administration (SAMHSA) has specified that supportive housing should include the following characteristics:

1. The full rights of tenancy, including a lease in the individual's name;
2. Assurance that housing is not dependent on service participation;

3. Tenants can choose from a range of services based on their needs and preferences;
4. A tenant's housing preference is considered, and the choice of potential housing settings is the same as for those without a mental disorder;
5. Housing is affordable, with tenants paying 30 percent of monthly income for rent and utilities;
6. Housing is integrated, with tenants living in scatter-site apartments in the larger community or in buildings where most of the units are not occupied by individuals with mental disorders;
7. House rules are typically limited to the terms and conditions of tenancy required by leaseholders in usual community settings;
8. Housing is not time-limited (SAMHSA, 2010).

In practice, few permanent supportive housing programs have adopted all or even most of SAMHSA's recommended characteristics, the notable exceptions being Pathways to Housing's "housing-first" programs and the U.S. Department of Housing and Urban Development–Veterans Affairs Supportive Housing Program (HUD-VASH) (Rog et al., 2014). Housing with treatment and support services is put into practice in numerous ways, and there is considerable variability in both the nature of housing and the range and intensity of support services. Use of scatter-site apartments for permanent supportive housing is dependent on the availability of low-cost apartment units in different markets across the country. Multi-unit housing is an efficient way to deliver services and increase the availability of quality housing for people with mental illness in tight low-cost-housing markets. The cost of construction or renovation of multi-unit housing, however, requires creative funding and skill in addressing the possibility of a "not in my backyard" response from the local community (Advisory Commission, 1991; Beggs, 1993).

Consumer Preferences

Consumer choice is often recommended as the most appropriate basis for housing placement decisions, and it is a key aspect of the supported housing approaches that involve independent and integrated community housing with individualized treatment and support (O'Connell et al., 2006; Tsemberis et al., 2004). The majority (from 50–90 percent) of people with severe mental illness seeking housing prefer independent living rather than staffed single-site dwellings (Goering et al., 1990; Schutt & Goldfinger, 1996). Although most individuals prefer independent housing, many acknowledge that supervised housing could be beneficial in the process of recovery (Schutt & Goldfinger, 2000; Tsai et al., 2010). In contrast to the views of consumers, clinicians are more likely to recommend supported group living for the vast majority of people with severe mental illness (Schutt & Goldfinger, 1996; Schutt et al., 2005). Thus there exists a range of housing options that address the perspectives of both consumers and providers of mental health services. In practice, housing decisions are often determined by the recommendations of mental health providers and the cost and availability of housing.

When given a choice of housing, what do most people want? Compared to a more structured community residence, the "housing as housing" approach offers the individual an opportunity to consider the most desirable characteristics of a housing setting. O'Connell et al. (2006) studied housing preferences in a 19-city federally funded program to assist homeless persons with psychiatric and substance abuse problems to secure housing with Section 8 housing subsidies. The study assessed housing preferences by asking individuals to rank the importance of housing features, and then querying whether they found those features when they obtained an apartment. The highest-ranking housing features were its affordability, its nearness to shopping and local transportation, the compatibility of its landlord, its physical condition, its privacy status and size, and its location in a safe neighborhood. Over 80 percent of individuals were able to find all of these features in the apartments they selected. A follow-up revealed that realizing an individual's housing preferences bore no relationship to clinical outcome but was important in future quality of life.

The Evidence for Supportive Housing

The variability in housing settings for people with mental illness and the wide range of characteristics in which they differ challenge both the development of research designs on studies of housing outcome and the generalizability of research findings. The scientific evidence for specialized housing for people with mental illness, imperfect though it is,[1] has yielded overwhelming evidence that *any type of housing* is effective in ending homelessness. Studies that contrast various types of supportive housing reveal

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[1] Limitations in the design and implementation of existing housing studies include poorly defined service models and control groups, the absence of experimental design, lack of detail on inclusion/exclusion criteria, small samples, and attrition over time (Bentson, 2015; Rog et al., 2014).

few differences in how long people retain their housing (Siegel et al., 2006), despite the fact that the service intensity of a housing setting is associated with markedly different resident characteristics (Lipton et al., 2000). A meta-analysis of 44 housing programs for people with mental illness—categorized as residential care and treatment, residential continuum, and permanent supportive housing—yielded greater housing stability outcomes for all programs compared to usual care or street or shelter living (Leff et al., 2009). An extensive literature on permanent supportive housing yields greater detail on housing stability and the effect of housing on clinical and social outcomes.

Housing Tenure

The earliest studies of supportive housing found that between 75 and 85 percent of people who enter supportive housing remain housed one year later (Barrow et al., 2004; Lipton et al., 2000; Martinez & Burt, 2006; Wong et al., 2006). Over time, however, housing retention is diminished. Two years after entering housing, between 63 and 77 percent remained housed (Barrow et al., 2004; Lipton et al., 2000; Martinez & Burt, 2006). By three years, only 48 percent remained in housing in a California study with a high prevalence of individuals with substance use comorbidity (Martinez & Burt, 2006). At five years, 50 percent remained continuously housed in a study of nearly 3,000 New Yorkers in a range of high, moderate, and low intensity settings (Lipton et al., 2000).

The Pathways to Housing "Housing First" program, developed by New York City psychologist Sam Tsemberis in 1992, is one of the two program models that meet SAMHSA's definition of permanent supportive housing. Through his work with a street outreach team, Tsemberis observed that the typical street-dwelling chronically homeless individual with severe mental illness and addictions was unable to meet the strict housing-readiness criteria of the prevailing stepwise continuum-of-care model that required treatment adherence and sobriety as a condition for obtaining housing. The Pathways program was developed to provide housing without preconditions. Individuals are offered housing in scatter-site community apartments, with services provided by assertive community treatment teams who implement a low-demand, individualized, harm-reduction treatment approach. A non-experimental study (Tsemberis & Eisenberg, 2000) and a controlled trial comparing the Pathways model to the continuum-of-care approach (Tsemberis et al., 2004) revealed housing retention rates of 80 percent or more. In the controlled trial, Pathways clients obtained housing earlier, remained stably housed longer over the two-year follow-up period, and reported greater perceived choice of housing.

More recently, findings on the efficacy of the housing-first model come from the "At Home/Chez Soi" two-year controlled trial of Housing First in five Canadian cities, funded by the Mental Health Commission of Canada. A "high need" sample of 950 homeless individuals with severe mental illness was randomly assigned to Housing First with assertive community treatment, or to treatment as usual. Housing First recipients were given a rent supplement, assistance in finding housing, and access to a community treatment team. Those assigned to the usual-care control condition had access to all other housing and treatment programs that existed in the community. At the two-year follow-up, 71 percent of Housing First participants had spent more time in stable housing, compared to 29 percent of participants in the usual-care control condition (Aubry et al., 2015a). In contrast to the usual-care group, Housing First participants who entered housing did so more quickly, had longer housing tenures at two years (281 days versus 115 days), and rated the quality of their housing more highly. In the final report of the At Home/Chez Soi study, 62 percent of high-need participants in Housing First were housed all of the time, 22 percent were housed some of the time, and 16 percent were not housed at all in the final six months of the two-year project. In the usual-care control condition, 31 percent were housed all of the time, 23 percent some of the time, and 46 percent were not housed at all (Mental Health Commission of Canada, 2014). Greater fidelity to the principles of Housing First (Tsemberis et al., 2004) was associated with improved housing outcomes (Davidson et al., 2014; Gilmer et al., 2014a; Goering et al., 2015).

Attrition: Why People Leave Supportive Housing

A Philadelphia study of why people leave supportive housing had two components; a retrospective analysis of administrative data on 943 mentally ill individuals who resided in permanent supportive housing, and a prospective study of people who left supportive housing compared to a matched group who stayed in their housing. Leaving supportive housing was common. Ten percent of people left within six months, and nearly 25 percent left within the first year. Nearly 40 percent of leavers left involuntarily due to violations of program rules such as drinking or using drugs, or because program staff considered them unable to be successful in the housing placement. The two-thirds classified as "non-positive" leavers left for a more service-intensive housing setting, an institutional setting such as a hospital or correctional facility, or a homeless shelter. The one-third deemed "positive leavers" left to live with family or friends or moved to a more independent setting without onsite treatment. The two leaver groups did not differ in background characteristics, psychiatric diagnosis, or level of functioning prior to entering housing, but after they entered permanent housing, the non-positive leavers were greater users of crisis services (Wong et al., 2006). A recent study of formerly homeless veterans who left supported housing prematurely compared to those who stayed found that premature leavers were more likely to have substance use disorders, criminal justice involvement, poor adherence with outpatient care, and frequent use of emergency departments. Half of premature leavers were either incarcerated or street homeless after leaving the housing program (Gabrielian et al., 2016).

CLINICAL, SOCIAL, AND SERVICE USE OUTCOMES OF PERMANENT SUPPORTIVE HOUSING

Impact on Use and Cost of Services

Permanent supportive housing has a salutary effect on the use of crisis health care services by homeless people with mental illness. A San Francisco study of formerly homeless people with psychiatric and substance-use disorder compared their use of crisis services in the two-year period before placement into supportive housing with their use of services in the two years after placement. Administrative data from the city's public health system revealed significant reductions in emergency department use and hospital admissions in the period following housing entry (Martinez & Burt, 2006).

