Evaluation of Advocacy and Outreach Activities in a Domestic Violence Program
For Persons who are Living with a Mental Illness and are Homeless

This memo was written in response to a request for technical assistance regarding tools for the evaluation of homelessness programs. Specifically, the caller was interested in evaluating outreach and advocacy components of a domestic violence service within a program for homeless people living with serious mental illness. Our response included evaluation tools and examples of evaluation applied to homelessness programs generally but likely applicable to this specific situation.

1) The first suggestion of where to go for information on homelessness and mental illness, including program evaluation, is the website for the National Resource Center on Homelessness and Mental Illness (NRC) operated by Policy Research Associates (PRA) at http://www.nrchmi.com/.

As the name suggests this site offers a wealth of information and resources related to a wide range of issues involving the population of persons who are both homeless and living with mental illness. Particularly useful are the online annotated bibliographies on various aspects of the field. For this specific request, the first place to check on the site is the Annotated Bibliography on Program Evaluation (July 2001) at http://www.nrchmi.com/text/bibliographies/ProgramEvaluation.htm. Other NRC bibliographies may have additional items relevant to this request. Among these are one that addresses more general issues of research design and methods for studying homelessness: Research Methods and Measures (September 2001) at http://www.nrchmi.com/text/bibliographies/ResearchMethods.htm.


2) A second resource is the Homelessness Programs Branch of the Center for Mental Health Services (CMHS). Their website at http://www.mentalhealth.org/cmhs/Homelessness/default.asp contains information about various grant programs including Projects for Assistance in Transition from Homelessness (PATH), Access to Community Care and Effective Services and Supports (ACCESS) Program, CMHS/CSAT Collaborative Program to Prevent Homelessness, and the CMHS Housing Initiative, CMHS/CSAT Collaborative Program on Homeless Families.

3) Of particular interest for this purpose is ACCESS a 5-year demonstration program to test the impact of the integration of fragmented services in treating homeless persons
with serious mental illness, CMHS conducted a 5-year demonstration program called Access to Community Care and Effective. Eighteen sites in nine States were funded from 1993 to 1998, and treatment outcomes were studied at both the system and client levels. This included an evaluation of outreach approaches, described in Lam, J.A., Rosenheck, R. Long-term street outreach for homeless persons with serious mental illness: Is it effective? Medical Care. 37(9):894-907, 1999 Sep. (Additional articles on the ACCESS program are included in the bibliography below.)

4) Another initiative supported by CMHS along with the other centers in the Substance Abuse and Mental Health Services Administration (SAMHSA) is the Women, Co-Occurring Disorders and Violence Study. This is a five-year multi-site study for which PRA is the coordinating center. The URL for the study website is http://www.wcdvs.com. It is likely that the study includes a common evaluation protocol for the sites that might be useful. This is not offered on the website but contact information for project leaders is available. Among the other resources is a page listing more generic evaluation resources, http://wcdvs.com/resources/research.asp.

5) Though it provides little related to evaluation per se, the website of the advocacy organization National Coalition for the Homeless (NCH offers extensive resources and background material at http://www.nationalhomeless.org. NCH also operates a Technical Assistance Project—this is program rather than evaluation TA, but may at least direct you to additional resources. Specific to the issue of domestic violence, the NCH website contains a page with a bibliography and other resources, at http://www.nationalhomeless.org/domestic.html.

6) Finally, the following are results of a literature search on Medline using the search terms Mental Disorders and Homeless Persons AND outreach OR Advocacy AND Program Evaluation (Methods).

Bindman, A. B., K. Grumbach, et al. (1993). “Collecting data to evaluate the effect of health policies on vulnerable populations.” Family Medicine. 25(2): 114-9. Public health policies often have disproportionate effects on the poor and other vulnerable groups. Standard survey techniques are often difficult to apply to these vulnerable populations, and many data bases systematically omit such individuals. The purpose of this paper is to review our experience in collecting primary survey data from public hospital, mentally ill, HIV-infected, and non-English-speaking patients. Important issues in conducting research on these populations include proper selection of subjects and comparison groups and difficulties involved in recruitment and enrollment of subjects. Maintaining longitudinal data on these populations is difficult and often requires tracking, secondary contacts, home visits and community outreach, and the use of organizations, institutions, and networks. Investigators must also pay careful attention to ethical issues involved in conducting research on vulnerable populations.

Bybee, D., C. T. Mowbray, et al. (1994). “Short versus longer term effectiveness of an outreach program for the homeless mentally ill.” American Journal of Community Psychology. 22(2): 181-209. Presents 12-month follow-up results from an outreach/linkage intervention with persons who are homeless and mentally ill, contrasting these with results obtained at 4 months. Both sets reflect the success of the program in placing individuals in independent housing. However, longer term data provide useful information regarding client movement patterns and increased tenure in nonhomeless living arrangements beyond the termination of specialized services. Analyses of 12-month residential outcomes identified four variables as significant predictors: recruitment source, project service duration, CMH service duration, and client age. In contrast to 4-month predictors, variables reflecting baseline client functioning were no longer significantly related to outcome, suggesting that the positive effects of the intervention may take longer to achieve with some clients. Discussion focuses on the implications of these effectiveness results for future research designs and measures as well as the utility and limitations of preexperimental approaches for evaluating innovative service models when implementation and efficacy experiences are lacking.

Supported housing, preferred by consumers and demonstrated as effective for individuals with psychiatric disabilities, has taken four approaches: residential services, intensive case management, hybrid, and homeless outreach. Evaluating the choices for local settings requires confronting issues of flexibility and responsibility.


