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National Institute of Mental Health

# Homelessness and Mental Illness: Toward the Next Generation of Research Studies

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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# HOMELESSNESS AND MENTAL ILLNESS:

# TOWARD THE NEXT GENERATION OF RESEARCH STUDIES

**Proceedings of a NIMH-Sponsored Conference***
**Bethesda, Maryland**
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* Each workshop summary was prepared by faculty based on their presentation and comments at the conference and therefore may not necessarily reflect the policies of the National Institute of Mental Health.

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# PREFACE

We are pleased to make available this conference report which highlights the content of both the plenary sessions and twelve workshops of the NIMH-sponsored meeting entitled, ***Homelessness and Mental Illness: Toward the Next Generation of Research Studies.***

Between 1982 and 1986, NIMH awarded grants to ten research groups to explore the relationship between homelessness and mental illness; these "first generation" studies examined the demographics, mental health status, and service needs of the population. In December, 1988, NIMH issued a new program announcement designed to build on these earlier efforts. Both the new announcement and this research development conference were intended to stimulate the "next generation" of studies. The hope for the future was to broaden-the base of NIMH-sponsored research to include studies of the paths leading into and out of homelessness, studies of the effectiveness and cost of different service interventions, and studies focusing more attention on the mental health needs of the growing subgroup of homeless children, adolescents, and their families.

We appreciate both the individual and collective contributions of the conference faculty, particularly their willingness to share expertise and pioneering experiences in a newly developing field of research with NIMH staff, with the 120 meeting participants from around the country, and with the many others who will read these proceedings.

We were fortunate to work with two extremely competent professionals, Joe Morrissey and Deborah Dennis, who assisted NIMH staff with the design and conduct of this meeting. When the scope of the meeting and the number of participants mushroomed tenfold, Joe and Debi remained not only flexible, but also gracious. They even retained their enthusiasm and commitment when the proposed proceedings grew from 10-15 pages to the size of this volume. The success of the meeting and the quality of the proceedings is due, in large part, to their understanding of the problem of homelessness and to their friendships and respect within the mental health community.

I would also like to thank the NIMH staff who provided both direction and support for this project. We appreciate the efforts of the planning committee comprised of Chuck Windle, Ann Hohmann, and Mary Farmer (all of NIMH), who helped us identify the broad range of research expertise necessary to conduct this meeting. Finally, I am most appreciative of the work of Debra Rog and Dawn Jahn of my office; they competently managed this important and challenging endeavor with insufficient resources and still made it "bloom."

We all hope that this volume will serve to interest, intrigue, and educate "a next generation" of research efforts that can potentiate the important work of service providers and advocates in seeking an end to the uncommon, but too common, tragedy of homelessness.

Irene S. Levine, Ph.D., Director
Office of Programs for the Homeless Mentally Ill
National Institute of Mental Health

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# INTRODUCTION

These proceedings are the fifth in a series of conference reports on the homeless mentally ill that have been sponsored by the National Institute of Mental Health. The purposes of these meetings and reports have been to simulate the exchange of research ideas, methodologies, and findings among investigators currently conducting work in this area and to inform a variety of government officials, policy analysts, advocates, service providers, and citizens about the current state of knowledge on the causes, concomitants, and consequences of being homeless and mentally ill. The meeting, which was held in February 1989, was attended by over 120 persons from across the country who participated in twelve workshops conducted by experts in homeless studies or other aspects of mental health services research. This report contains summary highlights of the plenary sessions at the two day meeting, along with a short synopsis of the ideas and issues presented in each workshop.

## NIMH Research Meetings

Earlier meetings centered around ten NIMH-funded research projects that were initiated in 1983. These were the "first generation" or foundation studies dealing with the homeless mentally ill in America. At that time, there was little or no common culture or research tradition that investigators studying these issues could draw upon. The conference goal was to provide these researchers with a forum to assess common goals and problems, to identify unifying themes, and to exchange technical information (Bachrach, 1984a, 1984b). Subsequent meetings allowed for an exchange of information about the current status of the research projects, a discussion of key findings and implications, identification of topics and funding strategies for future research, and recommendations to NIMH program staff for encouraging and facilitating future research on homeless mentally ill persons (Spaniol and Zipple, 1986; Morrissey and Dennis, 1986; Dennis, 1987). The ten studies yielded a set of highly consistently findings despite their different geographical locations, methodologies, and study populations.

The purpose and format of the fifth meeting which occurred on February 20-21, 1989 in Bethesda, Maryland was a departure from the other four. It was intended to serve as a stimulus for a second generation of studies in this field. Much of the earlier research on homelessness focuses on the demography and epidemiology of the population (e.g., "Who are the homeless mentally ill? What are their needs? How many have a serious mental illness?"). It was felt that future research also needed to include the identification of the kinds of services that are successful in meeting the multiple needs of the various subgroups which make up the homeless mentally ill population (i.e., "What works for whom under what circumstances?").

This judgement was heavily influenced by the passage of the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77) which provided an opportunity for the NIMH to strength the priority it places on stimulating high quality research and research demonstration efforts pertaining to the homeless population. A special research program announcement on the homeless mentally ill was released by the Institute in January 1988. This announcement authorized the expenditure in fiscal year 1989 of $2.5 million to support new research grant awards and up to an additional $2 million to support new research demonstration grants and unspecified amounts for future ongoing receipt dates. The purpose of this new initiative was to accelerate the development of methodologically rigorous knowledge that can contribute to more effective delivery of mental health services to homeless persons, reduce homelessness among the mentally ill, and reduce mental illness

among the homeless. The announcement was specifically targeted for research on severely mentally ill homeless adults and children.

The early planning for the fifth research conference was already underway when this announcement was released. In consultation with NIMH program staff, we shifted our thinking toward the opportunities that would be created by this new round of NIMH-supported research on the homeless mentally ill. The timing of the meeting in late February 1989 meant that there would be about six weeks lead time prior to the due date for submitting applications on April 10, 1989. We decided that the meeting would be a good way of calling attention to the announcement and in stimulating the submission of high quality research proposals.

We considered various formats for the meeting, such as commissioning state-of-the-art papers from experts or asking participants to submit concept papers and draft proposals for presentation and critique at the meeting, but ultimately opted for a workshop format due to the lack of lead time for presenters or participants to prepare materials in advance of the meeting. We reasoned that prospective applicants would benefit from the opportunity to both listen to and interact with experienced researchers. The idea was that the experts would present an overview of the latest techniques and research practices relevant to some aspect of homelessness and its relationship to mental illness drawing upon their own work for examples. In this way, participants would have the opportunity to update their understanding of services related research issues while considering their plans for proposal development relevant to the new research announcement. Moreover, by having the presenters prepare synopses of their workshops, we could subsequently develop a set of proceedings that could be distributed widely to others interested in conducting or otherwise supporting further research on the problems of homelessness and mental illness in contemporary society.

## Hiehliehts of the Fifth Annual Meeting

### *Introductions*

Welcoming remarks were offered by Irene Shifren Levine, Ph.D., Director of the NIMH Program for the Homeless Mentally Ill who also introduced Lewis L. Judd, M.D., the Institute Director and Alan Leshner, Ph.D., the Institute's Deputy Director.

Dr. Judd stated that improving the care and treatment of severely mentally ill individuals who are homeless or at risk 'of 'becoming homeless is among the most pressing public health needs facing this country. He endorsed the annual research meetings sponsored by the NIMH, but he stressed that things were not moving fast enough, given the magnitude of the problem. To accelerate this process, he recently created a special task force within the Institute, with representation from all Divisions, so that this topic would be an NIMH-wide priority rather than just an activity within the Program on the Homeless Mentally Ill. Dr. Judd noted that the demonstration projects associated with the McKinney Act had a specific emphasis on research and evaluation. He called particular attention to the need within this effort to find out what types of services are most appropriate for certain subgroups of homeless mentally ill persons, and how to organize these services into a comprehensive system of care. Dr. Judd emphasized it was his hope that, through such efforts, it won't be long before NIMH demonstration projects can offer credible knowledge-based interventions for the problems of homeless mentally ill people.

Dr. Leshner emphasized that research on homeless mentally ill persons is now one of the most important priorities across all divisions of the NIMH. He reviewed the aims of the special research announcement on homelessness that encourages investigator-initiated research including epidemiological studies, service system research, and research

demonstrations. He emphasized that research needs to produce information that is generalizable and that can be applied in other settings. He also referred to NIMH's Public-Academic Liaison (PAL) initiative and its relevance for homeless mentally ill research.

Following these remarks, Debra J. Rog, Ph.D., also of the NIMH Program for the Homeless Mentally Ill provided an update on the McKinney Homeless Assistance Act which was signed into law by President Reagan in July 1987. The Act's two mental health provisions relate to Block Grants and service demonstrations. The purpose of the block grants is to get an infusion of funds to the States on a noncompetitive basis for an expansion of services to homeless mentally ill persons. In 1987-88, $43.7 million was appropriated for these services; in 1988-89, $14.1 million was appropriated with a minimum of $275,000 per State and a maximum determined by a formula weighted toward urban places.