A New York City study of the effect of a large-scale public investment in supportive housing found a similar result. Information on nearly 4,700 people in receipt of supportive housing was combined with administrative data on the utilization of public shelters, public and private hospitals and outpatient services, and incarceration in state and local correctional facilities. Recipients of supportive housing and matched control subjects who were homeless but not placed in housing were tracked to determine their use of services over time. Study results revealed that individuals placed in supportive housing experienced marked reductions in use of shelters, hospitals, and incarceration in correctional facilities. Less use of these costly crisis services reduced annual service costs by about 40 percent (per person annual cost of services prior to housing placement was $40,449 in 1999 dollars, reduced by $16,282 in the post-placement period) (Culhane et al., 2002). Given that the annual cost of a supportive housing unit in 1999 was estimated at $17,277, the savings in reduction of service costs in the pre-placement period nearly offset the cost of housing.

Similar findings on the effect of supportive housing on reduction in crisis service use and cost have also been reported for chronically homeless people with severe alcohol problems (Larimer et al., 2009). In a study of service use and cost among shelter and street-dwelling chronically homeless people, Poulin et al. (2010) observed that about 20 percent of the highest-cost service users accounted for 60 percent of the total service costs. High service-cost users were predominantly found among people with a diagnosis of severe mental illness, and most of the costs were for psychiatric care and jail stays.

Despite a reduction in use of high-cost crisis services following placement in supportive housing, a California study found that greater use of enriched rehabilitation and recovery services in the post-placement period was costly. California's Full Service Partnerships combine subsidized permanent supportive housing with enriched services provided by multidisciplinary teams. A study of health care utilization and costs before and after obtaining housing was conducted comparing 10,000 participants in Full Service Partnerships with a matched control group of over 10,000 participants in receipt of usual care. Information on service use and costs, tracked through administrative data sets over a multi-year period, revealed that participants in the Full Service Partnership group experienced increased mental health outpatient visits following placement in the program, while outpatient utilization in the control group remained stable. The annual per person increase in service costs for the Full Service Partnership group exceeded $12,000 (Gilmer et al., 2014b), indicating that enriched rehabilitation and recovery services can be costly and should be efficiently designed and tailored to specific individual needs.[2]

Impact of Permanent Supportive Housing on Behavioral Outcomes

A small-scale non-experimental study of homeless people with serious mental illness in housing-first and treatment-first programs found that

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2. In the At Home/Chez Soi project, the average annual Housing First intervention cost for high-need recipients of assertive community treatment services was $22,257, and $14,177 for moderate-need recipients of the intensive case-management approach (Mental Health Commission of Canada, 2014).

the housing-first group had lower rates of both substance use and substance abuse treatment utilization compared to the treatment-first group (Padgett et al., 2011). To date, however, other studies have found no effect of permanent supportive housing on mental health status or use of alcohol and drugs (Leff et al., 2009; Padgett et al., 2006; Rosenheck et al., 2003; Tsemberis et al., 2004). More positive life changes (Nelson et al., 2015) and greater improvements in community functioning have been observed among Housing First participants in the At Home/Chez Soi Study at one year (Aubry et al., 2015b). At the end of two years, however, differences between Housing First participants and participants in usual care were not significant (Aubry et al., 2015b). In-depth analysis of the effect of permanent supportive housing on employment and family and social relationships has not yet been reported.

Consumer Satisfaction

The most favored model of permanent supportive housing among consumers is both low-demand and free of service requirements (Tsemberis et al., 2004). Compared to other types of community housing, tenants are more satisfied with permanent supportive housing (Leff et al., 2009; Siegel et al., 2006), particularly as it relates to autonomy and economic viability (Siegel et al., 2006). Participants in the Housing First/Chez Soi study reported improved quality of life over the two-year study period (Aubry et al., 2015b), but their reports did not differ from those of participants in usual care.

EXPANDING HOUSING OPPORTUNITIES AND LEARNING MORE ABOUT HOW THEY WORK

The value to society of ending homelessness has fueled the expansion of supportive housing. Permanent supportive housing is effective in ending homelessness for many people with mental illness, helping them to remain stably housed in the community and reducing the utilization and cost of crisis services (Rog et al., 2014). The “housing-first” model has demonstrated that severely disabled individuals with co-occurring addictions can be successfully housed without requiring treatment as a precondition to housing placement. The success achieved so far is laudable, but remaining questions suggest an agenda for future work. Efforts to expand housing and service opportunities can occur alongside research that could refine housing models, determine which housing models work best for whom, improve outcomes, and inform policy. Clearer definitions of program models using reliable fidelity assessments of housing and services could enlighten how programs are implemented in real-world service settings (Bentson, 2015; Goering et al., 2015; Rog et al., 2014).

Most controlled trials to date have compared a permanent supportive housing model to "usual care" control groups about which little is known. Future studies could advance the field by comparing two well-defined housing models that differ on important dimensions. For example, McHugo et al. (2004) compared two approaches to linking housing and services. A randomized controlled trial of integrated housing, in which case management and housing services were provided by coordinated teams within a single agency, was compared to a parallel housing condition in which case management services were provided by assertive community treatment teams, and housing was provided by typical apartment landlords. Over an 18-month follow-up period, the severely mentally ill study subjects at risk of homelessness assigned to the integrated housing condition experienced greater housing stability, greater life satisfaction, and greater reductions in psychiatric symptoms compared to their counterparts in the parallel housing condition. The study's findings have implications for the current policy emphasis on separation of housing and services. As such, the study of McHugo et al. (2004) deserves replication.

Although permanent supportive housing consists of both housing and supportive services, there is little information about how people in supportive housing use mental health and substance abuse treatment services, particularly when service use is not required and is subject to individual choice. Moreover, there is an unmet need for information about the transition from assertive community treatment to less intensive and less costly services as individuals move toward recovery. As housing stability is achieved, the range of outcomes should be broadened to include more detailed assessments of social functioning and community participation.

The Importance of Neighborhood

Despite the public good of ending homelessness, communities have sometimes opposed the presence of homeless people with severe disabilities in their midst, fearing an increase in crime, a decline in property values, or the presence of individuals whose behavior or appearance may reduce the quality of a neighborhood. Studies of the impact of supportive housing on neighborhood characteristics have failed, however, to uncover a negative impact of supportive housing on crime rates or property values (deWolf, 2008; Furman Center, 2008). In fact, property values in neighborhoods surrounding new supportive housing in New York City increased steadily in the five-year period following completion of the building construction (Furman Center, 2008).

Housing opportunities for entitlement-dependent individuals are typically found in poorer neighborhoods. A large-scale New York City study of the implementation of single-site supportive housing in 123 new developments found that the housing tended to be sited in census tracts with a higher poverty rate, a lower home-ownership rate, and in areas with greater distress compared to the city in general and to census tracts without supportive housing (Furman Center, 2008). Low-cost apartments in center cities also tend to be concentrated in poorer neighborhoods, limiting the options for scatter-site units funded with housing vouchers. A New York City study on the effect of housing-choice vouchers on rates of crime found that voucher use did not lead to increased crime. Rather, voucher use in a neighborhood increased following an increase in crime (Ellen et al., 2011).

Information on housing and neighborhood characteristics of single-site and scatter-site permanent supportive living settings is limited. Early studies suggested that demographically and economically mixed neighborhoods with both commercial and residential properties were associated with better mental health outcomes (Newman & Ridgely, 1994; Segal & Aviram, 1978). In a more recent study, Harkness et al. (2004) found that chronically mentally ill residents in newer and adequately maintained apartment buildings had lower mental health care costs and greater residential stability. Reduced mental health care costs were also associated with a richer set of building amenities and neighborhoods with newer buildings and no apparent deterioration. Residential stability was greater in smaller-scale buildings and where a greater proportion of tenants were also mentally ill. More information is needed on how housing and neighborhood characteristics might influence housing choice and facilitate social integration and life satisfaction.

The Cost of Scaling-Up Permanent Supportive Housing

Permanent supportive housing is the best option to date for ending homelessness for the severely mentally disabled and helping them embark upon a path toward recovery. At an annual cost ranging from $12,000 to nearly $20,000 per unit, permanent supportive housing is expensive. It is substantially less, however, than the annual cost of a stay in a homeless shelter, a jail or prison, or a psychiatric hospital (National Alliance to End Homelessness, 2015).

Progress in the development of permanent supportive housing has been achieved through a creative mix of public and private funding. Nationally, there are about 150,000 units of supportive housing.[3] Federal funding from the Department of Housing and Urban Development's Continuum of Care initiative has supported about one-fourth of permanent supportive housing units, with additional federal support through Section 8 housing subsidies for scatter-site apartment housing. States such as New York, California, Washington, and Connecticut have helped to fund housing for people with mental illness, as have city and county governments. Other sources of funding include Low-Income Housing Tax Credits, private foundations, and charitable donations to nonprofit housing providers. The Affordable Care Act Medicaid expansion program will permit Medicaid reimbursement for services provided to individuals in receipt of supportive housing (www.usich.gov/issue/affordable_care_act1), possibly freeing up state and local funds that could be directed toward housing development.[4]

Moving On: Where to Go from Single-Site Supportive Housing?

When people living in a single-site supportive housing program recover and no longer need to be in a setting with onsite services, how do you move them out? The lack of affordable housing in many cities leaves few options for alternative housing at the "back end" of single-site supportive housing. Consequently, individuals stay where they are, even though they don't need such service-rich housing, depriving people who do need it from placement.