Homeless people living with mental illness, particularly those in large urban centers, are one of the most stigmatized groups in American society. The author describes a specialized short-term hospital treatment program initiated by New York City that helped reduce stigmatization of this group by medical personnel. He suggests that training staff workers and increased government commitment to such inpatient programs with outreach capacity can foster a change in attitude among treaters, thereby improving treatment outcome of Homeless people living with mental illness


The development of outreach approaches to engage and provide services to the homeless mentally ill must account for the heterogeneity of the population. The homeless mentally ill as a group are symbols of the failure of a comprehensive and integrated system of community-based care to develop in conjunction with the widespread proliferation of deinstitutionalization policies over the past several decades. Life in a community is far more complex and less easily controlled than life in an institution. People are free to reject the label of patient and refuse all mental health services. An engagement strategy must therefore be devised from the knowledge of specific aspects of a person's life in that community, so that outreach and networking efforts can be sensitive to the total context of the problems experienced by that patient. A multidisciplinary team approach is essential to the effort to engage and monitor those chronically mentally ill individuals who are at risk for psychiatric and/or medical decompensation. A variety of skills are needed, and team members must be flexible about their roles on the team. The clinician, while maintaining expert psychiatric, diagnostic, and treatment skills, must at the same time be able to adapt to people in their own environments, provide them with necessary social and medical services, and interface with other agencies working with these persons. The work is very labor intensive. It may involve two or more clinicians spending entire days with one patient. During a crisis state, these patients will require even more intensive attention from multiple team members to prevent decompensation and rehospitalization. In conclusion, there is no one intervention style in the work of psychiatric outreach. While the type of intervention offered follows from the mission of the outreach program, all outreach teams must be able to address the totality of needs of people who are fragile and at risk for psychiatric and medical decompensation. Case management services cannot be segregated easily from the task of crisis intervention in the work with the seriously mentally ill. The failure
to establish an accessible network of community-based services for those chronically disaffiliated populations of mentally ill gives the outreach team the critical role of brokering any available services needed to support the individual in the community. The flexibility required of the outreach team derives both from the scarcity of community-based resources and the heterogeneity of the population of chronically ill adults who will most need these services.

Coverdale, J. H., T. L. Bayer, et al. (1995). “Sexually transmitted disease prevention services for female chronically mentally ill patients.” Community Mental Health Journal, 31(4): 303-15. Chronically and variably impaired autonomy makes women with chronic mental illness particularly vulnerable to contracting sexually transmitted diseases (STDs) including AIDS. A lack of female controlled protective devices also adds to the vulnerability of these patients. In this context, the authors make recommendations for the design of clinically comprehensive and ethically justified programs to minimize the risk of mentally ill women for STDs. When female chronically mentally ill patients are at risk of STDs, barriers to the exercise of their autonomy must be identified and clinically treated. Preventive clinical interventions can also be usefully augmented by educational strategies and facilitate patients' communication and behavioral skills, particularly in order to enable them to abstain from unwanted sex or to make prospective male partners wear a condom. Outreach efforts to the male partners of female patients and to the homeless mentally ill may also be required. Preventive services could be integrated and coordinated with STD clinics, substance abuse treatment programs and family planning programs.


Dhossche, D. M. and S. O. Ghani (1998). “A study on recidivism in the psychiatric emergency room.” Annals of Clinical Psychiatry, 10(2): 59-67. Our goal in this retrospective study was to assess empirical risk factors for repeat visits to the psychiatric emergency room. This information may be useful for targeted prevention and cost-effective service planning. Over a 7-month period, 400 (18%) of 2212 patients were repeat visitors, accounting for 36% of all visits. A diagnosis of a psychotic disorder at the first visit was a risk factor for a repeat visit, especially in young patients. Substance abuse, as suggested by positive urine toxicology, decreased the likelihood of recidivism, but positive toxicology screens in young schizophrenic patients increased the chances of a repeat visit. In a 1-month consecutive sample of 311 patients, unemployment and homelessness were stronger correlates than a clinical diagnosis of schizophrenia. These findings support previous evidence that psychiatric emergency services are often used by underprivileged patients. We suggest that a rational preventive approach to reduce recidivism in psychiatric emergency services may include substance abuse treatment and case management for young schizophrenics and community outreach projects for socially disadvantaged patients. Compliance of recidivist
patients poses a difficult task for case managers and community psychiatrists. More studies are needed to assess the efficacy of these interventions.


Despite recent prosperity in the U.S., homelessness is still a widespread social problem. It is estimated that 25% of homeless persons have a serious mental illness. This article will review the literature evaluating prevention services and specialized outreach, treatment, and housing programs designed to reduce homelessness for individuals who are mentally ill. Although these interventions have been helpful in addressing the complex needs of the homeless mentally ill, it is difficult to measure how they have improved outcomes. It is even more challenging to determine whether the programs are cost-effective. Since public resources are used to maintain services for the homeless mentally ill, policymakers must be informed about whether the best outcomes are achieved at the lowest possible cost. Following a discussion of the successes of the individual programs and the challenges they confront, several important questions are identified related to improving the efficiency of these programs. Although the establishment of such programs indicates that progress has been made toward alleviating the burdens facing people who are homeless and mentally ill, collaboration among all stakeholders—especially between the mental health community and consumer advocates—needs to be further enhanced. New research can be conducted in a way that improves how information is evaluated and used. [References: 52]


OBJECTIVES: This study describes how an Assertive Community Treatment (ACT) team which employs a family outreach worker (FOW) interacts with homeless persons with severe mental illness and their families. METHODS: The team's ratings of the frequency and importance of clients' and treatment team's family contact are summarized and compared with independent research reports on patients' satisfaction with family relations, housing and hospitalization outcomes. RESULTS: 73% of clients had contact with their families. ACT worked with families of 61% of clients. ACT had less contact with the families of men (p < .01) and substance abusers (p < .01). Client days in stable housing were associated with increased ACT family contact (p < .05). CONCLUSIONS: Most ACT clients had significant family contact. ACT established contact with most families, and the work with families appeared to be associated with higher levels of satisfaction with family relations and housing. The role of the FOW should be explored further.