Dr. Rog said that the demonstration program, in contrast, is an effort to develop innovative approaches for providing community mental health services for homeless individuals. In fiscal year 1987-88, $9.3 million was appropriated and allocated to the States on the basis of a competitive grant process. Thirty-three States applied, 19 applications were approved through a peer review process, and 12 were funded: nine to serve homeless mentally ill adults and three for serving homeless children at risk of emotional disturbance. Each demonstration was required to develop a basic template of comprehensive services involving outreach, intensive case management, mental health treatment, supportive and supervisory housing, and management or coordination services to link the individual components together into a system of care.

This appropriation also allowed for the development of the National Resource Center on Homelessness and Mental Illness operated under contract for the NIMH by Policy Research Associates, Inc., in Delmar, NY, under the direction of Henry Steadman, Ph.D., and Deborah Dennis, M.A. Dr. Rog indicated that the Center will serve as a central information clearinghouse for the field as well as source of consultation and technical assistance for the service demonstration sites. In addition, she said that an evaluation will be designed and conducted for the demonstration program.

Joseph P. Morrissey, Ph.D., from the University of North Carolina at Chapel Hill (who served as organizer and co-host for the meeting) then presented an overview of the goals and format of the conference. He described the history of the NIMH research conferences and the conference theme of "transitioning from first generation to second generation studies" of homeless mentally ill persons. He introduced Deborah Dennis to the audience as his colleague and meeting co-organizer who had helped to develop the topics and recruit presenters for the workshops. Dr. Morrissey indicated that NIMH staff were very interested to learn about the success of the workshop format for future research meetings and, consequently, attendees at each workshop would be asked to complete a one-page evaluation form.

### *Keynote Address*

The keynote address was presented by Richard Tessler, Ph.D., Professor of Sociology at the University of Massachusetts-Amherst. His remarks were based upon a recent synthesis of the "first generation" NIMH research studies on the homeless mentally ill that he had prepared in collaboration with Deborah Dennis (Tessler and Dennis, 1989). Professor Tessler described the research design features of the ten studies, highlighted selected findings, and discussed their research and policy implications. The complete text of his remarks is included in these proceedings (see page 9-18).

**Plenary *Session***

The conclusion of the morning program was a plenary session on designing high quality research plans. Three NIMH program staff offered a series of recommendations about the grant proposal development and presentation process: Ann Hohmann, Ph.D., Charles Windle, Ph.D. from the Division of Epidemiology and Applied Sciences and Althea **Wagman,** Ph.D. from the Division of Clinical Research. Dr. Hohmann encouraged potential applicants to submit brief concept papers or draft applications for NIMH staff review prior to submission of a formal application, She described the stages in the review process, the decisions (approval, deferral, disapproval) that Initial Review Groups would make, and the subsequent funding process for approved applications.

Dr. **Wagman** reviewed the scientific criteria used by the Initial Review Groups to evaluation research applications. She stressed the importance of clearly defining the research problem, responding to the aims of the Request for Applications, and close adherence to the guidelines and page limitations mentioned in the application kit. She encouraged prospective applicants to develop an abstract that really summarizes the research; a background statement that was to the point, with a literature review carefully chosen to demonstrate the problem; a methods section that describes what, when, and how the research will be carried out in a feasible and straightforward manner that allows hypotheses to be tested. She characterized the analysis plan as the heart of the application. Applicants need a solid background in research and experimental design or they must have competent consultants in this area. Explicit consideration must be given to sample size and generalizability, an adequate procedure to safeguard human subjects, and a carefully justified budget. If the initial submission was not approved, she asked applicants not to despair but to contact program staff for feedback and advice about revisions and resubmissions.

As an iliustration of **the** problems and pitfalls that must be avoided in the proposal writing process, Dr. Charles Windle then presented the results from his recent review of nine summary statements for research applications that had been disapproved. As a group, the nine applications had a total of 109 criticisms with an average of about seven major criticisms per application. These criticisms fell into six broad categories. First, the principal criticism was a lack of information or a lack of specifics about key elements of the study. Second, there were a number of flaws such as faulty logic, aiming to do too much or too little, flawed management, or doubtful assumptions. Third, reviewers often identified waste and inefficiencies such as analyses that could not answer questions, inflated budgets, or excessive personnel. Fourth, the importance of the study and its contribution was often questioned. Fifth, **inconsistencies** were often detected between the aims and plans or between different sections of the proposal. And sixth, the abilities of the researchers were suspect or found to be inadequate for the proposed research. Dr. Windle concluded by encouraging prospective applicants to explain their ideas and plans in detail, to carefully review the logic of their proposal, and to consider carefully the critiques returned to the principal investigator which are very helpful for planning resubmissions.

The remainder of the conference was conducted as a series of simultaneous workshops on twelve different research topics. As part of the conference registration process, participants were asked to identify their workshop preferences so that each of the individual sessions could be scheduled in an optimal fashion with about 30-50 attendees. Six workshops were conducted during the afternoon of the first day; the afternoon was divided into two and a half sessions with three simultaneous workshops in each session. Six additional workshops were conducted on the second day, three in the morning and three in the afternoon. Each of these workshops was scheduled to run for three hours.

## Overview of the Proceedings

The listing of the workshop summaries in this report departs from the actual schedule during the two day meeting. Here the summaries are grouped into five sections which reflect their broader research or methodological themes. Section I consists of Richard Tessler's keynote address.

Section II focuses on research design and measurement issues, and includes six workshop summaries. Alan Ross conducted a session on enumeration and sampling issues in homeless research, drawing upon his experiences in the Baltimore studies. Anne Love11 and Jay Sokolovsky conducted a session on social networks and social supports, drawing upon their experiences studying the homeless mentally ill in New York City and other locales. Gary Morse and William Hargreaves presented a joint session on experimental designs. They each prepared separate presentations which are included here in lieu of an integrated workshop summary. Paul Koegel and Beverly Ovrebo conducted a workshop on ethnographic and qualitative research methods, drawing upon their experiences studying the homeless mentally ill in Los Angeles and the San Francisco Bay area. This section concludes with Robert Rosenheck and Pamela Fischer's workshop summary on longitudinal research designs which draws upon their respective work in studying homeless veterans in multiple sites across the country and the homeless mentally ill in Baltimore.

Section III consists of three workshop summaries which focus on special population subgroups among the homeless mentally ill. Anne Love11 and David Shern conducted a session on assessing mental health status for homeless mentally ill adults; Patricia Cohen and Mary Schwab-Stone conducted a similar session for children's mental health assessment; and Leonard Saxe and Lisa Goodman conducted a workshop on families with a homeless mentally ill member.

Section IV shifts the unit of observation from individuals to organizations and service systems. Howard Goldman and Sandra Newman presented a workshop focused on financing and housing issues relevant to this client population. John Brekke conducted a workshop focused on program implementation analyses. Mary Fennel1 and Kathleen Dockett presented on interorganizational systems approaches to studying agencies serving the homeless mentally ill.

Finally, Section V is devoted to the larger social context surrounding homelessness in the U.S. Kim Hopper and Michael Sosin address conceptual and measurement issues in this area, and suggest ways in which social context variables can be incorporated into research on homelessness and mental illness.

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Section I

# KEYNOTE ADDRESS

# What Have We Learned To Date? Assessing the First Generation of NIMH-Supported Research Studies on the Homeless Mentally Ill

**Richard Tessler**
**University of Massachusetts at Amherst**

## Introduction

I am **tempted to begin with a paraphrase on the published title of my talk:** "What Have **I** Learned to Date?" At the time I got involved in this project, I was a relative newcomer to this area. Fortunately, I had a knowledgeable co-author (Deborah Dennis), an interested project officer (Debra Rog), and a number of research colleagues from around the country who wrote to me at length in response to an earlier draft. I also benefited from observations made by previous reviewers of these studies (Leona Bachrach, Leroy Spaniol, and Joe Morrissey).

My purpose today is to give a thumbnail sketch of the contents of the Synthesis, and to highlight some issues from it. Originally, we had hoped to distribute copies of the final draft at this conference, but unfortunately it is not quite complete. Hence, the presentation today is a preview of what you can read in more exquisite detail in the full report, to be distributed in the next couple of weeks.

I want to acknowledge that many of the researchers who contributed to this first generation of studies, and whose work is reviewed in the synthesis, are here today in the audience, and that some -- namely, Pam Fischer, Paul Koegel, Ann Lovell, and Gary Morse -- are also workshop leaders.

There are two handouts. One is a brief outline of my talk so that the progression can be followed more easily as I go along. The other, labeled Exhibit 1, provides some basic information about the studies I will be attempting to synthesize.

Finally, I want to say that due to the complexity of the material and my own need for structure I will be sticking very closely to my prepared text. However, I will leave time at the end for questions and comments.

## Description of the Studies

The story begins with grants awarded between 1982 to 1986 by the NIMH. A great variety of grant mechanisms were used to fund these studies. One was part of an Epidemiological Catchment Area grant. Five were supplements to CSP grants to state mental health authorities. Two were funded from a special grant announcement on state service system research. One was funded through an interagency agreement. And one was an investigator-initiated R01 research grant funded by the Division of Biometry and Applied Sciences. There were 10 studies in all, but our report focuses mainly on eight that were complete at the time we undertook the project.