Shared Housing: An Untapped Resource for Ending Homelessness?

People in permanent supportive housing typically live alone. In contrast, most single adults live in households with other adults, and shared living

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[3] Personal communication, Richard Cho, USICH, October 29, 2015.

[4] Section 811 housing subsidies for people with disabilities, living in nursing homes, institutional settings, and group homes, was retooled in 2008 into a rental program given to state funding agencies to partner with Medicaid. Although it has been proposed that Medicaid/Medicare pay for housing for the most disabled poor, so far no such plan has materialized.

markedly reduces the per-person cost for housing. Yet policies that support shared housing for homeless people are uncommon. The Section 8 housing subsidy program, for example, tacitly depresses the option of shared housing by reducing the amount of the subsidy if the individual lives with another person (He et al., 2010). There is no evidence that shared housing is associated with a worse outcome for homeless consumers. A study of shared housing among formerly homeless people with mental illness revealed that whether a person lived alone or in shared housing made no difference in quality of life, overall mental health status, social support, or safety. Shared housing was associated, however, with reduced psychotic symptomatology (He et al., 2010), suggesting that living with another person could improve functioning and be an antidote to social isolation. It is possible that, in today's economy, shared living may be a desirable option for mental health consumers, as it is for many adults across the age span. Shared housing should be studied further, as it could be part of the solution to homelessness.

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Figure 7.1: A. The Brook, Alexander Gorlin, Architects. B. The Prince George. C. The Christopher, formerly the Robert McBurney YMCA, which inspired the Village People song "YMCA." D. The Hegeman, Brownsville, Brooklyn, COOKFOX Architects. E. Apartment in the Hegeman, COOKFOX Architects. F. Apartment in the Schermerhorn.

Single-site supportive housing is a mix of new construction and rehabilitated older structures, as illustrated by the buildings of Breaking Ground in New York City. Photographs shown with permission from Breaking Ground, New York, New York.

CHAPTER 8

National Initiatives to End Homelessness

This chapter presents two large-scale governmental efforts to implement community-level projects to improve the availability of and access to housing and support services for homeless people with severe mental illness. It's one thing to have "evidence-based" housing and support services available, and another thing to try to bring them to scale in real-world community settings. How well do these community-level approaches work? Lessons learned from these efforts can help to guide future dissemination of evidence-based housing and support services.

THE ACCESS PROJECT: ACCESS TO COMMUNITY CARE AND EFFECTIVE SERVICES AND SUPPORTS

Homeless people with severe mental illness require services from multiple systems of care to achieve stable tenure in the community. The fragmented and poorly coordinated community services for the severely mentally ill have been a concern from the earliest days of the deinstitutionalization movement. The 1992 report of the Federal Task Force on Homelessness and Chronic Mental Illness, *Outcasts on Main Street*, recommended the development of a demonstration program to coordinate services. The Center for Mental Health Services funded five-year demonstration projects in 1992 to test whether a more integrated system of care could be developed that would provide service recipients greater services integration by increasing collaboration and cooperation among agencies providing mental health and substance abuse treatment, health care, income support, and housing (Randolph et al., 2002). Of the 25 states that vied for the initiative, nine were selected through a process of peer review to participate in the $17 million demonstration project. Each state selected two communities that had similar numbers of homeless people with mental illness and were comparable in terms of population size, housing, and median income.

Nine experimental communities were randomly chosen to receive funding and technical support to develop systems-integration strategies, such as forming interagency coalitions, co-locating services, developing interagency information systems, joint funding, and establishing interagency service delivery teams (Randolph et al., 2002). Nine communities in the same states served as comparison sites. Funding for assertive community treatment teams was provided to both experimental and comparison communities to serve 400 individuals at each site. Outcome of systems-change strategies was assessed through site visits and interviews with key representatives from community service organizations. To determine if systems-change strategies improved the service and behavioral outcomes of individual clients, over 7,000 homeless individuals in experimental and comparison communities were evaluated at study entry and over the follow-up year.

The study found that the ACCESS effort did not lead to greater service integration in the nine experimental sites. Although service integration did not improve across multiple human services agencies system-wide, the experimental sites had better services integration at the individual project level, giving clients greater access to the range of services available in the community (Goldman et al., 2002; Morrissey et al., 2002). Health status, community adjustment, and service-use outcomes improved for individuals in both the experimental and comparison groups, but greater efforts to implement systems-integration strategies in the experimental sites did not result in better client outcomes. Regardless of whether a site was experimental or comparison, however, individuals in sites with greater service system integration had better housing outcomes (Rosenheck et al., 2002).

THE TEN-YEAR PLAN TO END CHRONIC HOMELESSNESS

A major national effort, the Ten-Year Plan to End Chronic Homelessness, was initiated in 2000. The brainchild of the National Alliance to End Homelessness, it was inspired by two streams of research that had yielded findings with important policy implications. Culhane and Kuhn's benchmark findings on patterns of public-shelter use by homeless adults indicated that about one in five (18 percent) were long-stay shelter users who consumed a disproportionate share of the system's resources (Culhane & Kuhn, 1998). Individuals in the long-stay group were more likely to have mental health problems, substance abuse, and medical disorders.

At the same time, emerging findings from research on permanent supportive housing revealed that housing placement was associated with a marked lessening of the use of shelter, hospital, and correctional facilities prior to housing placement. Reduction in use of these expensive services nearly offset the cost of permanent supportive housing (Culhane et al., 2002). Thus, a high-need, high-cost group was identified for whom the remedy was permanent supportive housing. Malcolm Gladwell's account of "Million-Dollar Murray" in *The New Yorker* (Gladwell, 2006) publicized the high costs incurred by chronically homeless individuals. Having an intervention that could save public dollars would appeal to the political and policy communities whose support would be needed to implement the Ten-Year Plan.

With "A Plan, Not a Dream: How to End Homelessness in Ten Years," the National Alliance to End Homelessness led the charge for a national plan to end chronic homelessness. Nan Roman, president and chief executive officer of the organization, introduced the chronic homeless initiative to the Federal Interagency Council on Homelessness. The issue caught the attention of Secretary Mel Martinez of the Department of Housing and Urban Development (HUD), who saw the chronically homeless as a high-need group for whom a solution was available. It was seen as the most doable piece of the homeless problem. Wide support was garnered from Congress and the Bush administration. A goal was set, and the plan was put into the federal budget. Importantly, at the end of the Clinton administration there was a 30 percent set-aside for permanent supportive housing in the McKinney authorization available to jump-start the chronic homeless initiative. The executive director of the Interagency Council on Homelessness, Philip Mangano, a Massachusetts advocate known for his ability to apply business solutions to the problem of homelessness, would lead the initiative. A nationwide effort was underway with a challenge to 100 cities to develop plans to end chronic homelessness.[1]

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[1] Personal communication, Nan Roman, June 24, 2015.

The Target Group: Chronically Homeless Adults

The plan did not involve a new federal funding initiative. Rather, federal agencies that typically addressed the problem of homelessness prioritized chronic homelessness in various funding opportunities for federal homelessness assistance provided by the McKinney Homeless Assistance Act, such as HUD's Continuum of Care Program. The various branches of the federal government defined "chronic homelessness" as follows:

> An unaccompanied homeless individual with a long-term and disabling condition (severe mental illness, substance use disorder, dual diagnosis, a chronic medical condition, or two or more conditions that restrict work or the activities of daily living) who has either (a) been continuously homeless for a year or more, or (b) has had at least four episodes of homelessness in the past three years.

Tracking Homelessness Nationwide: "Point-in-Time" Counts

Progress toward the goal of ending chronic homelessness has been measured with the annual "point-in-time" count of unsheltered and sheltered homeless people, mandated by Congress in 2001, and implemented in 2005 (Annual Homeless Assessment Report to Congress). The point-in-time counts utilize data from the HUD Homeless Management Information System (HMIS) which collects client-level data and data on the provision of housing and services to sheltered homeless individuals. Coupled with a one-night count of unsheltered people in the streets and public places, the HMIS data and street counts provide the best estimate of the annual prevalence of homelessness nationwide (USDHUD, 2015). Occurring on a night during the last week of January, the point-in-time count is carried out by the local planning groups responsible for coordinating homeless services in a specific geographic area. The count involves classifying homeless people in various ways, such as whether the individual is homeless alone or a member of a family, is a veteran, or was staying in a street or a shelter location. Although there is a fairly specific definition of chronic homelessness, there is no guarantee that all raters involved in the point-in-time counts have applied this definition in a consistent manner. The counts have been affected to some extent by definitional changes mandated by HUD regarding the disability requirement for defining chronic homelessness, and the reclassification of some shelter and transitional housing beds from homeless beds to rapid rehousing.

In addition, there is variability in how cities report year-to-year changes in the number of homeless people.