Homelessness as a dimensional concept reflecting instability of community living arrangements was examined in an urban state hospital's sample of 187 aftercare patients with chronic mental illness. According to ratings by outreach clinicians, 17 percent of the patients were predominantly homeless, and 10 percent were occasionally homeless over the six months before evaluation. Younger, male patients were more likely to be homeless. Homelessness was strongly associated with abuse of alcohol and street drugs, treatment noncompliance, and a variety of psychosocial problems and psychiatric symptoms. Homeless patients were viewed by their primary clinicians as attracted to the hospital as a living alternative and, during prospective one-year follow-up, had a much higher rate of rehospitalization.


OBJECTIVE: This study was conducted to determine the seroprevalence of HIV-1 antibodies among hospitalized homeless mentally ill patients. METHOD: From December 1989 through May 1991 the authors collected discard blood samples from patients consecutively admitted to a psychiatric unit designated for the care of severely mentally ill persons removed from the streets of New York City. The blood samples were tested for HIV-1 antibodies, and the results were analyzed for associations with age, gender, ethnicity, male homosexual activity, and use of injected drugs. RESULTS: The HIV seroprevalence was 6.4% (13 of 203 samples). Patients between ages 18 and 39 accounted for 51.2% of the admissions and 84.6% of the 13 positive results, a seroprevalence of 10.6% for this subsample. Patients under age 40 were more than six times as likely to test positive for HIV antibodies as those 40 or over. Ethnicity did not predict seropositivity. Women were as likely as men to be infected. Although clinicians had noted high-risk behavior on the charts for only three (23.1%) of the 13 positive cases, a recorded history of use of injected drugs was associated with a 6.5-fold greater risk of HIV seropositivity. CONCLUSIONS: One in every 16 patients admitted to the special unit was HIV positive. Age under 40 and use of injected drugs were strongly associated with seropositivity. Because information on high-risk behavior was infrequent, the reasons for younger patients' greater risk are unclear. The homeless mentally ill require outreach efforts to reduce the risk of acquiring or transmitting HIV.


Mental health professionals and researchers have emphasized the importance of conducting outreach to locate homeless persons with mental illness, and of creatively engaging these persons into a therapeutic relationship. These outreach and engagement activities raise challenging issues in the areas of client-staff boundaries, professional ethics, and staff safety. While several issues in each of these three key areas have received attention in the growing literature on
homelessness, certain issues within each area remain unexplored. The authors
draw from the street experiences of outreach staff in a federally funded homeless
outreach project to further explore each of these areas, and suggest that
experiences of outreach workers are essential in shaping and redefining work
activities in these, and other important areas.

substance abuse among homeless veterans with mental illness.” Psychiatric
Services. 48(6): 792-5.
OBJECTIVE: A suspicion that disability payments may exacerbate substance use
among persons with chemical addictions recently led Congress to limit federal
disability entitlements of applicants whose disability status is related to substance
abuse, even if they have another serious mental disorder. This study empirically
explored the relationship between receipt of disability payments and substance
use among homeless mentally ill veterans. METHODS: The study sample
included 2,474 homeless veterans with a current diagnosis of schizophrenia and a
substance abuse or dependence disorder who were assessed in a community
outreach program sponsored by the Department of Veterans Affairs. RESULTS:
After adjustment for other relevant factors, receipt of disability payments showed
no significant relationship to the number of days of substance use a month, even
among frequent users of alcohol and drugs. CONCLUSIONS: Findings about
substance use among the homeless veterans with serious mental disorders in this
study provide no support for the assertion that disability payments exacerbate
substance use.

program for homeless clients with severe mental illness.” American Journal of
Orthopsychiatry. 67(4): 607-17.
A longitudinal study followed 55 homeless and severely mentally ill clients of a
hostel outreach program to assess outcomes and their relationship to program
elements. Results at 18-month follow-up indicated that, despite chronic histories
of transiency and shelter use, housing stability had been achieved, and that initial
gains in social functioning and symptom reduction had been increased.
Development of a strong working alliance proved a key program element in the
findings.

British Journal of Nursing. 6(21): 1236-8, 1240-3.
There has been a steady rise in the number of homeless mentally ill in Britain.
This article reviews the scale of the problem and identifies the need for change
within mental health services in order to address this challenge. It is argued that
mainstream psychiatric services need to become more diverse and open in their
approach to this potentially isolated group of users. The authors suggest that this
could be achieved by embracing assertive outreach interventions. Innovative
projects using a range of care providers, including voluntary workers, past users
of the service and professional mental health workers, are discussed as an
alternative framework to traditional services. In conclusion, the article highlights some of the professional and social implications for psychiatric nurses and mental health practice. [References: 45]