These eight were mainly cross-sectional. None were restricted to homeless mentally ill persons, but instead chose to sample homeless persons in general and to treat psychiatric status as a variable. Generally speaking, the focus is on adult homeless individuals, and not on families and children. All used quantitative methods but none were "counting studies" per se. The primary vehicle for data collection was structured interviews with homeless persons. Some of the studies also interviewed key informants and reviewed agency records.

EXHIBIT 1. PROFILES OF NIMH-FUNDED RESEARCH PROJECTS ON THE HOMELESS MENTALLY ILL •

| Site | Principal Investigator(s) | Source/Amt. of Funding | Duration | Study Focus | Sample Characteristics | Data Collection Methods | Mental Health Status/ Need Indicators |
|---|---|---|---|---|---|---|---|
| Baltimore | Y.R. Breakey<br>Johns Hopkins University | $500,000<br>NIMH | 2.5 years<br>June 1985-<br>Dec. 1987 | Homeless<br>Longitudinal<br>Sample | Users of missions, shelters, jails (N=600) | Key Informants<br>Structured Interviews<br>Psych./med. exams | Psychiatric evaluation and diagnoses<br>Physical examinations |
| Baltimore | P. Fischer<br>Johns Hopkins University | $125,000<br>NIMH ECA Substudy | Completed 1983 | Homeless<br>Cross-Sectional Sample | Male mission users in E. Baltimore (N=51)<br>Male community sample from ECA Study (N=1338) | Structured Interviews | General Health Questionnaire (GHQ)<br>Dirgmstic Interview Schedule (DIS) |
| Boston | V. Mulkern<br>Human Services Research Institute | $95,642<br>NIMH-CSP Supplement | 1.5 years<br>Feb. 1984-<br>June 1985 | Both Homeless/ MI Homeless<br>Cross-Sectional Samples | Male & female users of shelters & streets (N=328)<br>State hosp. discharger (N=155)<br>MH day program users (N=92) | Structured Interview | Global Assessment Scale (GAS)<br>Selected items from other psychiatric rating scales<br>Interviewer symptom checklist |
| Detroit | C. Mowbray<br>Michigan Dept. of Mental Health | $61,210<br>NIMH-CSP Supplement | 2.0 years<br>Dec. 1983-<br>Dec. 1985 | Both Homeless/ MI Homeless<br>Cross-Sectional Samples | Users of 4 Inner-city shelters (N=75)<br>Admissions to state mental hospital (N=724) | Key Informants<br>Structured Interviews<br>Hospital Social Worker Interviews<br>Record Abstracts | Brief Symptom Inventory (BSI)<br>Psychiatric hospital history |
| Los Angeles | R. farr and P. Koegel<br>LA County Dept. of Mental Health | $135,000<br>NIMH-CSP Supplement | 2.5 years<br>Feb. 1984-<br>July 1986 | Homeless<br>Cross-Sectional Sample | Sheltered and unsheltered users of missions/shelters, rcuplines, and indoor congregating areas in L.A.'s Skid Row (N=379) | Structured Interviews | Diagnostic Interview Schedule (DIS)<br>Depression Scala (CES-D) |
| Milwaukee | M. Rosnow<br>Human Services Triangle, Inc. | $72,600<br>NIMH-CSP Supplement | 1.1 years<br>Apr. 1984-<br>May 1985 | Both Homeless/ MI Homeless<br>Cross-Sectional Samples | Male & fwla users of shelters (N=185), streets (N=52), other places (N=237)<br>Comparison sample of mental health program users (N=84) | Structured Interviews | Self-reported psychiatric hosp./service use<br>Interviewer observed/ rated symptoms |
| New York City | E. Struening and S. Barrow<br>NYS Psychiatric Institute | $159,771<br>NIMH, State, and Local | 2.5 years<br>Jan. 1984-<br>J-1986 | Mentally 111 Homeless<br>Program Evaluation<br>Longitudinal | Homeless mentally 111 individuals in 5 outreach, shelter and/or drop-in programs (N=-113) | Structured interviews<br>Record Abstracts<br>Participant Obs. | Schedule for Affective Disorder and Schizophrenia (SADS-L/SADS-C) |
| New York City | S. Ladner<br>NYC Human Resources Admin. | 1255,000<br>NIMH & Office of Human Dev. Serv. | 1.8 years<br>June 1984-<br>Mar. 1986 | Homeless<br>Cross-Sectional Sample | Users of municipal shelters (N=8,061) | Record Abstracts | Self-reported symptoms, problems and psychiatric hosp./service use |
| Ohio | D. Roth<br>Ohio Department of Mental Health | $160,265<br>NIMH | 1.3 years<br>Nov. 1983-<br>Feb. 1985 | Both Homeless/ MI Homeless<br>Cross-sectional Samples | Male & female users of missions, shelters, streets, & other places in 20 counties (N=979)<br>State hosp. admissions snd discharges (N=17,181) | Key Informants<br>Structured Interviews<br>contact Logs<br>Record Abstracts | Psychiatric Ststur Schedule (PSS)<br>Self-reported psychiatric hosp./service use |
| St. Louis | G. Horse<br>Four County Mental Services, Inc. | $21,000<br>NIMH-CSP Supplement | 1.4 years<br>Sept. 1983-<br>Jan. 1985 | Homeless<br>Cross-sectional Sample | Male & female users of 13 shelters (N=248) | Structured Interview<br>Record Abstracts | Brief Symptom Inventory (BSI)<br>Self-reported psychiatric hosp./service use |

• Adapted from Morrissey and Dennis, 1986.

Much of the background information about these studies is summarized in Exhibit 1, which is adapted from a previous report by Morrissey and Dennis. It shows the names of the P.I.s, the research sites, the dollar amounts, and methodological highlights. As shown, the studies were geographically disparate. One was in the West (Los Angeles); most of the studies took place in large urban areas in Central and Eastern sections of the United States (Detroit, St. Louis, New York City, Milwaukee, Boston, and Baltimore). One study in Ohio was statewide and included rural, urban, and mixed urban-rural counties. For my own convenience, I shall refer to these studies by their sites.

The studies vary greatly in research design, in the approach taken to measuring psychiatric impairment, and in the operational definition of homelessness. Such differences can have a profound impact on the results produced, their interpretation, and the significance accorded to them. Among the important dimension of variation is how the different research groups chose to define homelessness. Accordingly, it makes sense to begin with some methodological considerations.

## How Was Homelessness Defined?

Among the important dimensions of variation is how the different research groups chose to define homelessness. While most did not explicitly address the issue of definition, in drawing their samples mainly from missions, municipal shelters, and street locations, the majority focused on the "literal homeless" who clearly lacked (at the time of the study) customary and regular access to a conventional dwelling.

Two studies did include persons who rotated among a variety of short-stay situations, thus going somewhat beyond a literal definition. But none went so far as to include as "homeless" persons who were "doubled up" with relatives or friends, or were living in cheap motel and hotel rooms for more than short periods.

The most common settings sampled were shelters and missions which provided sleeping arrangements. All of the studies drew their samples at least in part from this source. The most common additional source was "the streets." Four of the eight studies drew part of their sample from the streets, although in the case of the Los Angeles study the street sample was part of a pilot study only.

The next most frequent sources were represented by meals programs (largely soup kitchens), and by short-stay situations. Persons in the Ohio study were considered homeless who relied temporarily on the resources of other persons, typically family or friends, for assuring shelter, or who had slept or lived in cheap hotels or motels for 45 days or less. When they were encountered, persons residing in short-stay situations were also included in the sample for the Los Angeles study.

Finally, some of the studies also sampled from mental health settings, from among state hospital admissions and discharges, and clients enrolled in community support and day treatment programs. The rationale was to identify psychiatric patients who were at risk of homelessness and/or to provide a clinical basis for comparison with individuals in the homeless population.

## How Were Respondents Sampled?

The synthesis discusses some of the sampling issues involved. The basic problem is that the absence of convenient lists make it impossible to define a sampling frame in which each homeless individual in the population has a known probability of being selected.

The problem with most samples is that it is difficult to determine whether the individuals studied are representative of the larger population of interest. This is especially true of studies that selected respondents from non-shelter settings such as soup kitchen lines, congregating areas, and the streets by approaching those who appeared to be homeless. Many persons who eat in soup kitchens have access to a conventional dwelling and are not appropriate for inclusion. Others in the streets or other public areas may be homeless but do not fit the commonly held image of a homeless person as someone carrying their belongings and appearing unkempt, and thus may not be identified. For these reasons, screening systematically for homelessness is essential, and the more rigorous studies asked people a set of short screening questions in order to ensure that they were eligible for sampling.

A related and even more serious issue is the consequence of sampling from a limited number of facilities, and not accounting for overlapping use among different facilities. In Los Angeles, for instance, different missions are known to attract different clienteles. Were one to use only one or two such facilities and extrapolate to the skid row population at large, systematic bias would be introduced. Likewise, some people only use one facility while others use many. Hence, patterns of use have to be taken into account if one is to feel confident that every individual has an equal probability of being sampled.

In terms of sampling methods, the Los Angeles study is exemplary. To ensure that proportionate numbers of sheltered and unsheltered individuals were included in the L.A. study, cases were allocated between groups defined by type of service in a manner that was proportionate to their representation in the total homeless population, and in a manner that insured no case was counted more than once. Cases were sampled randomly within each group yielding a representative sample of homeless persons on an average day in the Skid Row area of Los Angeles.