Development of Ten-Year Plans

The National Alliance to End Homelessness issued a blueprint for the development of community level plans that included four steps:

1. Plan for Outcomes: Improve the quality of data at the local level, establish a planning process that seeks to end homelessness, and bring stakeholders responsible for homeless-targeted resources into the planning process.
2. Close the Front Door: Encourage mainstream poverty programs to prevent homelessness by assuming greater responsibility for their client outcomes.
3. Open the Back Door: Help people exit homelessness as quickly as possible, such as with a "housing first" approach and permanent supportive housing for the chronically homeless.
4. Build the Infrastructure: Develop an adequate supply of affordable and subsidized housing, and address persistent poverty that focuses on affordable housing, livable incomes, and appropriate services for those who need them. (http://wwwendhomelessness.org/library/entry/fact-sheet-what-is-a-ten-year-plan-to-end-homelesness)

The implementation of the federal ten-year plan initiative was, however, a matter for the Interagency Council on Homelessness. To assist in the plan-development process, policy academies to educate stakeholders were sponsored by the Department of Health and Human Services (DHHS) and HUD. Philip Mangano, executive director of the Interagency Council on Homelessness, was the instrumental leader of the ten-year planning process. In travels to hundreds of communities across the nation, he inspired communities to garner local assets and implement best practices in utilizing federal McKinney-Vento funds targeted at disabled chronically homeless individuals.

By 2009, there were 234 completed plans to end chronic homelessness. Of these, 84 percent were anticipated to be ten years in length. Fewer than 10 percent of plans were developed by 2003, but by 2009, all 234 plans were completed (National Alliance to End Homelessness, 2009).

With plan expiration dates ranging from 2012 to 2019, the ten-year plan initiative developed during the presidential administration of George

W. Bush and was dependent on ending chronic homelessness remaining a priority in the presidential administrations of both Barack Obama and his successor. Public policy change is, however, inevitable. Unemployment and housing loss associated with the economic recession of 2007–2008 placed greater numbers of individuals and families at risk of falling into homelessness. To address this problem, the new administration of Barack Obama instituted the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act) in 2009, significantly expanding homelessness prevention and rapid rehousing, particularly for homeless families. The prior emphasis on permanent supportive housing for chronic homelessness continued under the HEARTH Act. Eligibility for federal housing assistance expanded, however, to include homeless families with long-term homelessness. Details in the HEARTH Act defined eligibility for prevention services, reclassified housing assistance programs, and added the heads of the Social Security Administration, Department of Justice, Office of Management and Budget, and the Office of Faith-Based Community Initiatives to the Interagency Council on Homelessness.

In 2009, Barbara Poppe was appointed to be the executive director of the Interagency Council on Homelessness, to succeed Philip Mangano. That same year, $1.5 billion in American Recovery and Reinvestment Act funds were allocated for homelessness prevention and rapid rehousing services, which target the newly homeless and those at risk of losing their housing. In June 2010, the Interagency Council on Homelessness issued “Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness.” Advocating for collaboration with the private sector, philanthropy, and state and local governments, the goal of this initiative was to end chronic homelessness and homelessness among veterans in five years (2015), and within ten years to end homelessness for families, youth, and children. Laura Zeilinger, who joined the Interagency Council in 2011 to assist with the implementation of “Opening Doors,” was appointed to be its executive director in early 2014. Zeilinger left the position later that year, and was succeeded by Matthew Doherty. In 2015, the timeline for ending chronic homelessness was extended to 2017.

Status of Implementation of Ten-Year Plans

The shifting focus of the Interagency Council’s policy priorities was reflected in the subpopulations targeted in the development of ten-year plans. In the earliest plans developed, the vast majority aimed to address chronic homelessness. In later plans, however, only about half aimed to combat chronic homelessness, while the number of plans focused on family and youth homelessness increased. Ex-offenders, veterans, and the elderly were also targeted in later ten-year plans (National Alliance to End Homelessness, 2009).

Although ten-year plans were developed by a large number of communities, there has never been a comprehensive evaluation of the extent to which plans have been implemented. In 2009, the National Alliance to End Homelessness analyzed the content of existing plans to determine if key factors thought to lead to successful plan implementation were included, such as having a person or group responsible for implementing the plan, setting numeric goals, identifying a funding source, and setting an implementation timeline. The study findings determined that few plans included these four factors thought to be predictive of success.

Outcome of Ten-Year Plans to End Chronic Homelessness: Case Studies of Implemented Plans

In the summer of 2015, this writer interviewed key informants involved in the implementation of ten-year plans to end chronic homelessness in five American cities: Portland, Oregon; San Francisco, California; Houston, Texas; Salt Lake City, Utah; and Washington, D.C. These cities were reported to have achieved some measure of success by either the National Alliance to End Homelessness or media reports. The ability of these cities to put their plans to work signaled an opportunity to explore how the plans were implemented, the critical elements associated with goal achievement, obstacles that had to be overcome, and the level of success in ending chronic homelessness. The point-in-time data from each city's annual count of sheltered and unsheltered homeless people was the source for determining progress in reducing chronic homelessness.

Portland, Oregon

"Home Again: A Ten-Year Plan to End Homelessness in Portland and Multnomah County" was released in December of 2004. Inspired by the national effort focused on chronic homelessness, Portland's city government established a blue ribbon committee, composed of the mayor, the local representative of HUD, business leaders, and health care providers, charged with mobilizing stakeholders in housing, health, and mental health care to work collaboratively to address chronic homelessness at the city and county levels. Leadership responsible for implementing the plan included

Heather Lyons, a community organizer, and City Commissioner Eric Sten, who headed the housing authority. The expansion of permanent supportive housing was an early accomplishment of the ten-year plan initiative. Two federal grants were obtained to support existing apartments clustered throughout the community. In addition, the Corporation for Supportive Housing awarded a seed money grant to Portland to develop new construction for 1,600 units of supportive housing.

Before the ten-year plan reached the halfway point, changes in the political leadership of city and county government, with accompanying staff changes, interfered with its implementation. Moreover, the economic recession of 2007–2008 increased unemployment among low-wage workers and placed greater numbers of Portlanders at risk of homelessness. A revised plan for ending homelessness, "A Home for Everyone: A United Community Plan to End Homelessness in Multnomah County," was developed in 2012, broadening the focus on ending homelessness to include families with children, unaccompanied youth, women, veterans, and adults with disabilities. Operational changes included the creation of a governance committee to oversee the work of the plan, and the development of an action plan that emphasizes goal achievement, outcome assessments, and cost effectiveness. Sally Erickson assumed a leadership role in implementing the new plan, succeeding Heather Lyons.

The 2015 point-in-time count, carried out on January 28, 2015, revealed that there were 3,801 homeless people in Multnomah County, 837 of whom were chronically homeless (Kristina Smock Consulting, 2015). Although there was a 54 percent increase in number of chronically homeless people between 2011 and 2013, by 2015, the number of chronically homeless people had decreased by 15 percent compared to the 2013 high. The report noted that the community's continuing struggle with homelessness has occurred in the context of high housing costs, low vacancy rates, stagnant wages, and persistent unemployment among low-wage workers.

Washington, D.C.

"Homeless No More: A Strategy for Ending Homelessness in Washington, D.C., by 2014" was developed during the administration of Mayor Anthony A. Williams in 2004, and continued through the mayoral administrations of Adrian Fenty and Vincent Gray. The plan addressed ending chronic homelessness but also focused on the development of affordable housing for the working poor and homeless families. A goal of the plan was to create at least 6,000 new housing units over ten years, some with supportive services for people whose homelessness has been chronic and sustained.

Laura Zeilinger led the District's implementation of the ten-year plan goals and strategies.

An initial effort was a survey added to the annual point-in-time count to gather additional information on how the city could best meet the needs of chronically homeless people by leveraging existing resources. The survey facilitated a better match of the needs of chronically homeless individuals with community-based resources. Four groups were identified: people with HIV/AIDS, the elderly, victims of violence and violent offenders, and people in need of behavioral health or addiction services. Results of the survey led to the conclusion that specific programs combined with housing could address the underlying problems associated with homelessness. The provider community was then engaged to prioritize housing and services for people with the greatest vulnerability and the longest duration of homelessness. Additional funding for permanent supportive housing, obtained from the federal and District of Columbia governments, facilitated housing placement using a housing-first approach. Scatter-site housing in community apartments funded with vouchers was the most frequently used housing paradigm, since existing apartments could be quickly and easily obtained, obviating the need for long-term new construction.

The election of Mayor Vincent Gray in 2011 led to changes in the plan to end homelessness, with greater emphasis on homelessness in families and veterans. Although chronic homelessness increased during the peak of the recession of 2008 (Metropolitan Washington Council of Governments, 2010), the annual point-in-time count revealed that chronic homelessness was reduced from 2,093 people in 2011 to 1,593 in 2015, a reduction of 24 percent (Chapman, 2015).

Houston, Texas

The 2006 "Plan to End Chronic Homelessness" was developed by a Blue Ribbon Commission formed in April 2004, in collaboration with the Coalition for the Homeless of Houston/Harris County, city and county officials, service providers, business leaders, economic development professionals, philanthropic organizations, and a representative of the Interagency Council on Homelessness. An Executive Directors Group, made up of directors of homeless services agencies, participated in a study to enumerate the homeless population and identify unmet needs.

Following earlier, unsuccessful attempts to develop a plan to end homelessness, a renewed effort was begun in response to the HEARTH Act of 2009. In 2011, Houston was named a priority city by HUD. This designation brought technical assistance on the ground beginning in 2012. Before a new plan was created, research was done which included a system mapping of existing housing and services and a gap analysis.

A resource gap analysis was conducted to guide the development of a strategic plan based on social science research and evidence-based approaches. Initially, the Houston effort prioritized chronic homelessness and veterans' homelessness. The strategic plan set detailed goals for permanent supportive housing, outreach to chronically homeless individuals, systems management, and assurance that funding for housing and programs would be sustainable. The plan specified action steps, progress measures, and expected outcomes. The plan acknowledged that implementation would require a combination of federal, state, and local support.