OBJECTIVE: Because little is known about homeless individuals' satisfaction with mental health services or the association between satisfaction and measures of treatment outcome, the study examined those issues in a group of homeless veterans. METHODS: Demographic and clinical data were obtained from intake assessments conducted before veterans' admission to residential treatment facilities under contract with the Department of Veterans Affairs Health Care for Homeless Veterans program, a national outreach and case management program. Clients completed a satisfaction survey and the Community-Oriented Programs Environment Scale, which asks them to rate dimensions of the treatment environment. Outcome data came from discharge outcome summaries completed by VA case managers. RESULTS: Overall satisfaction with residential treatment services was high among the 1,048 veterans surveyed. Greater satisfaction was associated with more days of drug abuse and more days spent institutionalized in the month before intake and with an intake diagnosis of drug abuse. Regression analyses indicated that satisfaction was most strongly related to clients' perceptions of several factors in the treatment environment. Policy clarity, clients' involvement in the program, an emphasis on order, a practical orientation, and peer support were positively related to satisfaction; staff control and clients' expression of anger were negatively related. Satisfaction was significantly associated with case managers' discharge ratings of clinical improvement of drug problems and psychiatric problems. CONCLUSIONS: Homeless veterans are more satisfied in environments they perceive to be supportive, orderly, and focused on practical solutions. The results indicate that client satisfaction is not related to treatment outcomes strongly enough to serve as a substitute for other outcome measures.


OBJECTIVE: This study estimated the proportion and representation of Native Americans among homeless veterans and compared their psychiatric and substance abuse problems with those of other ethnic groups of homeless veterans. METHODS: The study was based on data from the Department of Veterans Affairs' Health Care for Homeless Veterans program, a national outreach program operating at 71 sites across the country. Alcohol, drug, and psychiatric problems of Native American veterans (N=950) reported during intake assessment were compared with problems reported by white, black, and Hispanic veterans (N=36,938). RESULTS: Native Americans constituted 1.6 percent of veterans in the program. Age-adjusted analyses suggested that relative to the general veteran population (of which 1.3 percent are Native Americans), Native Americans are overrepresented in the homeless population by approximately 19 percent.
Regression analyses controlling for demographic characteristics found that Native American veterans reported more current alcohol abuse, more previous hospitalizations for alcohol dependence, and more days of recent alcohol intoxication than members of other ethnic groups. In contrast, Native American veterans reported fewer drug dependence problems than other minority groups and fewer current psychiatric problems and previous psychiatric hospitalizations than the reference group of white homeless veterans. CONCLUSIONS: Native Americans are overrepresented in the homeless veteran population. They have more severe alcohol problems than other minority groups but somewhat fewer psychiatric problems.


This study compared two types of residential programs that treat dually diagnosed homeless veterans. Programs specializing in the treatment of substance abuse disorders (SA) and those programs addressing both psychiatric disorders and substance abuse problems within the same setting (DDX) were compared on (1) program characteristics, (2) clients' perceived environment, and (3) outcomes of treatment. The study was based on surveys and discharge reports from residential treatment facilities that were under contract to the Department of Veterans Affairs Health Care for Homeless Veterans program, a national outreach and case management program operating at 71 sites across the nation. Program characteristics surveys were completed by program administrators, perceived environment surveys were completed by veterans in treatment, and discharge reports were completed by VA case managers. DDX programs were characterized by lower expectations for functioning, more acceptance of problem behavior, and more accommodation for choice and privacy, relative to SA programs after adjusting for baseline differences. Dually diagnosed veterans in DDX programs perceived these programs as less controlling than SA programs, but also as having lower involvement and less practical and personal problem orientations. At discharge, a lower percentage of veterans from DDX than SA programs left without staff consultation. A higher percentage of veterans from DDX than SA programs were discharged to community housing rather than to further institutional treatment. Program effects were not different for psychotic and non-psychotic veterans. Although differences were modest, integration of substance abuse and psychiatric treatment may promote a faster return to community living for dually diagnosed homeless veterans. Such integration did not differentially benefit dually diagnosed veterans whose psychiatric problems included a psychotic disorder.


OBJECTIVE: The study examined client characteristics, case management variables, and housing features associated with referral, entry, and short-term
success in a Department of Veterans Affairs (VA) national intensive case management and rental assistance program for homeless veterans. METHODS: Information collected from homeless veterans at the time of initial outreach contact and from case managers during the housing search was used to create logistic regression models of referral into the program and successful completion of several stages in the process of obtaining stable independent housing.

RESULTS: Overall, only 8 percent of the more than 65,000 eligible veterans contacted by outreach workers were referred to the program. Those referred were more likely to be female, to have more sources of income, to have recently used VA services (including residential treatment), and to have serious mental health problems. Once in the program, 64 percent of veterans eventually moved into an apartment, and 84 percent of those who obtained an apartment were stably housed one year later. In general, activities of case managers, such as accompanying the veteran to the public housing authority and securing additional sources of income, were associated with success in the housing process. The therapeutic alliance, clients' housing preferences, and the quality of housing were unrelated to retention of housing. CONCLUSIONS: This supported housing program was judged appropriate for a small percentage of eligible veterans. However, a large proportion of clients were successful in attaining permanent housing, which lends support to the effectiveness of the supported housing approach.


A demonstration program for the homeless mentally ill that succeeded at one site and failed at another serves as the basis for analysis of the effects of local conditions on program implementation and outcomes. Chen's program implementation framework is utilized. Implications are drawn for funders, service providers, and evaluators.