When response rates could be determined they were reasonably high. Response rates reported were 98% (Baltimore), 73% (Detroit), 85% (Los Angeles), 96% (Milwaukee), 85% (Ohio), and 96% (St. Louis). Such high response rates are impressive considering that the interview protocols sometimes required over an hour to complete. The high response rates are probably due to a number of factors, including: care taken in the selection and training of interviewers, payment to respondents (Baltimore, Los Angeles, and St. Louis respondents were each paid $5), and the good faith and patience shown by those who consented to be interviewed.

## How Was Mental Illness Measured?

There was much diversity in the approaches taken to measuring mental illness in these studies. The specific measures employed ranged from the New York City shelter study which relied on self-reported service history and/or self-acknowledged mental problems to indicate psychiatric impairment, to those using standardized screening instruments (administered by interviewers) such as: the Brief Symptomatology Inventory (BSI) which was used in the St. Louis and Detroit studies, the General Health Questionnaire (GHQ) which was used in the Baltimore study, the Psychiatric Status Schedule (PSS) which was used in the Ohio study, and the Diagnostic Interview Schedule (DIS) which was used in the Los Angeles and Baltimore studies to yield psychiatric diagnoses fulfilling DSM-III criteria.

In order to estimate the prevalence of mental illness in the populations of homeless persons under study, most established cutoff points which separate mentally ill persons from non-mentally ill persons. The cutoff points chosen are idiosyncratic to each study, which is not surprising considering that the studies varied so much in terms of the measures employed.

**A** word on reliability and validity of measurement: There is reason to be concerned about each, as I have learned from Paul Koegel and Ann Lovell, who have both written extensively about these matters. While the use of standardized measures with known psychometric properties is encouraging, it provides no guarantee that mental illness was reliably measured because in most cases the psychometric integrity of the measure had not been previously established with the homeless population. There is also reason to question the validity of the mental health measures. Observed "symptoms" may be caused by mental illness, but they may also result from some combination of factors tied to the individual's homeless condition. A related question is the extent to which adaptive behavior by homeless persons comes to be labeled as pathological. For example, poor hygiene is often noted as a sign of poor functioning but some homeless women purposely neglect personal hygiene as a way to ward off potential aggressors.

## What Other Data Elements Were Included?

These studies cast a broad net encompassing much more than psychiatric impairment. Virtually every study included a socio-demographic cluster comprised at a minimum of age, gender, marital, and minority status. Several studies also attempted to measure sources of income, employment status, and residential status. The scope of data elements makes these NIMH studies comparable with other recent studies of homeless persons in the United States.

## Selected Findings

### *What are the Characteristics of the Homeless Populations Studied?*

1. The majority of homeless respondents were male; median aged across all studies ranged from 29 to 38.

2. The size of the non-white homeless population, mainly blacks and hispanics, was impressive. Non-white homeless numbered 47% in Baltimore, 30% in Boston, 74% in Detroit, 73% in L.A., 40% in Milwaukee, 83% in New York City, 35% in Ohio, and 65% in St. Louis. Comparisons with domiciled samples in Baltimore, Los Angeles, and Ohio indicate that minorities are clearly over-represented among the homeless relative to their proportion in the general population.

3. Homeless persons are poorly educated (only 40-57% had graduated from high school) and unemployed (only 1-25% were currently employed full or part-time).

4. Public benefits (social security, welfare, or SSI) are received by only about one-third; at least twice as many were eligible for some form of income maintenance.

5. The proportion of homeless who were veterans ranged from 18-51% across the five studies which included this question; many of these were VietNam vets.

6. The homeless population in the Northeast appears to be less mobile than of that of the West or Midwest. Nearly two-thirds or more of homeless persons in the studies conducted in the Northeast had lived there over five years. But all the studies show that homeless individuals are most likely to be long term residents.

7. The results also add to accumulating evidence of poor physical health in this population; 12-50% reported current health problems or rated their health as poor.

8. According to their own report, the majority of homeless persons in these studies have been in recent contact with a family member or friend, but it is difficult to characterize the extent or nature of these relationships. We do know that family involvement is largely restricted to family of origin since one to two-thirds of all homeless respondents have never married.

9. Homeless persons face serious threats to their personal safety and property. The proportion victimized was 36% in Detroit, 54% in Los Angeles, and 28% in St. Louis. The Baltimore study found that homeless persons have more frequent arrest and conviction rates than the general population.

10. Between one-quarter and one third of homeless persons were abusing alcohol; drugs, or both. The Los Angeles study found that 31% could be diagnosed as current substance abusers. This was more than 3 times the six month prevalence rate of substance abuse disorders in the domiciled population in Los Angeles.

***What is the Mental Health Status and History of Homeless Persons?***

1. Statistics on the prevalence of mental illness varied considerably, but if one restricts the studies to those which used standardized assessment instruments to determine current psychiatric status, prevalence ranges from 28% to 37%. The one exception is the St. Louis study which found that 46% of their sample scored above the cut-off point on the Global Severity Index of the Brief Symptom Inventory, but many of these cases were not chronic. Clearly, not all homeless persons are mentally ill, but the mentally ill do constitute a significant subgroup.

***2.*** Six month prevalence rates of DSM III diagnosis comparing homeless and domiciled samples in Baltimore and Los Angeles reveal very large differences especially in the categories associated with severe and chronic mental illness. Koegel, **Burnam,** and Farr report that the Los Angeles homeless were 38 times more likely to be diagnosed with schizophrenia, 38 times more likely to have experienced a manic episode within the last six months, and 5 times as likely to have had a major depressive episode. In the Baltimore study, the prevalence of any mental disorder among the homeless (45%) was twice that of men in the domiciled sample (23%).

3. In every study reviewed (except the Milwaukee study), nearly half of the mentally ill subgroup were judged to be abusing alcohol and/or drugs. In the Los Angeles study, for example, 46% of those who were seriously mentally ill were found to be chronic substance abusers.

***4.*** The proportion of homeless persons who had ever been a psychiatric inpatient ranged from one-quarter to two-fifths. The Ohio researchers found that of those who had been hospitalized for a psychiatric illness at some point in their lives, only half were currently symptomatic.

***How do the Mentally Ill and Non-Mentally Ill Subgroups Compare?***

1. The synthesis examines the mentally ill and non-mentally ill subgroups only to a limited extent because, ironically, the two groups are not systematically compared in each of the final reports. Based on the comparative analyses that are available, we conclude that mentally ill and non-mentally ill homeless persons are similar in terms of age, sex, ethnicity, the extent to which they are long-term residents of the geographic area in which they were surveyed, the degree to which economic reasons and family conflict played a role in their current situation, and the extent of substance abuse. Compared to non-impaired homeless individuals, mentally disabled

homeless persons are more likely to be homeless for longer periods of time, to have less contact with family and friends, to have more barriers to employment, poorer physical health, and more contact with the legal system.

***What are the Service Needs of Homeless Persons?***

1. All of the studies emphasized that what homeless and homeless mentally ill persons needed most was housing, access to and maintenance of entitlements and/or employment. Mental health services were generally assigned low priority. In the St. Louis study, almost four out of every 10 homeless persons (37%) agreed to some degree that they needed help or treatment for emotional (psychiatric) problems. Of these, more than one-half (58%) said they were willing to receive mental health services or treatment. However, a **60-day** follow-up of persons who were offered a referral for mental health services **(N=119)** found that one-quarter (24%) refused the referral; half (52%) accepted the referral,but never received the service. Only about one-quarter (23%) accepted the referral and received services.

2. In the Milwaukee study, people who were judged to need mental health services "generally expressed little interest in becoming involved in a mental health treatment program. Many had received treatment in the past and were apparently disillusioned by their experience.

3. Results from these studies highlight the extent to which homeless persons with serious psychiatric problems are not receiving mental health services. The reasons for the lack of care and for the disjuncture between apparent willingness to receive services and actual utilization of mental health services can only be inferred. However, as the Milwaukee researchers observed, "there is a sense that they would be receptive to outside help on their terms.

## Implications

I now turn to some of the implications of these studies. As Morrissey and Levine have previously suggested, these were in one respect "first generation studies" undertaken in response to considerable pressure to produce timely information for public policy. Considering the climate in which they were conducted and the relative paucity of precedents for designing and implementing studies of homeless persons, it is impressive that the studies were carried out with as much care and attention to methodology as was exhibited. The yield in terms of knowledge gained is also impressive in light of the often modest resources they were granted.

**Sampling.** An important conclusion from the Los Angeles study is that knowledge of facility contact and patterns of use can be used to define the population and still capture the vast majority of cases. Whether this approach to developing a sampling frame and drawing a representative sample is more generally viable needs to be investigated further. However, there is no question about the utility of expanding the definition of a facility beyond shelters and missions and accounting for overlapping use among different facilities.

Measurement of **Psychiatric** Disorder. We now know that it is feasible to administer not only standardized psychiatric scales but also structured clinical interviews to respondents who are homeless, and that with modest payment high response rates can be achieved. Although questions persist about the reliability and validity of the measures employed, including whether measured morbidity is confounded with life style and adaptive behavior, indications are that such problems are not insurmountable and that appropriate adjustments can be made.