Plan implementation has been the responsibility of the Coalition for the Homeless, headed by Marilyn Brown. Local efforts were aided by the political support of Mayor Annise Parker, who was strongly committed to the homeless initiative and brought key stakeholders into the process. Noting that people tend to support what they help to create, weekly meetings were held with 15–20 people who work in different parts of the homeless services system to maintain ongoing links with activities "on the ground." Additionally, over 20 workgroups composed of varying staff from homeless service provider agencies met regularly to design, implement, and improve each new process in the system. Despite a low vacancy rate following a downturn in the economy, Houston's stock of affordable housing enabled rapid housing placements for high-need individuals using vouchers from the housing authority. A local nonprofit housing developer constructed single-room occupancy units, some of which were allocated to the chronically homeless individuals.

Early on, policy changes mandated by the 2009 HEARTH Act and the Interagency Council on Homelessness 2010 initiative, "Opening Doors," presented an organizational challenge. Prior to 2009, federal funding terms and conditions were based on an individual agency's performance, without considering whether a program was necessary or whether it accomplished what was needed. HEARTH Act funding was based on the success of the *community as a whole* in reducing homelessness and improving housing stability. As a consequence, federal funding requirements encouraged the collaboration of 30 Houston agencies (60 programs) to create a single Continuum of Care grant request as an alternative to multiple grant requests by individual agencies. What evolved was a stronger central administration of the ten-year planning process with greater agency collaboration.

The 2015 Houston point-in-time count revealed that, of the 4,609 sheltered and unsheltered individuals who were homeless on January 29, 2015, 899 people were chronically homeless. Between 2011 and 2015, the number of chronically homeless people decreased by 46 percent. From 2014 to 2015, the number of chronically homeless people decreased by 17 percent (Troisi, 2015).

San Francisco, California

"The San Francisco Plan to Abolish Chronic Homelessness" was adopted in 2004, supported by Mayor Gavin Newsom, who made ending homelessness a priority in his mayoral campaign. Strong support from the mayor brought governmental and nonprofit agencies into the process. The plan targeted 3,000 chronically homeless individuals, contending that getting this high-cost, high-burden group into stable housing would make it easier to manage the homeless problem in San Francisco. Dariush Kayhan served as coordinator of the citywide homeless initiative, working closely with Trent Rhorer of the San Francisco Human Services Agency, Dr. Josh Bamberger of the San Francisco Health Department, and Mark Trotz, who directed the Department of Public Health's Direct Access to Housing. In implementing the plan, new housing resources were directed at chronic homelessness. Single-site housing settings were preferred since they facilitated concentration of services in one place. Old hotels were leased by nonprofit developers, who negotiated with landlords to undertake renovation and create spaces on the ground floor for case management and medical services. A percentage of units were then set aside for chronically homeless people with mental illness. The plan prioritized outreach to the street homeless, a group likely to include individuals with multiple disabilities.

To create a good referral system, regular meetings focused on ten high-need individuals at a time, getting into each person's story, assessing clinical needs, and then matching housing to clinical need. When necessary, difficult cases were "hand-held" to get them into housing. Federal support for housing was obtained from HUD's Continuum of Care, and the mayor allocated county general funds for housing leases and operating costs.

Since the adoption of the Ten-Year Plan, San Francisco has created 2,699 units of permanent supportive housing. The retention rate in supportive housing is 90 percent. Chronic homelessness declined by 57 percent between the peak of the recession in 2009 and 2015 (from 4,039 to 1,745) (Applied Survey Research, 2015; San Francisco Human Services Agency, 2014).

Salt Lake County, Utah

"New Vision, New Opportunity: Ten-year Plan to End Chronic Homelessness," was developed in 2005. Lloyd Pendleton, a community leader and former manager of field operations for the Church of Jesus Christ of the Latter Day Saints (Mormons), served as director of the Homeless Task Force. Mr. Pendleton led the development of the plan and its later implementation from 2003 to 2015, believing that follow-through was essential in guaranteeing the success of the plan. In the Utah planning process, local leaders in 12 areas across the state established committees to devise local plans inspired by an overall statewide plan. Local involvement in plan development was viewed as an important element in the commitment to carry it out. It was centrally led but locally developed. Key elements of the plan included adding over 1,000 units of supportive housing for people experiencing chronic homelessness, expanding outreach efforts, increasing access to mainstream services, improving service coordination, and adding prevention activities directed to people at risk of homelessness when leaving jails and treatment facilities.

Initially, no additional funds were allocated to the ten-year plan effort. Rather, existing resources were redirected to address the goal of ending chronic homelessness. New York City's Pathways to Housing "Housing First" program inspired a pilot project in Salt Lake City targeted at the most challenging group of chronically homeless people. Collaborating landlords were engaged in the implementation of a scatter-site "housing first" model for 17 severely mentally ill homeless individuals. After 22 months, all 17 individuals remained housed. Following the success of the pilot effort, about 1,300 single-site and scatter-site apartments were made available for the expansion of "housing first."

The Low Income Housing Tax Credit program assisted nonprofit supportive housing developers to construct over 600 units of single-site supportive housing. Funding for housing came from Section 8 vouchers allocated from the Salt Lake City and Salt Lake County housing authorities. Overall, about 8 million dollars annually were received through HUD Continuum of Care. In addition, block grants, HUD Home Investment Partnership (HOME) funds, and general fund dollars were used to provide the housing and support for this housing-first initiative. The Homeless Trust Fund, created and funded by the State of Utah Legislature, awarded $4 to $5 million annually to support case-management services, used throughout the homeless service system, instead of more costly multidisciplinary treatment teams.

Salt Lake City had the benefit of extensive community support directed at the homeless effort. The Church of Jesus Christ of the Latter Day Saints contributed funds for the development of housing. Vouchers for use in the church's thrift stores were made available for furnishings and food supplies. Private contributions also helped to fund the cost of operating local shelters. In addition, commercial banks in Utah contributed community reinvestment dollars to the homeless effort.

During the recession of 2008, homelessness in families increased by 300 percent. At the same time, the Homeless Trust Fund was reduced because of the financial downturn, but less than its fair share. By that time, considerable progress had been made in reducing chronic homelessness among single adults, so it was possible to convert single beds to family beds without creating new homeless shelters. In 2005, when the ten-year plan was initiated, 1,932 people were chronically homeless (Day et al., 2014, p. 9). In 2015, 178 people were chronically homeless (Utah Homeless Management Information System [HMIS], 2015). In the period from 2005 to 2015, chronic homelessness in Utah was reduced by 91 percent.

ENDING CHRONIC HOMELESSNESS

Findings from the ACCESS project and the initiative to end chronic homelessness reveal the challenges of organizing and coordinating large-scale community-level efforts to address homelessness. The greatest success in both programs was achieved at the local level, in places where the commitment to the objective and the ability to influence implementation were greatest.

Nationwide, homelessness was reduced by 31 percent between 2007 and 2015 (USDHUD, 2015). The national data and the five case studies of Ten-Year Plans to End Chronic Homelessness reveal that it is possible to reduce chronic homelessness, even though the goal of ending it has so far been elusive. Success has been achieved in this vulnerable population despite a severe economic recession, the persistent scarcity of affordable housing, a fragmented system of mental health care, and disability entitlements that fall far below the poverty level. Successful implementers of ten-year plans have had to pivot in response to policy, funding, and staff changes that invariably occur with transitions in political leadership at all levels of government, without losing sight of the goal to end chronic homelessness. Homelessness among people with severe mental illness still rages, however, in metropolitan centers like New York City and Los Angeles, and in cities and hamlets across the nation. The importance of ending the scourge of homelessness in a prosperous nation such as this demands a careful consideration of lessons learned so far.

Staying the Course

Throughout the ten-year plan duration, the most successful plans remained focused on chronic homelessness, addressing the needs of this high-risk, high-cost group by expanding the stock of permanent supportive housing. Surveys and research tools to identify the most vulnerable homeless individuals and a referral and placement system that matched individual needs to the most appropriate housing placement informed the best use of existing resources.

Public Will and Community Engagement

The ability of plan leadership to engage community stakeholders across many disciplines and areas of influence was a feature of successful plan development and implementation. Salt Lake City's good fortune in having a plan leader whose involvement spanned the entire ten-year period of development and implementation was undoubtedly a factor in that plan's success.

Creative Funding for Permanent Supportive Housing

The housing and treatment support services needed for helping people exit homelessness and establish stable lives in the community are costly. These assets should be targeted to the most vulnerable individuals with the greatest need. All five ten-year plans were able to garner funding for housing from federal and state or local governments. Citing the need for creative funding for housing the homeless, Philip Mangano has pointed out that "government can't do it all." Sources of funding for housing in successful plans also included foundations, religious institutions, individual donors, the Low Income Housing Tax Credit program, and Community Reinvestment Act dollars from commercial banks.

Question: What will it take to complete the task of ending chronic homelessness?

> "We virtually eliminated homelessness among veterans through a commitment to do so and focused resources, and the same could be accomplished for the chronically homeless."