OBJECTIVES: This study examined data on case management clients who are homeless and have a severe mental illness to determine how those contacted through street outreach differ in their socio-demographic characteristics, service needs, and outcomes from those clients contacted in shelters and other health and social service agencies. METHODS: As part of the Center for Mental Health Services' Access to Community Care and Effective Services and Supports (ACCESS) program, data were obtained from potential clients over the first 3 years of the program at the time of the first outreach contact (n = 11,857), at the time of enrollment in the case management program (n = 5,431), and 3 months after enrollment (n = 4,587). RESULTS: Clients contacted at outreach on the street, as opposed to being contacted in shelters and service agencies, were generally worse off. They were more likely to be male, to be older, to spend more nights literally homeless before the contact, to have psychotic disorders, and took longer to engage in case management. They expressed less interest in treatment.
and were less likely to enroll in the case management phase of the project. Subjects contacted on the street who did enroll were more impaired than their street counterparts who did not enroll. Three month outcome data showed that enrolled clients contacted through street outreach showed improvement that was equivalent to those enrolled clients contacted in shelters and other service agencies on nearly all outcome measures. CONCLUSION: Street outreach to homeless persons with serious mental illness is justified as these clients are more severely impaired, have more basic service needs, are less motivated to seek treatment, and take longer to engage than those contacted in other settings. Street outreach is further justified as it engages the most severely impaired among the street population. Street outreach also appears to be effective as the clients reached in this way showed improvement equal to that of other clients in most outcome domains when baseline differences were taken into account.

To make appropriate treatment and public policy recommendations to address the problems of homeless mentally ill persons, it is important to differentiate the homeless mentally ill population from the homeless population in general. Effective advocacy for homeless mentally ill persons should have realistic goals that address the specific needs of that population rather than attempt to change the basic problems of society. The effective advocacy that has secured services for developmentally disabled persons can serve as a model. Mental health professionals' limited response to the problems of homeless mentally ill persons has further stigmatized mentally ill persons in general; one of the most powerful actions mental health professionals could take to fight stigma would be to help provide treatment and residential alternatives for homeless mentally ill persons. The recommendations of both the first and the second American Psychiatric Association task forces on the homeless mentally ill are discussed.

Interest has developed in the use of mental health consumers as staff members in community programs for persons with serious mental illness. The present study investigates consumer service delivery in a mobile assessment program designed to assist homeless people with severe psychiatric disorders. Consumer and non-consumer staff were generally comparable. Results suggest that consumer staff engaged in more street outreach and were less often dispatched for emergencies. There was a trend for consumer staff to be more likely to certify their clients for psychiatric hospitalization. In sum, consumer staff appear to provide a valuable contribution to this form of service delivery.

The care of persons with severe, persistent and disabling mental illness has received increasing attention during the past ten years. This focus is due, to some
extent, to the increased visibility of a subset of this population, the large number of individuals with psychiatric problems who have become homeless. These men and women, who are without homes or in temporary residences, present a sophisticated array of needs and a multiplicity of problems which have rendered most communities impotent to provide appropriate and adequate rehabilitative services. To date, there is no "perfect" community-based system of care for these men and women. What exists is a hodge-podge of shelter, outreach and drop-in center services. Most of these provide little more than a bed (or a chair) to sleep on, a hot meal and refuge from inclement weather. This article discusses some of the issues and assumptions that inhibit and foster the development and provision of a comprehensive system of community-based care for persons with serious and persistent mental disorders who have become homeless. A framework, useful in reconceptualizing the clients, the services and the interaction between them is presented.


A decade ago, urban street outreach was part of a rapid response to the epidemic of homelessness. Today it struggles to develop into a clinical craft that will define its own niche in the system of services to the homeless mentally ill.


The purpose of this study was to use a time-lag design to evaluate the effectiveness of a Mobile Outreach and Crisis Services unit in remitting psychiatric symptomatology, improving global functioning, and decreasing homelessness in a population of homeless, severely mentally ill residing in a mid-sized urban center. Using a time-lag study design, two groups of subjects--25 individuals before receiving services (control group) and 25 individuals after receiving services (experimental group)--were contrasted across outcome measures. The results indicate that a MOCS unit utilizing a Program for Assertive Community Treatment mode was effective in significantly decreasing psychiatric symptomatology, reducing homelessness, and increasing global functioning. If carefully implemented and interpreted, a time-lag design may be a means of providing valuable feedback and information in a timely manner.


A longitudinal experimental design was used to compare the effectiveness of three community-based treatment programs serving homeless mentally ill people: traditional outpatient treatment offered by a mental health clinic, a daytime drop-in center, and a continuous treatment team program that included assertive
outreach, a high staff-to-client ratio, and intensive case management. At 12-month follow-up, clients in all three treatment programs spent fewer days per month homeless, showed fewer psychiatric symptoms, and had increased income, interpersonal adjustment, and self-esteem. Clients in the continuous treatment program had more contact with their treatment program, were more satisfied with their program, spent fewer days homeless, and used more community services and resources than clients in the other two programs.

This paper describes a model of outreach predicated on developing a trusting, meaningful relationship between the outreach worker and the homeless person with mental illness. We describe five common tasks inherent in this model of outreach (establishing contact and credibility, identifying people with mental illness, engaging clients, conducting assessments and treatment planning, and providing ongoing service). Other issues discussed include: (a) Responding to dependency needs and promoting autonomy; (b) setting limits while maintaining flexibility; (c) resistance to mental health treatment and follow-up service options.

Homeless mentally ill persons are highly visible subjects of ongoing public discussion and potent symbols of a host of contemporary social problems. They present psychiatry with a scientific challenge that calls for further elucidation of the sources of their mental illness and for fashioning possible solutions to their problems. They also present a moral challenge that requires psychiatrists to acknowledge the cultural, political, legal, and economic context of the mental problems of the homeless in the course of deciding what should be done to help them. H. Richard Lamb has proposed a program of aggressive outreach and psychiatric hospitalization for the homeless mentally ill. The authors believe that his proposal misconstrues the problems and needs of homeless mentally ill individuals; it would also needlessly infringe upon their freedom, further stigmatize them, and probably not help them. The authors offer an alternative understanding of the plight of the homeless mentally ill which places their problems within a larger context of social trends and domestic issues that society has been reluctant to confront. Psychiatrists can help the homeless mentally ill by championing their liberty rights and by focusing public discourse on the broad national need for improved access to medical and psychiatric care.