Measures of Service Need and Use. The measurement of service need and use was only explored in a subset of the studies. Those that did examine service-relevant issues report findings consistent with Barrow's observation that "there is an emerging consensus that mentally ill homeless persons are difficult to engage in services, that they tend to perceive their needs differently from the way mental health providers see them, and that they give basic needs priority over clinical treatment." Clearly, in designing studies in the future, it is necessary to take into account not only the characteristics of homeless individuals but also the characteristics of service providers and the nature of the services offered.

## Areas for Further Research

Opportunities exist for secondary analyses that attempt to replicate findings across studies. In particular, the correlates of degree and type of psychiatric impairment among homeless men and women are not analyzed in a fashion that is consistent from study to study. Further comparison and contrast among the eight studies in terms of the co-occurrence of mental illness and substance abuse and the impact of co-occurrence on a variety of outcome measures would also be instructive. Finally, some of the data sets could be usefully extended through comparison with other relevant studies of the general population in the same geographic area, as has already been done in Los Angles, Baltimore, and Ohio.

Few program evaluations have been undertaken to date, although the newly released New York City program evaluation study by Barrow, Struening, and colleagues is a notable exception. More studies along these lines are needed. Some of the challenges that lie ahead are suggested by experiences in the evaluation of community support programs for the mentally ill, where a recent review of 33 controlled studies by John Brekke (who is also leading a workshop) has highlighted the difficulties involved in evaluating complicated service delivery programs characterized by multiple methods and modes of treatment, changes in client needs, and highly individualized treatment plans and intervention strategies.

Another important area for future research concerns the social networks of homeless persons. Although a number of studies included family involvement as a variable, none actually conducted interviews with family members. Interviews with family members would seem to be an obvious next step, although doing so will surely be fraught with methodological difficulty. The most obvious difficulty will be obtaining a representative sample of family members. In any event the study of family involvement needs to be put in a larger context of social ties including non-kin such as program workers, other homeless individuals, psychiatric patients, and neighborhood acquaintances. The extent to which it is possible to shore up an impoverished social network, to rekindle family ties, or to substitute for such through relationships with professionals and paraprofessionals, also deserve systematic inquiry.

At the time the first generation studies were funded, homelessness was defined primarily as a problem besetting single adults. Since that time, both the number of homeless families and children and consciousness of their plight has increased. The fact that three of the twelve McKinney demonstration programs are focused on this special population is a clear invitation to design innovative research in this important area.

Finally, there is now broad agreement in the research community about the significance of longitudinal designs for addressing particular issues involving homelessness and mental illness, including the causal relationship between these two constructs. We need to know considerably more about both homelessness and mental illness as processes, and about the factors that impinge on employment, housing, and family contact. The fact is

that many persons move in and out of homelessness, and between sectors of the public system of care, and that a host of situational as well as individual factors determine the physical distribution and psychological status of homeless persons at any single point in time.

## Policy and Program Development

The synthesis also includes a section on implications for policy and program development which highlights the need for multiple interventions, the need to respond to consumer perception of need, the need for a variety of housing types, the need for linkages to entitlements and opportunities for employment, and the need for policies which address the root causes of homelessness. Some of these implications arise directly out of the findings of the studies under review, while others arise more broadly out of the collective experiences of people who are working in the field. Summarized briefly, the synthesis affirms the following implications for policy and practice:

1. Mental health services that are offered without efforts to house homeless people are of limited value.

2. No single housing initiative will meet the needs of this diverse population --a variety of options with varying levels of support (including low-cost, non-serviced housing) are needed.

3. Voluntary non-traditional mental health services are needed to attract and retain clients who find traditional mental health services unacceptable.

4. Client perceptions of needs and priorities must be incorporated into service planning in a way that is meaningful to them.

5. Case management efforts should be continuous across service and residential settings to reduce the possibility of "losing" clients at each change of service.

6. Opportunities for gainful employment and continuity of entitlement benefits are critical to reversing and preventing homelessness among mentally ill individuals.

7. Policies that address residential stability among mentally ill (and non mentally ill) persons before they become homeless need to be developed.

## Concluding Note

In conclusion, I think it is important that all involved maintain a broad perspective on homelessness in America. It is no accident that there exists considerably higher levels of psychiatric as well as other types of disability among the homeless, for as my colleague Peter **Rossi** states in his new book, "it is the disabled who are least able successfully to negotiate the labor and housing markets, to use the welfare system, or to obtain support from family, kin and friends. Among the destitute,the disabled are the most vulnerable."

It is instructive in this regard to distinguish the episodically homeless from the long-term homeless. Homelessness in America consists of persons who are in that condition for short periods of time, for whom being homeless is episodic and tied to situational factors and temporary reversals, **and** persons who have been and may continue in that condition for much longer periods. A plausible hypothesis is that persons with severe mental disability are more likely to be found among the long-term homeless because their

disabilities make it more likely that they will become chronically unemployed and because family, kin, and friends are less willing to provide indefinite support for them.

As we consider strategies for reducing homelessness and for designing future research, there is a very real danger of confusing the problem with the symptom. Homelessness is actually a symptom of a larger set of problems which include gentrification and the housing market, reduced opportunities for unskilled labor, limited access to welfare and entitlement programs, and the failure of the society to provide support to families with dependent adults. In this sense it can be misleading to focus on homelessness per se, if in so doing the larger social and cultural problems are ignored. Homelessness needs to be viewed in the context of extreme poverty in America and of the failure of societal institutions to provide minimally decent levels of care and support to its most vulnerable members.

# Section II

# RESEARCH DESIGN AND MEASUREMENT

# Enumeration and Sampling Strategies

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## Introduction

The material offered in the workshop dealt with planning studies of domiciled homeless persons, with a focus on delineating objectives and organizing the outlines of field work in accordance with objectives. Attendees seemed to be less concerned with strategy than with immediate, practical aspects of drawing a random sample of homeless individuals. It is entirely understandable that many investigators, and some of those who govern distribution of funds to investigators, view achieving a random sample as the crucial element of enumeration and sampling. One senses broad agreement that if it isn't random, it isn't any good.

Individual prescriptions for sampling were not given to attendees. Instead, emphasis was placed on the importance of m-sample data collection, observation of how facilities for the homeless actually work and how the operators of the facilities say they function. Quantitative and qualitative information on bed counts, censuses, food queues, and length of stay is indispensable for consideration of strategy and construction of sampling frames, as well as devising tactics.

Sampling of homeless people in rural areas was mentioned frequently on registration questionnaires as a topic of interest. Accordingly, a workshop participant, who is in government in Ohio, described her recollections of a survey of homeless people in rural Ohio. The preliminary work for that survey illustrates some of the general points on pre-sample data collection. The Ohio operation was able to identify and track homeless people by diligent inquiry of government welfare offices and voluntary organizations, mainly churches. These first-level inquiries frequently led to non-organizational informants, such as tavern keepers and farmers, who could give current information on the whereabouts of homeless persons. The extensive pre-sample work provided a frame, and it gave the investigators information for detailed planning of other field work. It was also noted that the pre-sample scouting served to establish rapport with some of the homeless in the target population.

It became clear, as the session wound down, that many of the participants did not fully appreciate what the purposes of random sampling really are. The old, limited notion than randomization sanctions inference seemed prevalent. The workshop venue was not appropriate for discussion of the matter, except to note that investigators probably would settle for a sample that was not distorted in terms of the population, a sample that was reasonably representative, a sample that was balanced on characteristics of the population. It was not clear how these ideas of a decent sample related to "getting a random sample".

The next section is an essay that is intended to explain some of the background and thinking that leads to tilting old survey doctrine toward contemporary practical and theoretical ideas that can be implemented, along with randomization, in sampling homeless people. The material is offered here to supplement the workshop presentation.

## State of the Art

The standard approach to finite population sampling for surveys, as we know it today, goes back more than 50 years. Most survey statisticians would probably agree with R. J. Jessen's remark, "The fifties appear to have been a decade of improving, extending,

and optimizing various techniques and principles and developing the idea of multiple frames. The sixties seem to have been almost entirely devoted to polish. Perhaps the big developments are over." (Jessen, 1978). Refinements in theory - e.g., admissibility - and computational methods that use jackknife-type techniques for variance estimation in complex sample designs continue to appear. Finite population sampling did not advance fundamentally, however, until the late 1960's, when studies of "superpopulations" set new directions.

The essence of the new directions lies in restating the nature of the statistical variable in such a way that the mainstream of statistical theory and methodology (regression, least squares, likelihood, etc.) can be brought to bear on finite population sampling. In its unvarnished form, traditional sampling is structured as a collection of N objects. A fixed number or value is attached to each object, a sample of the objects is designated by application of a probability sampling plan to the N objects, and the objects in the sample are observed for their fixed values. The observations in the sample are combined in some way with the probability sampling plan to form estimates of characteristics of the aggregate (mean or total or ratio) of values for the population of all N objects.

The random aspect of this setup is the determination, via the probability sampling plan, of objects to be sampled. The estimate for a sample, together with the probability on that sample, induces the probability distribution of the estimate when the estimate-probability pair is considered for all possible samples. For a probability sampling plan and a specified estimating formula, there is one distribution of the estimate. For reference, we call that distribution the randomization distribution of the estimate.