Tony Hannigan
Executive Director, Center for Urban Community Services
New York, New York

> "We know how to end chronic homelessness: permanent supportive housing. Getting enough such housing to do the job will require three things: national political will to provide the resources; local determination to deliver quality housing and services and house every chronically homeless person; and a robust effort to prevent any disabled person from ever again being chronically homeless."

Nan Roman
CEO, National Alliance to End Homelessness
Author of, and advocate for, the Ten-Year Plan to End Chronic Homelessness
Washington, D.C.

> "We know that permanent supportive housing is the key solution for chronic homelessness in this country, proven to improve people's lives while also saving communities money. If we can bring the supply of supportive housing to the scale that's needed, and if communities can target that supportive housing effectively, it will no longer be a matter of whether communities can end chronic homelessness, but when."

Matthew Doherty
Executive Director, United States Interagency Council on Homelessness
Washington, D.C.

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CHAPTER 9

Can Homelessness Be Prevented?

The policy emphasis on chronic homelessness is an important, albeit incomplete, solution in the quest to end homelessness among people with mental disabilities. There is ample evidence that permanent supportive housing has improved many lives. By prioritizing high-need, high-cost individuals who have extensive histories of street and shelter living for access to this highly specialized resource, people with mental disabilities who may be at risk of homelessness but do not meet the stringent criteria for chronic homelessness are left out. The lack of prevention and early intervention services can result in a constant influx of newly homeless people with severe mental illness whose homelessness may eventually become long-term and chronic. Ending homelessness requires opening the "back door" of the homeless services system to housing opportunities for people already homeless, but also closing the "front door" with effective interventions to prevent people from experiencing a first homeless episode (National Alliance to End Homelessness, 2009). The federal response to homelessness following the recession of 2008, the Homeless Prevention and Rapid Rehousing Program, gave new currency to a prevention paradigm whose effect is still being assessed (Culhane et al., 2011).

A prevention approach that considers a distinction between high-risk prevention and population-level prevention (Rose, 1992) is applicable to people who are extremely vulnerable to homelessness. It has the advantage of drawing attention to the need to address prevention, not only by intervening directly with those at high risk, but also by modifying the overall social and economic context in which homelessness can occur. The knowledge that people with severe mental illness constitute a group at high risk for homelessness obviates to some degree the problem of accurate targeting of prevention interventions when the risk for homelessness cannot easily be specified, an issue widely discussed in the literature (Burt et al., 2007; Culhane et al., 2011; Shinn et al., 2001). At present, there are no evidence-based homelessness prevention approaches, but ongoing work in the area is promising.

POPULATION-LEVEL PREVENTION

Actions that add to the development of more affordable housing, increase the dollar amount of disability entitlements, or expand subsidized housing would benefit a wide swath of very low-income people, expanding the safety net and preventing some from falling into homelessness. The Section 8 program is a major source of federal housing assistance to individuals and households living at or below 30 percent of an area's median income. The tenant who receives a housing choice voucher pays 30 percent of the cost of a private market dwelling, while the program covers the remainder of the rent costs up to a maximum amount. The Section 8 program currently operates as a lottery, as funding for the program falls far short of providing rental assistance to all who may need it. It has been suggested that making a housing subsidy an entitlement for people with incomes at the poverty level could markedly reduce the homeless problem in the United States (Olsen, 2010).

The Homelessness Prevention and Rapid Rehousing Program (HPRP), an initiative of the American Recovery and Reinvestment Act of 2009 (ARRA) that allocated $1.5 billion over three years, pushed mainstream homeless policy toward prevention (Culhane et al., 2011). When ARRA funding ended, the Homelessness Emergency Assistance and Rapid Transition to Housing Act (HEARTH) established the continuation of homeless prevention through the Emergency Solutions Grant program. Intended to serve people on the brink of homelessness, assistance provided includes short- and longer-term rental assistance, housing relocation, and stabilization services, such as mediation, credit counseling, security and utility deposits, utility payments, moving cost assistance, and case management (USDHUD, 2009).

HIGH-RISK PREVENTION

New York City's Homebase Program: Preventing the Loss of Existing Housing for At-Risk Households

New York City developed a homelessness prevention program, known as Homebase, in 2004, applying many of the elements that would later be incorporated into the Homeless Prevention and Rapid Rehousing Program. The Homebase program, initially targeted at family households, consists of neighborhood-based centers designed to serve community residents at risk of losing their housing, thus preventing an entry into the city's shelter system. The threat of homelessness can occur for a variety of reasons, such as an impending eviction, job loss, or a behavioral health problem. Eligible householders are assigned a case manager who addresses the immediate threat to housing loss and develops a sustainable plan for housing stability. Service plans, developed in collaboration with and tailored to the needs of the householder, can involve direct case management services, tenant and landlord mediation, employment assistance, legal services, mental health and substance abuse services, and short-term financial assistance.

In the start-up phase of Homebase, the program was established in only a select number of community districts in the city. Messeri et al. (2012) took advantage of the pattern of implementation of Homebase to conduct a quasi-natural experiment to estimate the impact of Homebase on entries into the shelter system. Using New York City Department of Homeless Services administrative data, shelter entries in Homebase districts were compared with shelter entries in a matched sample of community districts without the Homebase program. Findings revealed that Homebase reduced between 10 and 20 shelter entries for every 100 families it served. The average decrease in shelter entries among equally weighted census tracts was 5 percent, and about 11 percent among equally weighted community districts (Goodman et al., 2016). In a controlled trial of a later version of Homebase, Rolston et al. (2013) found that Homebase reduced shelter entries and also lessened the length of shelter stays for those who entered the shelter system. Homebase has not been studied with severely mentally ill people at risk of losing their housing. The state of Massachusetts has, however, developed a homelessness prevention program for this high-risk group.

Massachusetts' Tenancy Preservation Program: Serving Disabled People at High-Risk of Homelessness

The Massachusetts Tenancy Preservation Program (TPP), a collaborative effort of the state housing authority, the Massachusetts Housing Court, and regional service providers, is designed to prevent homelessness among people with disabilities threatened with eviction. The Housing Court generates referrals of pending evictions involving disabled people to a TPP clinician, who functions as a neutral intermediary between the landlord and the disabled tenant. Individuals eligible for the TPP program must have a disability that is directly related to a lease violation. Under the Fair Housing Law, a disabled tenant in this situation has the right to a reasonable accommodation, allowing the court to delay eviction proceedings until an accommodation can be established. Reasons for the eviction are then evaluated, a plan for needed services is developed, and adherence to the recommended plan is monitored. Work on a case may require that the TPP clinician interact with an array of community providers, such as local housing authorities, property managers, and income-support and legal services, in the development of a service plan. If the tenancy cannot be preserved, the TPP clinician assists the individual to find more appropriate housing. If the issues that led to the pending eviction cannot be resolved within the confines of TPP, the clinician works with community-based service providers for appropriate continuing care (Burt et al., 2007; Citino & Glasgow, 2010).

A descriptive evaluation of 676 cases in the Tenancy Preservation Program revealed that the majority were either tenants of a local housing authority or recipients of subsidies in single-site or scatter-site housing. The most common lease violation, found in nearly two-thirds of cases, was nonpayment of rent or utilities. Conflicts with neighbors and unsanitary conditions were also observed in about 20 percent of cases. In resolving a case involving nonpayment of rent, an accommodation might include an agreement to have a representative payee manage a tenant's entitlement income (Citino & Glasgow, 2010, p. 5). Other accommodations might involve a commitment to behavior change or adherence to recommended treatment. Of 486 closed cases, stable housing was achieved through either preservation of the existing housing or a move to more appropriate housing in 82 percent of cases (Citino & Glasgow, 2010, p. 19). The average duration of a TPP intervention was about five months, at an average cost of $2,377 per case. Long-term outcome of the TPP program has not been assessed, and there has not been a controlled trial of TPP.

Discharge Planning: Preventing Chronic Homelessness

In the early period following deinstitutionalization, several states, including Massachusetts, Rhode Island, and New York, passed discharge-planning laws to address the service needs of the severely mentally ill discharged from hospitals to the community. In general, these laws mandated that comprehensive community care tailored to individual needs, including psychiatric outpatient treatment, an adequate living arrangement, and adequate economic and social support, be arranged before hospital discharge (New York State Mental Hygiene Law, Chapter 804, Section 29.15, subdivision 2f, g, h) (Caton et al., 1984). Despite early studies of discharge planning (Hogarty, 1968; Zolik et al., 1968) that revealed the benefits of a comprehensive discharge planning approach in reducing early rehospitalizations (Caton et al., 1984), homelessness as an outcome has not been assessed, and there is no evidence-based discharge planning intervention (Moran et al., 2005).

Discharge planning is an important element in the national effort to address chronic homelessness (Backer et al., 2007; National Alliance to End Homelessness, 2009). It is well known that homeless people with severe mental illness often experience admissions to institutional settings such as emergency departments, hospitals, correctional facilities, and shelters (Hopper et al., 1997). If they are released from institutional care without adequate housing, follow-up clinical care, income support, or rehabilitation services in the community, vulnerability to homelessness can persist. Discharge planning practices have been specified that underscore its multidisciplinary nature and the need for service coordination among institutional and community-based providers. Needs assessment is typically the responsibility of the institutional provider, who then must partner with housing programs and community service agencies to develop an appropriate service plan and set the stage for its implementation (Backer et al., 2007; Mangano & Hombs, 2002).