In this article the authors report on the self-perceived needs of 40 homeless people who are coping with psychiatric problems. These people were among 207 with psychiatric problems participating in an innovative advocacy project based
outside the formal mental health system. Compared with domiciled participants, the homeless participants had more accentuated and somewhat different major daily living needs in the areas of income and benefits, housing, legal services, employment, and health care. On the basis of these findings, the authors draw implications for social work practice with homeless people coping with psychiatric problems.


The Access to Community Care and Effective Services and Supports (ACCESS) demonstration program was initiated in 1993 by the U.S. Department of Health and Human Services as part of a national agenda to end homelessness among persons with serious mental illness. Demonstration projects have been established in nine states to develop integrated systems of care for this population. This paper provides an overview of the ACCESS program and presents definitions of services integration and systems integration. Evaluating the effectiveness of integration strategies is a critical aspect of the program. The authors describe the evaluation design and the integration strategies being evaluated and summarize findings from a formative evaluation of the project's first two years. The evaluation revealed several problems that were addressed by providing technical assistance to the states. States were helped to articulate a broader mission of addressing system-level barriers, develop an expanded plan, strengthen the authority of interagency councils, involve leaders at the state and agency levels, and develop joint funding strategies.


The authors provide an overview of the ACCESS program (Access to Community Care and Effective Services and Supports), which evaluated the integration of service systems and its impact on outcomes for homeless persons with severe mental illness. The ACCESS program provided funds and technical assistance to nine community sites to implement strategies for system change that would promote systems integration. These experimental sites, along with nine comparison sites, also received funds to support outreach and assertive community treatment for 100 clients a year for four years at each site. Data on the implementation of system change strategies were collected from 1994 to 1998 during annual visits to the sites. Data on changes in systems integration were obtained from interviews with key informants from relevant organizations in each community. Client outcome data were obtained at program entry and three and 12 months later from 7,055 program participants across the four annual client cohorts at all sites. Detailed findings from the ACCESS evaluation are presented in two accompanying articles, and overall conclusions are offered in a fourth article.

OBJECTIVE: About one-quarter of homeless Americans have serious mental illnesses. This review synthesizes research findings on the cost-effectiveness of services for this population and their relevance for policy and practice.

METHOD: Service interventions for seriously mentally ill homeless people were grouped into three overlapping categories: 1) outreach, 2) case management, and 3) housing placement and transition to mainstream services. Data were reviewed both from experimental studies with high internal validity and from observational studies, which better reflect typical community practice. RESULTS: In most studies, specialized interventions are associated with significantly improved outcomes, most consistently in the housing domain, but also in mental health status and quality of life. These programs are also associated with increased use of many types of health service and housing assistance, resulting in increased costs in most cases. The value of these programs to the public thus depends on whether their greater effectiveness is deemed to be worth their additional cost. CONCLUSIONS: Innovative programs for seriously mentally ill homeless people are effective and are also likely to increase costs in many cases. Their value ultimately depends on the moral and political value society places on caring for its least-well-off members. [References: 29]


OBJECTIVES: The study examined relationships between specific treatment elements and their costs and ten outcome measures using data from a longitudinal outcome study of a Veterans Affairs program for homeless mentally ill veterans. METHODS: Baseline and outcome data over an eight-month period were analyzed for 406 homeless veterans with psychiatric and substance use disorders who were treated in VA’s Homeless Chronically Mentally Ill Veterans Program. Multivariate techniques were used to examine the relationship between ten measures of outcome and six treatment elements: program entry via community outreach, the number of contacts with program clinicians, the number of referrals for other services, duration of program involvement, number of days of residential treatment, and increased public support payments. RESULTS: Each of the six treatment elements was significantly related to improvement on at least one of the ten outcome measures. The number of clinical contacts with program staff and the number of days in residential treatment were associated with improvement in the greatest number of outcome domains. However, improvement associated with residential treatment was far more costly than improvement related to other treatment elements. CONCLUSION: This study provides evidence of the effectiveness of a multimodal approach to the treatment of homeless mentally ill persons. However, results indicate that special attention should be paid to differences in the cost of improvement associated with various treatment elements.
OBJECTIVES: This study evaluated a joint initiative of the Social Security Administration (SSA) and the Department of Veterans Affairs (VA) to improve access to Social Security disability benefits among homeless veterans with mental illness. METHODS: Social Security personnel were colocated with VA clinical staff at 4 of the VA's Health Care for Homeless Veterans (HCHV) programs. Intake assessment data were merged with SSA administrative data to determine the proportion of veterans who filed applications and who received disability awards at the 4 SSA-VA Joint Outreach Initiative sites (n = 6709) and at 34 comparison HCHV sites (n = 27,722) during the 2 years before and after implementation of the program. RESULTS: During the 2 years after the initiative began, higher proportions of veterans applied for disability (18.9% vs 11.1%; P < .001) and were awarded benefits (11.4% vs 7.2%, P < .001) at SSA-VA Joint Initiative sites. CONCLUSION: A colocation approach to service system integration can improve access to disability entitlements among homeless persons with mental illness. Almost twice as many veterans were eligible for this entitlement as received it through a standard outreach program.