Traditional theory is directed toward deriving formulas that summarize statistical properties of randomization distributions, and in finding ways to estimate those properties with the observed results of just one sample, the only sample the investigator is likely to have. The mean value and the variance of the distribution over all possible samples are of particular interest. A simple random sampling plan (every possible sample of size n has probability $\binom{N}{n}^{-1}$), for example, generates a distribution of the sample mean $\bar{y}$. The mean of that distribution is average y for all N objects in the population; and the variance of the distribution of sample $\bar{y}$ is the familiar $(N - n)S^2/Nn$, where $S^2$ is mean square deviation of the population of all N values of y. The variance of y is the same for every sample. Statistics more complicated than sample mean $\bar{y}$, e.g., ratio and regression estimators for population mean and total, have their own theoretical variances. Like the variance for $\bar{y}$, theoretical variances for other estimating formulas are constants that do not depend on observed values in any particular sample. Every possible sample ratio estimate has the same standard error. Every regression estimate has the same standard error. Average height in a sample of athletes has the same standard error for an unlucky sample of jockeys as for a sample of basketball players as for a sample that is generally representative of all athletes.

The idea of stating a standard error as a result of averaging over all possible samples contradicts intuition and reason. We know that different samples provide different information, that some samples are better than others, even though we may not be able to set down the specifics in advance of selection and observation.

Those who have done a course in statistical methods will recall that constant standard error is not the case in linear regression: standard error of a predicted value depends on dispersion among the sample regressor variables and departure from sample mean. Methods books display diagrams of confidence bounds that are curved. Standard errors for predictions toward the extremes of the regressor variables are larger than standard errors at more representative values of the regressors.

There are important theoretical flaws in the randomization distribution that lead to the standard error problem and other anomalies. Least squares has been an accepted theory and methodology for generations, but Godambe (1955) showed that the theme of least squares, which concerns "best linear unbiased estimators", does not apply to the randomization distribution approach to sampling. Nor does maximum likelihood, another widely-accepted theory and methodology (Godambe 1966).

In a remarkable series of papers, beginning in 1970, Royal1 and his associates brought finite population sampling into mainstream least squares theory and methodology. (The elements of likelihood theory were also worked out, but they have not been extended to methods and applications.) The essence was to model the y value attached to each population object as a regression random variable, not as a constant. That puts N random variables into the system, but these random variables are the subjects of the inquiry, not indicators of whether an object is observed, which is the case in the traditional approach.

Having adopted a regression model for a variable to be observed, we find that least squares provides formulas for estimation of population means, totals, and ratios, for stating theoretical standard errors that are free from paradox and anomaly, and for estimating standard errors.

A consequence of calculating estimates and standard errors by way of regression models is that a probability sampling plan is no longer central to the structure of inference. This is the case in standard least squares, likelihood, and Bayesian inference, where random selection of the objects to be observed plays no role. Conventional regression methodology, for example, starts with the idea of fixing the regressor variable (x) and then observing (random) responses (y) at the fixed x. Application of regression methods requires adoption of a regression model in order to derive estimating formulas that have known statistical properties (bias, variance, optimality). Strategy and tactics appropriate for one model generally do not work well under a different model. The immediate problem in survey sampling is choosing a model when there is not enough data on which to base intelligent choice. The randomization approach, by contrast, generates **its** distribution when the sampler specifies a probability sampling plan and an estimating formula. There is no dependence on uncertain models.

Fortunately, there is a practical and sound way to avoid the serious consequences of basing estimates and their standard errors on models that may be wrong. First, one must agree to the proposition that most kinds of observations that one might make in a survey can reasonably be modeled as polynomials in the regressor (intercept, linear, quadratic, etc., terms), by a multivariate regression equation, or by a mixture of several regressors in various powers. That is, the "true model" may be logarithmic or trigonometric, but the graph of expected trend can be adequately represented by a suitable polynomial/ multivariate regression equation. Royal1 and **Herson** (1973) showed that if the sample is balanced, and certain constraints on error variance are satisfied, the best unbiased least squares estimate for each of the myriad of plausible models collapses to the same simple formula. Balancing means to select a sample whose mean regressor x is equal to the population mean of x, the second moment of x in the sample is equal to the second moment of x in the population, and so on for each regressor variable up to the highest power of the regressor in the any of the plausible models. Moments are averages of powers of the variables in question. Moments describe the location and shape of statistical distributions. Center, variance, skewness, and kurtosis are functions of moments. A well-balanced sample is one whose moments are approximately equal to the moments of the population from which the sample was drawn. Balance is a quantitative representation of the idea of representative sample.

Although probability sampling plans and randomization distributions do not play a direct role in regression and prediction, random sampling, on the average over all possible

samples, gives a balanced sample. The larger the sample, the more likely it is well balanced. In small samples chosen at random, there is no assurance of balance. (For example, random selection of four persons from a population of five men and five women has less than a 50% chance of being balanced on gender.)

Balancing the sample on all factors related to the outcome variable y is, in theory, the best approach to avoiding bias in estimation. The role of random sampling is adjunctive - a device to try to balance factors that have not been identified, or to balance factors that are impractical to control otherwise. If it is recognized that balance in the sample is the property that one should aim for, learning tricks to get a random sample becomes much less important than devising simple protocols, such as systematic sampling (which is **not** random sampling), that are likely to give balance.

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## APPENDIX

## ENUMERATION AND SAMPLING STRATEGIES FOR HOMELESS POPULATIONS

### Preliminaries

Observe the functioning of organized services for the homeless. Shelters, missions, jails -- these are organized, recognized placed with administrative structures. Government, voluntary, religious, private. Investigate them. Learn their policies, their rules, their record-keeping. Special arrangements and functions (e.g., adults only, limited to one sex, women with children, families with children, detoxification).

Assemble administrative data. Number of beds. Do censuses. How many homeless? Adults, children, gender. Find our hours and locations which could be used for interviews and other subject contacts.

If your study will extend beyond the homeless in domiciliary arrangements to those with contacts at other organized services, canvas the feeding stations and drop-in centers. Observe the numbers of people according to time of day. Count the number in the queues.

### Sample Allocation

Decision on total number of observations stems from budget. Cost per interview, examination, other subject contacts, such as lab tests. Some aspects of form-handling and data reduction directly related to numbers of subjects: conferences to settle on diagnoses, care and treatment program.

Allocation among subgroups depends upon objectives of the study.

| Objective | Sample Allocation |
|---|---|
| Description | Between equal and proportional among subgroups. Avoid giving very few observations to one group while another group receives most attention. |
| Compare Subgroups | Allocate equally among the subgroups, irrespective of their numbers. |

### Plan and Organize Field Work

Recognize patterns of subject movements and availability. Missions and jails are likely to have rigid schedules and rigid attitudes. Put survey time slots into schedules where they can be best accommodated.

Break field work into waves or cycles with scheduled intermissions to clean up, catch up, review and revise. If each wave is a complete survey, then calling a halt before the project is completed (if that becomes necessary) should leave a salvageable data set over the target population.

### Selection of Subjects

When there is a choice among eligible respondents for a specified time slot, use a randomizing device to designate the subjects. The idea is to try to keep a balance among respondents: clean - dirty, co-operative - unfriendly, etc.

Shelters can be expected to have a registration list. Attach accession numbers to the list and use a random number table.

Missions are likely to conduct new registrations every day. Their clients queue up at a prescribed hour and are logged in for the night as they advance through the waiting line. The last ones are likely to be different from those near the front of the line. Force selection from all parts of the queue.

Jails will have rosters that are essentially complete at the time the roster is drawn up. Find out how homelessness is obtained from inmates and how homelessness may be detected in the printed rosters. Select at random from those on the roster who are evidently homeless at the time of incarceration. Adjust the sample take to compensate for misinformation on homeless status.

Estimation

The approach given here is limited to the homeless population that is registered in some sense for a night's stay. On a given night we can learn how many there are at each place, and, in theory, we could observe all who are eligible for the project in question. The analogy is a study of hospital inpatients on a certain date. The population is well-defined in terms of time and place. The places are observed on a number of occasions. The observations may be modeled as realizations of random variables. Represent the expected value of the distribution in one place as $M_i$, where i indexes the places. (For example, $M_j$ is the "true" proportion of homeless jail inmates who have a major mental disorder.) If the sample subjects are balanced over other factors affecting mental disorders, the observed sample proportion is an appropriate estimate of $M_i$. If it turns out that the sample is distorted in a detectable manner, the observed mean or proportion should be adjusted. For example, repeated sorties to the jail could produce an overall sample with too many young homeless men relative to the average age distribution of homeless men in the jail.

A plausible estimate for an overall average is the average of means for places, each mean weighted by the census for its place.

ILLUSTRATION

THE BALTIMORE HOMELESS STUDY

1. Preliminary data collection. Baltimore had two missions (men only), one jail, and 24 shelters. Although some agencies operated neighboring facilities for different target groups, we amalgated 22 into five shelters for men, seven for women, and three for men and women. (Some shelters had provisions for children; since BHS was directed towards adults, we did not differentiate on places for children.) The last two were deleted on grounds that they accommodated only very few homeless persons, and their directors were unwilling to permit us to interview their clients.