While there is considerable consensus on what good discharge planning should consist of, roadblocks to successful discharge planning include inadequate housing opportunities, a fragmented community service system, and lack of staff training. Moreover, discharge planning takes time, a precious commodity among overburdened institutional staff in real-world service settings (Backer et al., 2007; Moran et al., 2005). A major gap in conceptualizations of discharge planning is the lack of a procedure for follow-up after an individual leaves an institutional setting that could help guarantee that a discharge plan is adequately implemented. A brief version of critical time intervention (BCTI), in which a case manager works with an individual for a three-month period following discharge from a psychiatric hospital to ensure an adequate connection to community-based resources, has been shown to reduce early rehospitalizations (Shaffer et al., 2015) and facilitate greater service engagement and improved utilization of outpatient services post-discharge (Dixon et al., 2009). An intervention such as BCTI has the potential to also improve implementation of discharge planning for people with mental illness at high risk of homelessness.

A FUTURE STRATEGY FOR HOMELESSNESS PREVENTION

As homelessness prevention policies and programs develop in the United States and elsewhere (Ontario Ministry of Municipal Affairs and Housing, 2013), the scientific study of prevention interventions would help to identify what works best for whom. Burt et al. (2007) have emphasized that an effective overall prevention approach must not be limited to stopping people from ever becoming homeless, but must also involve the rapid return to stable housing when people experience an initial episode of homelessness, and end long-term homelessness for those with persistent street and shelter living. In a study of community-wide strategies for preventing homelessness, Burt et al. (2007) identified five activities that could address all levels of homelessness prevention: housing subsidies, supportive services combined with permanent housing, mediation in housing courts, cash assistance for rent arrears, and rapid exits from shelters (Burt et al., 2007, pp. 219–220). Culhane et al. (2011) have suggested that prevention resources could be allocated through a process of "progressive engagement." By conducting triage and multiple assessments to determine changing needs over time, individuals would be matched with differing intensities of housing support and services. Less intensive supports, such as time-limited small or "shallow" rent subsidies, would be tried first and could be effective with a large number of people who experience homelessness. More intensive services such as permanent supportive housing and longer-term rental assistance would be reserved for disabled and high-need individuals (Culhane et al., 2011; Montgomery et al., 2013). A reverse process could take place for people with mental illness in supportive housing. With clinical improvement and greater social competence, a lessening of treatment and support needs may signal readiness for more independent living. Homelessness prevention interventions could reduce the long-term dollar costs of homelessness and markedly improve the quality of life for those at risk. There is ample reason to continue to develop this important area of service delivery.

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CHAPTER 10

Beyond Housing: Opening the Door to Community Participation

Advances in housing and service programs for people with severe mental illness have enabled many to move from the streets to homes in the community. Despite the many successes, the goal to prevent and end homelessness remains elusive. The hard-won skills and knowledge on how best to house the homeless mentally ill could inform bringing it to scale if only there were the political will to do so. In a free-market society with multiple competing interests for public funding, those who are committed to solving this problem—researchers, advocates, and service providers—will need to redouble their efforts to advance the science of "evidence-based" housing and service interventions to inform what works best for whom, for how long, and under what circumstances. Attention to quality of care, cost-effectiveness, and efficiency, the lingua franca of legislators and policy makers, will be needed to garner the support of holders of the public purse. In the end, the willingness of the advantaged to share a slice of the American dream with the impoverished and disabled will be a legacy of the nation. At the same time, addressing the housing needs of homeless people is not enough. The modern recovery movement in mental health, with its mantra of helping people with severe mental illness to achieve self-fulfillment and involvement in mainstream society (Davidson & Strauss, 2010; Leff & Warner, 2006; President's New Freedom Commission on Mental Health, 2003; Ware et al., 2008), is reminiscent of the noblest intent of proponents of the shift from asylum to community care. With current advances in mental health treatment, housing, and rehabilitation, a focus on social inclusion is timely.

THE RECOVERY MOVEMENT

With its roots in the social justice movements of the 1970s, the recovery movement in mental health emerged in part from the lived experiences of people with mental illness. Dissatisfied with their encounters with the professional mental health system, consumers formed their own support networks that were opposed to the "medical model" of mental illness that focused on clinical recovery rather than an existential recovery of hope, empowerment, and self-agency (Hunt & Resnick, 2015). It was, however, findings from well-designed longitudinal follow-up studies of severe mental illness (Harding et al., 1987; Harrow & Jobe, 2007) and first-person accounts of recovered individuals (Deegan, 1996; Frese et al., 2009) that challenged the prevailing view that a diagnosis of schizophrenia has a uniformly guarded outcome. Findings that substantial improvement and recovery occurred over time moved the discipline of psychiatry toward a recovery orientation.[1]

The Medical Model of Illness and Recovery

The medical model is based on an observable set of symptoms that are characteristic of a specific diagnostic entity. Schizophrenia, for example, is characterized by delusions, hallucinations, disorganized speech and behavior, and other symptoms that cause social or occupational dysfunction (American Psychiatric Association, 2013). A complex brain disorder associated with an uncertain etiology, the condition spans the life course and is associated with periods of remission and exacerbation of symptoms (Lieberman et al., 2008). Typically, the medical model would define "recovery" as the absence of disease (a cure) or a return to normal function. Noting advances in neuroscience research and treatment, Lieberman et al. (2008) have proposed a definition of recovery in schizophrenia that

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[1] The study conducted by Harding et al. (1987) of severely mentally disabled "back ward" patients at Vermont State Hospital enrolled in a rehabilitation program in the 1950s followed the participants for over 30 years. Upon follow-up in the 1980s, one-half to two-thirds had markedly improved or recovered.

acknowledges improvements in specific domains of outcome, such as cognitive or vocational functioning, rather than defining recovery globally.

Being in Recovery: Developing a Meaningful Life Beyond Illness

An alternative view is that being "in recovery" involves living an active, productive life despite the enduring presence of symptoms of the illness (Davidson et al., 2008). Essentially, recovery is an aspirational goal that includes a sense of hope, empowerment, self-agency, and existential or spiritual well-being (Jacobson & Greenley, 2001; Whitley & Drake, 2010). The recovery perspective has been accepted into mainstream mental health policy (Barber, 2012; Hunt & Resnick, 2015; Mulligan, 2003; President's New Freedom Commission on Mental Health, 2003), and incorporated into the development of recovery-oriented services (Anthony, 1993; Copeland, 1997; Davidson et al., 2008; Whitley & Siantz, 2012), and interventions such as supportive employment (Drake et al., 2012; Drake et al., 1999) and supportive housing (see chapters 6 and 7, this book). The recovery movement has also led to a more equitable partnership between consumers and providers, with greater emphasis on consumer preference and active consumer participation in decision-making (see Chapter 4).

The Substance Abuse and Mental Health Services Agency (SAMHSA) has presented a working definition of recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their potential." Four major dimensions that support a life in recovery include:

1. Health: overcoming or managing one's diseases or symptoms, such as abstaining from alcohol and drug use, and making informed healthy choices that support physical and emotional well-being;
2. Home: having a stable and safe place to live;
3. Purpose: having meaningful daily activities, such as a job, school, family caretaking, or creative endeavors, and having the independence, income and resources to participate in society; and
4. Community: relationships and social networks that provide support, friendship, love, and hope. (SAMHSA, 2012)

The recovery movement parallels changes in society that have lauded examples of individuals with physical disabilities, such as Helen Keller and Franklin Delano Roosevelt (Barber, 2012, p. 278), and people with psychiatric illness, such as Nobelist John Forbes Nash, Jr. (Nasar, 1998), who overcame their disabilities and went on to forge productive lives. Moreover, there has been a trend across medicine in general to endorse person-centered care in which patients are educated about their conditions and are encouraged to be active participants in treatment (Barber, 2012).

CONFRONTING DISCRIMINATION AND THE STIGMA OF MENTAL ILLNESS

People with severe mental illness, including those who are homeless, experience disadvantages in housing, health care, employment, and education. The attitudes and behavior of the general public toward people with mental illness constitute a challenging environment that must be confronted in the process of recovery. Following the Surgeon General's report on mental illness in 1999 and the President's New Freedom Commission on Mental Health in 2003, there has been a wide-scale effort to present mental illness as a medical condition ("an illness like any other") in an effort to increase service use and reduce stigma. A study of public attitudes toward mental illness assessed in 1996 and again ten years later revealed that, by 2006, a greater proportion of respondents attributed mental illness to an underlying neurobiological condition requiring medical treatment. While a neurobiological view of mental illness was associated with support for treatment, it did not lead to a decrease in stigma or the widely held stereotypes that people with mental illness are dangerous and to be avoided (Pescosolido et al., 2010). People suffering from mental illness experience the effects of stigma and the lack of concern and support from the general public (Kobau & Zack, 2013; Thornicroft, 2006). Stigma can markedly interfere with help-seeking behavior (Henderson et al., 2013; Pattyn et al., 2014; Thornicroft et al., 2007; see Chapter 4), but it can also harm the self-esteem of people with mental illness (Link et al., 2001), interfere with their pursuit of personal life goals and the course of recovery (Corrigan et al., 2013), and influence the quality of life for the individual and family members (Allerby et al., 2015). The challenges imposed by the stigma of mental illness are even more daunting for people who are homeless and members of racial or ethnic minorities, who may face discrimination and social marginalization based on multiple factors that can affect educational, employment, or relationship opportunities (Gabbidon et al., 2014).