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Descriptive data derived from initial assessment interviews and from standardized 3-month progress reports are presented on 1684 homeless, chronically mentally ill veterans who were contacted at nine sites in a national Department of Veterans Affairs outreach program. Levels of involvement in the program were modest, with only 16% of those screened having over 10 clinical contacts and 24% still involved after 3 months. Demographic and clinical characteristics were weakly associated with continued involvement, but those admitted to residential treatment were 5.4 times more likely to be involved in the program than those not admitted. Admission to residential treatment appears to be the strongest determinant of clinical engagement of the homeless mentally ill.


OBJECTIVE: This study evaluated the impact of a Department of Veterans Affairs outreach and residential treatment program for homeless mentally ill veterans on utilization and cost of health care services provided by the VA. METHODS: Veterans at nine program sites (N = 1,748) were assessed with a standard intake instrument. Services provided by the outreach program were documented in quarterly clinical reports and in residential treatment discharge summaries. Data on nonprogram VA health service utilization and health care costs were obtained from national VA data bases. Changes in use of services and
cost of services from the year before initial contact with the program to the year after were analyzed by t test. Multivariate analyses were used to examine the relationship of these changes to indicators of clinical need and to participation in the outreach program. RESULTS: Although utilization of inpatient service did not increase after veterans' initial contact with the program, use of domiciliary and outpatient services increased substantially. Total annual costs to the VA also increased by 35 percent, from $6,414 to $8,699 per veteran per year. Both clinical need and participation in the program were associated with increased use of health services and increased cost. Veterans with concomitant psychiatric and substance abuse problems used fewer health care services than others. CONCLUSIONS: Specialized programs to improve the access of homeless mentally ill persons to health care services appear to be effective, but costly. Dually diagnosed persons seem especially difficult to engage in treatment.


OBJECTIVE: Clients' and providers' perceptions of clients' needs were compared in 18 community treatment programs participating in the Access to Community Care and Effective Services and Supports program of the Center for Mental Health Services, a national demonstration project on treatment of homeless persons with mental illness. The study sought to determine whether perceptions differed and whether assessed needs for services were related to service use. METHODS: A total of 1,482 clients contacted through community outreach who entered the case management phase of the program after an average of 32 days were given an evaluation interview at entry into the program. The clients and outreach workers identified clients' needs in seven core domains-mental health, general health, substance abuse, public financial support, housing assistance and support, dental care, and employment. Use of related services in the 60 days before the case management evaluation was determined. RESULTS: The greatest differences between clients' and providers' perceptions of service needs were in dental and medical services, which were more frequently identified as needs by clients, and in substance abuse and mental health services, which were more frequently identified by providers. Clients' and providers' assessments of need were significantly, but not strongly, correlated with each other, and both were correlated with use of mental health and substance abuse services.

CONCLUSIONS: Mental health service providers are less likely than clients to identify needs for services other than mental health services. Service use, at least in the short run, is related to both clients' and providers' assessments of need.


In May 1987 the Veterans Administration established the Homeless Chronically Mentally Ill Veterans Program at 43 sites to provide outreach, health care, and residential rehabilitation services. Intake assessment data on 10,529 homeless
veterans screened as potential candidates for clinical services during the program's first 11 months are presented. With a median age of 40, the homeless veterans were considerably younger than veterans in the general U.S. population. More had served in the Vietnam era than in other military eras. Almost three-fifths were white, and a third were black; more than 40 percent were receiving some form of public support. Almost half manifested one or more severe psychiatric symptoms at screening, and almost two-thirds had previously been hospitalized for either a psychiatric or a substance abuse problem.


OBJECTIVE: This study examined the relationship between receiving disability payments and changes in health status, community adjustment, and subjective quality of life. METHODS: The study evaluated outcomes among homeless mentally ill veterans who applied for Social Security Disability Insurance or Supplemental Security Income through a special outreach program. Veterans who were awarded benefits were compared with those who were denied benefits; their sociodemographic characteristics, clinical status, and social adjustment were evaluated just before receiving the initial award decision and again three months later. RESULTS: Beneficiaries (N=50) did not differ from those who were denied benefits (N=123) on any baseline sociodemographic or clinical characteristics. However, beneficiaries were more willing to delay gratification, as reflected in scores on a time preference measure. Three months after the initial decision, beneficiaries had significantly higher total incomes and reported a higher quality of life. They spent more on housing, food, clothing, transportation, and tobacco products but not on alcohol or illegal drugs. No differences were found between groups on standardized measures of psychiatric status or substance abuse.

CONCLUSIONS: Receipt of disability payments is associated with improved subjective quality of life and is not associated with increased alcohol or drug use.


OBJECTIVE: The authors evaluated the second of the two core questions around which the ACCESS (Access to Community Care and Effective Services and Supports) evaluation was designed: Does better integration of service systems improve the treatment outcomes of homeless persons with severe mental illness? METHODS: The ACCESS program provided technical support and about $250,000 a year for four years to nine sites to implement strategies to promote systems integration. These sites, along with nine comparison sites, also received funds to support outreach and assertive community treatment programs to assist 100 clients a year at each site. Outcome data were obtained at baseline and three and 12 months later from 7,055 clients across four annual cohorts at all sites. RESULTS: Clients at all sites demonstrated improvement in outcome measures. However, the clients at the experimental sites showed no greater improvement on
measures of mental health or housing outcomes across the four cohorts than those at the comparison sites. More extensive implementation of systems integration strategies was unrelated to these outcomes. However, clients of sites that became more integrated, regardless of the degree of implementation or whether the sites were experimental sites or comparison sites, had progressively better housing outcomes. CONCLUSIONS: Interventions designed to increase the level of systems integration in the ACCESS demonstration did not result in better client outcomes.