**Census of Shelters**

| Male | Male and Female | | Female |
|---|---|---|---|
| | 3 | 15 | |
| | 10 | 9 | |
| | 3 | 4 | |
| 24 | | | **7** |
| 14 | | | **27** |
| 6 | | | 19 |
| 4 | | | 12 |
| **16** | | | 9 |
| 80 | | | 20 |
| | | | **11** |
| | | | 133 |

**Census of Domiciled Homeless Adults**

| | Mission | Shelter | Jail | Total |
|---|---|---|---|---|
| Male | 216 | 80 | 30 | 326 |
| Female | -- | **133** | 4 | **137** |
| **Total** | **216** | **213** | **34** | **463** |

**2.** **A** focus of the Baltimore homeless study was to compare homeless men and women on baseline characteristics, health status (including mental health), and needs for services. Our budget (money and time) was projected to allow for 600 interviews and psychiatric and physical examinations on half of those who were interviewed. The objective of comparing men versus women directed us toward equal numbers of men and women in the sample.

**Target Sample Allocation**

| | Mission | Shelter | Jail | Total |
|---|---|---|---|---|
| Male | 150 | 50 | 100 | 300 |
| Female | -- | | | **300** |
| **Total** | **150** | 200 250 | 100 200 | 600 |

3. Constraints on availability of subjects, clients, and necessary personnel used up almost all degrees of freedom for adjustment and flexibility. The contract allotted one or two slots on Tuesday, Wednesday, and Friday mornings. (This arrangement was precarious. It was subject to dispute, abrupt change, and finally cancellation.) Normally, shelter inmates could be interviewed a day or two before a clinic appointment. Some had to be escorted to the clinic.

The missions ordinarily emptied between 5:30 and 6:30 a.m. Subjects had to be selected and interviewed between registration and prayers the day before a clinic slot was reserved. Mission subjects scheduled for clinic tended to vanish unless they were escorted.

The Baltimore City Jail had a census of roughly 2000 during the year of BHS. Routine operations of the criminal justice system limited selection and interviewing to mornings between 9:30 and 12:30. Disruptive commotions and difficulties in locating and escorting selected subjects to the interview area were commonplace.

The fieldwork was broken into six cycles of seven weeks each. A seventh cycle was added to bring the sample numbers as close as possible to the targets. As the survey progressed, we learned that homeless women were not available through domiciliary services in the numbers we had expected. The women's jail, in particular, produced only 33 interviews during the course of more than one year's repeated canvasses. The census in the women's jail ran about 150.

**BHS Interviews**

| | Mission | Shelter | Jail | Total |
|---|---|---|---|---|
| Male | 142 | 46 | 110 | 298 |
| Female | -- | 197 | 33 | 230 |
| Total | 142 | 243 | 143 | 528 |

4. In the shelters, the normal pattern was one or two interview time slots on a shelter's designated day. The supervisor selected from the current roster according to random numbers written in advance. The routine for selecting a person for clinic consisted of writing the two interview respondents' names on the outside of a prepared, sealed envelope. The envelope contained a slip with either a "1" or a "2", which designated the first or second name in alphabetic order.

In forays to the missions, the supervisor went equipped with a number of random digits in the range of the anticipated length of queue. The digits were used to identify positions in the queue. In most instances, designees for clinic visit were picked by the sealed envelope device.

## Social Networks and Social Supports

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One of the most pressing questions for homelessness research concerns the relevance of the social context to the course of homelessness and illness among persons with severe and persistent psychiatric disorders. Social network and social support analyses provide a means of understanding the relation of homeless persons to contextual factors.

Social networks have been defined as the web of ties or the structural configuration of relationships among people. They are characterized by such dimensions as size, degree to which people are connected, accessibility between members and the extent to which exchanges or transactions between people are symmetrical. Social support, on the other hand, is a by-product of social networks; it refers to the content of the exchange. The concept of social support is often based on attachment theory (the need for social interaction or bonding) or on some theory of psychological well-being. Social support is exchanged in dyadic relationships and may refer to affective bonds, informational, material or other resources.

The study of social supports and social networks of homeless persons falls into two bodies of literature: the "Skid Row" studies of the post-World War II period and the homelessness research that emerges from the 1980's. Although there are well over one hundred and fifty studies of skid row areas, few issues remain as muddled as those concerning social relations, survival and the functioning of Skid Rows. Until recently the social networks of Skid Row inhabitants were rarely measured directly or effectively. Nevertheless, researchers' views of the sociability of Skid Row men (there were few women) fell into two camps (Cohen and Sokolovsky, 1989, Chapter 6). According to the first, Skid Row men are undersocialized and "lacking a need for attachments", and, once they adapt to a life as outcasts, disconnected, isolated, and totally friendless.

The second camp views the Skid Row way of life as a form of social, replacement and enculturation. Homeless men seek to reestablish their social ties in an ecologically appropriate manner, with small, highly active but fluid networks, such as those focussed on drinking.

Studies falling into both of these camps, however, have found few intimate relations and little connection to kin among homeless men. These interpretations may in part be explained by a dependence on methodologies which examine sociability through the lens of middle class norms, with their emphasis on structural links to family and household, local neighborhoods, long-term jobs, and voluntary associations. By contrast, the ethnographic, qualitative approaches, which tend to fall into the "social replacement/enculturation" camp, take the point of view of homeless men themselves. As such, they found thriving, though marginal, networks on Skid Rows. Until recently, however, no Skid Row study had systematically examined the actual workings of whole social networks.

To fill this gap, in the 1980's Cohen and Sokolovsky carried out a network study of older men on the Bowery in New York City, using a Network Analysis Profile (Sokolovsky, 1986). The Bowery study used both quantitative and ethnographic techniques to determine the networks of a sample of 281 men aged 50 and over. Eighty-six of these men lived on

the street; the others resided in flophouses and nearby apartments. While this study concerns a particular sample - elderly homeless men - its findings illustrate the usefulness of a network approach to homelessness research in general.

Among the more salient findings was the almost total absence of isolated men, although street men's networks were one-third smaller than those of domiciled men (6.0 versus 9.6 linkages). Most men belonged to at least one social group; but street men tended to have small,. informal network clusters rather than the one large and one small cluster that characterized the domiciled subgroup. Most Bowery men had at least one intimate, but almost half could name no one they could talk to about problems.

Far from being **kinless,** all Bowery men reported at least one family tie. But fewer than one in thirty could rely on relatives for material support. For these needs, Bowery men turned to formal linkages, such as social service agencies.

Psychiatric symptoms were assessed by items on a structured questionnaire, the Comprehensive Assessment and Referral Evaluation. Almost one-fourth of the sample, called the Psychotic/Psychiatric Hospitalization (PPH) group, had a history of psychiatric hospitalization and/or a high score on a psychoticism scale. No significant difference was found between the PPH and non-PPH groups on any social network variable. Contrary to stereotypes, the PPH men were not, for the most part, isolates and did not lack intimacy or empathetic relationships. The strongest association between psychiatric symptoms and networks, which held for the entire group, was a negative one between depression and network size, clustering (being in a group formation), and network proclivity (the desire to use the help of others).

Until recently, homelessness in the Eighties, like that of earlier Skid Rows, was equated with isolation and the absence of personal and institutional support. The Skid Row research tradition contributed the imagery of blight and desolation and the concept of "disaffiliation" to this newer homelessness, ignoring that people can be unconnected to mainstream institutions while integrated into marginal and even geographically dispersed networks. The bag lady stereotype and the identification of mental illness with homelessness perpetuated the isolate imagery, perhaps because psychiatric disorders are associated with relatively small networks. This assumption changed somewhat when attention shifted to homeless women and children, who by definition comprise at least dyads.

Marital status, as a proxy for network, provides one of the most consistent findings across studies. Homeless persons are less likely to be married than individuals in the general population, although homeless women are less likely than homeless men to be single or never married and more likely to have children. Very few studies report total isolation for the majority of respondents, although networks of the homeless tend to be smaller than those of domiciled comparison groups (Fischer et al, 1986). Comparisons of network size across' **studies** is hampered by differences in type and number of questions used to elicit network members.

The findings concerning links to relatives are not clear cut. For example, in a representative survey of New York City adult shelter users, over half reported having had contact - ranging from phone calls to sleeping over -- with a family member in the past month (Lovell, 1988). In a representative sample of Chicago homeless, 60% of the respondents mentioned contact with relatives **(Rossi** et al, 1986). Relatives comprised the majority of networks of residents at a Midwestern shelter (Solarz, 1985). However, Bassuk et al (1984) found that most guests in a Massachusetts shelter had no relationships to family. Among clients of programs for the mentally ill homeless in New York City, family members accounted for the most frequent network exchanges, but did not comprise the majority of network members (Lovell, 1988).

**EXHIBIT 2.1**

**SOCIAL SUPPORT AND SOCIAL NETWORK INSTRUMENTS**

**USED IN HOMELESSNESS RESEARCH**

| Study | Instrument |
|---|---|
| Cohen and Sokolovsky (1983, 1988) | Network Analysis Profile (Sokolovsky, 1986) |
| Bassuk, Rubin, and Lauriat (1986) | Modified Social Support Network Inventory (Flaherty et al., 1979) |
| Solarz (1986) | Modified Social Support Questionnaire (Solarz and Bogat, no date) |
| Love11 (1988) | Social Support and Social Network Interview (Lovell, Barrow, and Hammer, 1984) |

The relationship of network characteristics to psychiatric status appears clearer. Bassuk et al (1984) reported that 90% of respondents with a history of psychiatric hospitalization had no friends or family. Similarly, in a survey of intake forms of over 8000 men and women entering the New York City shelter system, psychiatric indicators (self-reported current mental problems, current outpatient treatment or past psychiatric hospitalization) were associated with not having lived with relatives or friends prior to entering the shelters (Crystal et al, 1986).