Federal legislation to address discrimination in employment and housing through the Americans with Disabilities Act of 1990, and in health care through the Mental Health Parity and Addiction Equity Act of 2008, limits the prejudicial behavior that results in people with mental illness being treated differently from others when they seek opportunities or assistance in these areas. Anti-discrimination laws cannot, however, change the stereotypes and prejudices of the general public or the impact that such attitudes can have on individuals with mental illness (Cummings et al., 2013). Efforts to change public attitudes toward mental illness have an extensive history in the post–World War II period (Arboleda-Florez & Sartorius, 2008). Anti-stigma efforts have included a range of approaches, such as social activism, public education campaigns, and efforts that involve contact with people who have a living experience of mental illness. Overall results of anti-stigma approaches have been mixed. A meta-analysis of the outcome of efforts in multiple countries to reduce public stigma involving 79 separate studies revealed that both education and personal contact had the greatest positive effects on the reduction of stigma. Contact, particularly when it was face-to-face, was most effective in reducing stigma among adults, suggesting that personal encounters with people with mental illness are more challenging to stigma and stereotypes than factual information about the nature of mental illness (Corrigan et al., 2012).

Community-wide campaigns to reduce stigma include those carried out in England and California. England's "Time to Change" program was a national program initiated in 2009 designed to engage individuals, communities, and stakeholder organizations in a marketing campaign to change negative attitudes and discriminatory behavior toward people with mental illness. The outcome of the program, assessed with a telephone survey of the experiences of a sample of service users, revealed that, one year after the program was initiated, the goal to reduce stigma and discrimination was just shy of its 5 percent objective. Although significantly less discrimination was reported from family, friends, and employers, experiences of discrimination from mental health professionals, reported by about one-third of respondents, did not change (Henderson et al., 2012).

California's statewide plan to reduce such stigma is part of the effort to transform the mental health system to focus on health, wellness, and improved community services for the under-served. Elements in the anti-stigma effort, such as social marketing and capacity building at the local level, include the participation of consumers of mental health services to increase public knowledge of the lived experience of the mentally ill. The outcome of the California anti-stigma effort will include its impact on behavioral health service use (Clark et al., 2013).

The noxious effects of discrimination and stigma remain challenges to be overcome in establishing a more welcoming community environment that can foster social inclusion as an essential element in the recovery of mental illness. Although stigma has not been eliminated for symptomatic individuals with mental illness, improved mental health treatments have helped to make the symptoms and dysfunctional behavior associated with these disorders less problematic and less visible (Goldman, 2010).

SOCIAL INCLUSION AND THE HOMELESS MENTALLY ILL

A major goal of psychiatric rehabilitation is to enable people with disabilities to exercise their inherent right to live, study, work, and achieve the capacity for interpersonal connectedness and citizenship in the same manner as people without disabilities (Rosenheck, 2012; Ware et al., 2008; Wong & Solomon, 2002). Having a stable and secure home in the community is a necessary condition for the achievement of social inclusion. Steps in that direction are evidenced by the subjective experiences of homeless adults with mental illness who were placed in the Housing First arm of the Canadian At Home/Chez Soi study as they transitioned from life on the streets to having their own homes. Positive changes observed after obtaining housing included feelings of security and pride, a focus on adjustment to living alone, and the challenge to develop meaningful activities, such as finding a job, building new friendships, or reconnecting with family members (Patterson et al., 2015). The availability of services and supports was viewed as helpful in facilitating change, while cumulative life experiences of trauma and loss, loneliness, and substance use were threats to positive change. Successful transition through the process of adjustment to stable housing paves the way for greater participation in mainstream activities.

Evidence from Supportive Housing

The achievement of full community integration has, however, eluded participants in the most innovative housing and service intervention efforts to date. Supportive housing studies have demonstrated impressive gains in improving housing stability and reducing homelessness for the mentally ill. Success in achieving clinical objectives, quality of life, and participation in the life of the community has, however, been insignificant. In a multi-site study of over 500 chronically homeless adults with mental illness who received supportive housing, Tsai et al. (2012) observed that, despite strong gains in housing stability one year after housing placement, many remained socially isolated and experienced limited improvements in community participation and civic involvement. Similarly, Baumgartner and Herman (2012) reported that neither critical time intervention (CTI) nor housing stability were associated with improved community integration. Yanos et al. (2012) found that, when formerly homeless mentally ill individuals living in scatter-site supportive housing were compared to residents without mental illness living in similar neighborhoods, the mentally ill individuals did not achieve the same level of community integration as their non–mentally ill counterparts. Noting that the differences in community integration found between mental health consumers and the community participants were small, both groups shared common educational and racial/ethnic characteristics and residence in poor and disadvantaged communities, any or all of which could constrain opportunities for community integration. A rehabilitative group-housing model that has embodied the values of empowerment and self-efficacy has also failed to facilitate community integration for formerly homeless people with mental illness (Ware, 1999). Peer support groups (Castelein et al., 2015) and consumer-run organizations and business enterprises (Mandiberg, 2012) offer promise for the creation of supportive environments for people with severe mental illness; their development will be followed with interest.

Serving People with Multiple Disabilities

Housing and service programs for the homeless mentally ill typically serve people with extensive histories of illness and deprivation, whose mental illness has been compounded by addictions, abject poverty, and the knocks and bruises of street and shelter living. In their effort to enable this challenging group of severely disabled individuals to achieve a modicum of housing stability, housing programs have not focused on community integration as a service objective (Baumgartner & Herman, 2012). The extent to which community integration can be achieved with this severely disabled population requires further study and evaluation.

TOWARD SOCIAL INCLUSION: THE PROMISE OF EARLY INTERVENTION

In the years following World War II, mental health policy shifted its focus away from mental hospitals and toward outpatient and prevention programs for the treatment of mental illness. Improved treatments held out the promise of a more normal existence outside of the asylum, and it was hoped that early intervention would forestall relapse and the decline into chronicity (Grob, 1991, pp. 3–4). In subsequent years, community service development bypassed the needs of the severely mentally ill, hindering the possibility of their recovery by exposing them to inadequate care and leaving them vulnerable to clinical decline, social disability, substance abuse, social isolation, and homelessness. Now, more than a half-century after the doors of the asylum were flung open, early intervention for individuals with severe mental illness is at the forefront of mental health program development.

The thrust toward early intervention in psychotic disorders was motivated by the notion that untreated psychosis has a toxic effect on the brain (Wyatt, 1991). The veracity of this hypothesis has been supported by research findings indicating that the longer the period of untreated psychosis, the poorer the outcome (Lieberman et al., 2013; Loebel et al., 1992). Moreover, the early phase of psychosis is a period of high risk for clinical deterioration and subsequent disability. Intervening in the early months following the onset of psychosis is viewed as key in facilitating a more rapid and stable recovery, preserving of social skills, maintaining family and social support, and reducing the possibility of relapse (Addington, 2007).

First-episode psychosis treatment programs were first developed in the United Kingdom, Europe, Canada, and Australia. More recently, the U.S. National Institute of Mental Health's Recovery After an Initial Schizophrenia Episode (RAISE) initiative has supported first-psychosis-episode treatment programs in a number of locales. Typically, these programs provide an enriched array of treatments such as personalized medication management, family psycho-education, resilience-focused individual therapy, supported employment and education, substance abuse treatment, and suicide prevention (Dixon et al., 2015; Mueser et al., 2015).

NAVIGATE, a multidisciplinary team-based treatment program for first-episode psychosis, was investigated in a study in which 34 clinics in 21 states across America were assigned to NAVIGATE or usual community care (Kane et al., 2015). Follow-up at two years revealed no differences in rehospitalization, but NAVIGATE participants remained in treatment longer, experienced greater improvement in clinical status and quality of life, and were more involved in work and school than participants in usual community care. A non-experimental study of the RAISE Connection program in New York also found improved occupational and social functioning and improved clinical status over a two-year period (Dixon et al., 2015). Moreover, Connecticut's randomized controlled trial of first-episode services for psychotic disorders versus usual care revealed reduced hospitalizations and improved vocational functioning in the first episode treatment group at the one-year follow-up assessment (Srihari et al., 2015).

The American studies demonstrate the feasibility of implementing first-episode services in multiple sites (Kane et al., 2015) and in routine mental health service systems (Dixon et al., 2015; Srihari et al., 2015). A Cochrane review of much of the international work on early treatment for psychosis concluded that, although there is support for specialized early intervention services, including treatment focused on employment and family functioning, there is a need for replication with larger samples and longer trials that can answer the question of how long gains are maintained (Marshall & Rathbone, 2011).

As studies of early treatment for psychosis advance, greater effort will be needed to identify and engage young people from disadvantaged communities whose early lives have been marked by family fragmentation, abuse and neglect, and out-of-home placement. In the presence of psychotic disorder, childhood adversity markedly increases the risk of a host of negative outcomes, including homelessness (Norman et al., 2012; Read et al., 2005; see Chapter 3). As presently constructed, first-episode psychosis programs will most likely require adaptation to assist those without stable family support and who bear the scars of early life trauma. Early intervention could address substance abuse, a major precipitant of homelessness, and facilitate educational and employment opportunities to better ensure housing stability. Lest history repeat itself, the door to evidence-based services must be kept open for even the most service-resistant and difficult-to-serve individuals, for they, too, deserve a chance at recovery and a self-fulfilling life.

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