Segal, S. P., T. Gomory, et al. (1998). “Health status of homeless and marginally housed users of mental health self-help agencies.” Health & Social Work. 23(1): 45-52. The study discussed in this article investigated the health status of 310 homeless and marginally housed people to determine the usefulness of mental health self-help agencies (SHAs) in addressing their physical health needs. The study compared self-reported health problems among SHA users with similar reports and clinical assessments of other homeless or marginally housed populations. Findings indicate that frequencies of health problems among respondents were similar to those of other homeless or marginally housed groups and that the study group had a higher prevalence of HIV infection and tuberculosis than the general population. Because this hard-to-reach group actively seeks SHAs, these organizations may be uniquely suited to health outreach, education, testing, and treatment.


Stovall, J. G., L. Cloninger, et al. (1997). “Identifying homeless mentally ill veterans in jail: a preliminary report.” Journal of the American Academy of Psychiatry & the Law. 25(3): 311-5. Increasing evidence exists that suggests associations between mental illness, homelessness, and criminal activity and arrest. This article describes a program for identifying and providing treatment and housing for homeless mentally ill veterans detained at the Cook County Jail in Chicago. Preliminary data are provided describing characteristics of the veterans assessed in the jail, as well as those veterans who follow up with services upon release. The usefulness of an urban jail as a site for outreach efforts targeting homeless mentally ill veterans is discussed.

BACKGROUND: Persons with mental illness are over-represented among the homeless relative to the general population, and mental illness is most likely one of many vulnerabilities that confer risk for homelessness. METHOD: This paper elucidates the pathways to homelessness for persons with mental illness by comparing and contrasting groups of mentally ill homeless persons, non-mentally ill homeless persons, and housed mentally ill persons drawn from RAND's Course of Homelessness (COH) study and the Epidemiological Catchment Area (ECA) survey. RESULTS: Homeless persons share childhood histories of economic and social disadvantage. The mentally ill homeless appear to have a "double dose" of disadvantage: poverty with the addition of childhood family instability and violence. Among the mentally ill homeless, those who became homeless prior to becoming mentally ill have the highest levels of disadvantage and disruption; while those who become homeless after becoming ill have an especially high prevalence of alcohol dependence. CONCLUSIONS: Mental illness may play a role in initiating homelessness for some, but is unlikely in and of itself to be a sufficient risk factor for homelessness. In addition to outreach and treatment programs for adult mentally ill homeless persons, emphasis should be placed on interventions with children and on addressing more pervasive causes of homelessness.


OBJECTIVE: The author examined the methodology and results of studies that surveyed mentally ill clients' preferences related to housing and support services to gain an overview of demographic characteristics, current and preferred housing situations, and preferred types of staff supports and social and material supports in a nationally representative sample of clients. METHODS: Through mailings to state departments of mental health and local mental health providers and advocates, a national survey of residential providers, and other contacts with mental health agencies, the author identified a total of 43 studies of mental health consumers' preferences for housing and supports conducted between 1986 and 1992. The results of 26 of the studies whose methodologies permitted comparison of findings were summarized. RESULTS: Consumers consistently reported that they would prefer to live in their own house or apartment, to live alone or with a spouse or romantic partner, and not to live with other mental health consumers. Consumers reported a strong preference for outreach staff support that is available on call; few respondents wanted to live with staff. Consumers also emphasized the importance of material supports such as money, rent subsidies, telephones, and transportation for successful community living. CONCLUSIONS: To accommodate consumers' preferences, mental health systems should work toward providing flexible supports corresponding to the episodic nature of psychiatric disability and should expand their advocacy for affordable housing and for increased income for people who depend on disability benefits and other entitlements.
Outreach teams use a range of strategies to engage people who are homeless and mentally ill and living on the streets. This chapter describes and evaluates the effectiveness of various voluntary and involuntary approaches and presents a new model program for serving this population.

OBJECTIVE: This study measured the impact of an assertive case management program for psychiatrically disabled homeless persons in metropolitan Toronto. It was hypothesized that the program would improve residential stability, reduce psychiatric symptoms, improve social functioning, improve social networks, and increase use of appropriate services. METHOD: For 59 clients admitted to the program, assessments for the nine-month period before program entry were completed and were repeated nine months later. The Brief Psychiatric Rating Scale and a version of the Scale for Level of Functioning were the main measures of outcome. RESULTS: At follow-up significant improvements in residential stability and reductions in psychopathology were demonstrated. Improvements in social functioning and increases in social network size were significant. Although no baseline data about service use were collected, clients used basic support services during their first nine months in the program. CONCLUSIONS: The success of the program demonstrates that a difficult-to-treat patient population can be helped in a humane fashion if trained personnel are available.

This chapter discusses twelve principles that have guided the development of a large, inner-city assertive outreach program. The program serves clients who are at high risk for hospitalization and homelessness.

This study examined the relationship among cocaine use, psychiatric distress, and HIV risk behaviors of homeless men. A 3 x 2 ANOVA was computed to determine overall mean HIV risk behavior, with the first factor representing three levels of psychiatric distress (low, moderate, and high) and the second factor representing use or no use of cocaine. Overall, homeless men who used cocaine had significantly higher HIV risk scores than did noncocaine users. Among the homeless men who used cocaine, those men who reported high psychiatric distress had significantly higher HIV risk scores than did noncocaine users and cocaine users with low psychiatric distress. Moreover, these risk scores predominantly represented three high risk sexual behaviors; lack of condom use, multiple sex partners, and participation in commercial sex. Outreach efforts that
target both substance use and especially high-risk sexual practices are urged for this population.