Whether support comes from formal (programs and social services) or informal (kin, friends, etc.) sources is of concern to health services research on the homeless. Homeless mothers in Massachusetts tended to name recent shelter or professional contacts as their supporters (Bassuk, Rubin and Lauriat, 1986), while marginal persons comprise the majority of network members among mentally ill homeless persons in New York (Lovell, 1988). Support is not interchangeable, however. In two surveys, the quality of support from families is perceived to be better than that from friends (Solarz, 1985; Farr et al, 1986).

Ethnographic studies have implicated network characteristics as possible reasons for service refusal. For homeless women in a Midwestern shelter, moving to permanent housing meant losing supportive ties (Merves, cited in Koegel, in press). Martin (1983) described a homeless woman, who, having suffered a heart attack in a transportation terminal, with friends around her, feared moving into a welfare hotel, because she might die there alone. These examples correspond to anecdotal evidence that long-term shelter users are apprehensive about moving to residences, where they know no one and cannot maintain their shelter ties.

Ethnographic research also raises the question of whether homelessness has an equalizing effect that might be greater than that of psychiatric disorder on networks. Among homeless persons with severe psychiatric disorders, having a kin-dominated network was related not to diagnosis but to a pattern of homelessness, specifically the back-and-forth movement between apartments in abandoned neighborhoods and shelters, as opposed to circulation between streets, shelter, parks and other dwelling places. The first homelessness pattern resembled that of m-mentally ill shelter users rather than that of other mentally ill homeless persons (Lovell, 1988).

The somewhat contradictory findings from some of these post-1980 surveys may be due to methodological issues. For one, the samples on which the findings are based differ. Secondly, of the non-Skid Row studies of homelessness in the Eighties, only three have used actual network instruments (Solarz, 1985; Bassuk et al, 1986; Lovell, 1988). The rest base their support and network variables on proxy measures and questions that rely on categories, such as “friend” and “close to”, whose meanings are class- and culture-bound. When support is measured by only a few questions attached to the survey, the index of social relations taps the lowest level of sociability, usually based on white middle class notions of residence, employment, family, and so on. Finally, the questions asked do not tap meaningful content areas of exchange.

## Methodological Issues in Studying Networks and Homelessness

Network analysis provides numerous advantages over social support studies (Hammer, 1981; Wellman, 1981), some of which can only be summarized here. Network analysis allows us to understand under what conditions support is possible, not just if it is absent or present. It also illustrates how structural relations influence how people act. An example is Granovetter’s (1983) notion of weak ties. He found that persons whose networks include acquaintances, and therefore have low density (few network members know each other) provide greater access to resources than high-density networks made up mostly of

close friends who know each other. The "weak ties" provided by acquaintances are bridges to other networks with new resources. This raises interesting research questions concerning homeless persons, whose supporters are often recent contacts. Other network dimensions, such as reciprocity of "support" and duration of ties between people, can reveal alot about power, dependency, and self-esteem. Network analysis can also connect individual-level experience with mid and even macro-level forces by tracing back through the network to family, institutions, neighborhood, etc. Finally, networks, unlike social support, provide windows on multiple worlds. Support, such as a place to stay or someone to confide in, will have different implications according to where it comes from - social workers, other homeless persons, kin, etc. Network members represent worlds with different ideologies and norms which govern their relations with the homeless individual we are focusing on. In fact, different types of support may conflict with each other, rather than being inherent to an integrated support system. A typical example involves support, such as the companionship, drink and an occasional floor to sleep on provided by a "bottle gang" versus the services promised by a case manager. The latter are often contingent upon not associating with homeless alcoholics, which means a loss of several sources of support.

In choosing a network instrument,' the researcher must weigh the advantages and disadvantages presented by ethnographic approaches and structured, quantitative approaches. Ethnographic research enhances reliability by combining structured interviews, observation, and information from multiple sources. Two interviews at different points in time increase completeness of information. To enhance reliability, correspondence should be maximized between ideal statements (cognitive networks) and what is observed or recorded in daily activity logs (behavioral networks).

With the ethnographic method, the same information may not be obtained for all subjects, as opportunities for observation or questioning the respondent's entourage will vary. By contrast, the sole use of structured interviews, characteristic of an epidemiological approach, has the advantage of providing comparability across subjects. Information obtained by methods other than structured questions can also be recorded, as long as it is coded differently.

Rather than using pre-determined categories, the data itself should be allowed to define the roles, such as "friend", or "social worker". Often ethnographic work is necessary prior to administering questionnaires to produce such categories. For example, Cohen and Sokolovsky (1989) found that the construct "friend" often elicited "everybody" or "nobody" as answers. The more appropriate term on Skid Row was "associate". Lovell, Barrow and Hammer (1984) developed their role categories and exchange questions on data from field work. While social network questionnaires usually ask about support for household, job and child care chores, their questionnaire includes exchanges concerning food, a place to stay, clothes, and other needs more relevant to homeless persons. "Hanging out" was found to be more useful terminology than "friend" for eliciting recent relationships formed in shelters or on the streets.

Similarly, not using a defined time frame, such as one year, may enhance studies of homeless and/or psychiatric patients. An open time frame may elicit persons who are symbolically important, though not actively present in the network, such as a deceased parent or estranged offspring. This may provide clues about the process of breakdown in networks.

Social support questions themselyes should not be necessarily accepted as generating indices of positive support. For example, surveys indicate that while homeless persons may

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[1] A comparison of the Network Analysis Profile, described in Sokolovsky (1986), and the Social Support and Social Network Interview (Love11 et al, 1984) illustrates these points.

be in contact with family members, emotional or material help may not be forthcoming from kin. Similarly, dependency on others (support that is not reciprocal) may involve loss of self-esteem. Social network interviews should include some indication of how respondents perceive their support, or indications of whom they have pleasant or unpleasant interactions with.

In descriptive studies, it is important to use control groups, such as domiciled low-income persons. The design issues for outcome studies are more complicated. The relationship between psychiatric illness and social support is usually tested by the stress buffering hypothesis, according to which social ties buffer or moderate the adverse effects of stressful life events on psychiatric disorder. To tease out whether psychiatric problems contribute to change in networks or vice-versa, a longitudinal design is necessary. The network may also reflect external circumstances (homelessness as a network-breaking phenomenon) or individual personality traits. As most homeless people are under tremendous stress all the time, the variance in stress levels may be too little to test the stress-buffering hypothesis. A more meaningful question for homelessness may be to understand how networks break down, who is available as a network source, and in what ways networks are supportive.

## Recommendations for Future Research

1. Research should address etiological questions of how networks break down, both for persons at risk for becoming homeless and among homeless persons themselves.

2. Attention should be paid to gender and ethnic differences in networks. These will affect not only the meaning of support, but also the structure, the fluidity of boundaries, and the importance of extended family and friends (see, for example, Milburn, 1986).

3. Research should address policy issues related to networks of homeless persons. For example, how does the assignment of homeless persons to specialized shelters ("segmentation") affect their already-existing networks?

4. Action-oriented research should address questions such as how recent network contacts can be mobilized to organize homeless persons and how dormant networks can be revived and supported, for example, family members of homeless persons with severe and persistent psychiatric disorders.

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**Experimental Approaches to Studying Service Models for Homeless Mentally 111 Persons**

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Prior research on homelessness and mental health has primarily focused on documenting the extent of mental illness among the homeless. In recognition of the high prevalence rates which have been found in previous studies (see Robertson, in press; Tessler and Dennis, **1989),** service providers, policy makers, and researchers have forcefully expressed the need for the delivery of mental health services to this population (e.g., Bassuk, 1984; Frazier, 1985; Levine, Lezak, and Goldman, 1986; Morse et al., 1986; National Association of State Mental Health Program Directors, 1985). Specific recommendations have varied, but have often called for the provision of a set of comprehensive community support system services, ranging from outreach and outpatient services to residential or day programs (e.g., Levine et al., 1986; Morse et al., 1986). There is a shortage of information on the exact nature and extent of newly implemented services for the homeless, but it is clear that recent federal, state, and local funding decisions and initiatives have led to a rapid increase of new programs for this population. For example, within fiscal years 1987 through 1989, $57 million dollars in federal block grants have been appropriated to states for mental health services for the homeless.

It is encouraging from a humane and an advocacy perspective that efforts are being made to help mentally ill individuals who are homeless, but there is currently a critical lack of information as to what service models are actually effective. More generally, as Dr. Hargreaves pointed out in his presentation, research on the efficacy of psychosocial treatments and mental health services in general have lagged behind the study of psychotropic medications. It is critical, however, for deepening our knowledge about homelessness and mental health in a manner that can guide policy and practice, that research be conducted to determine the effectiveness of mental health services for the homeless.

## Literature Review

Outcome evaluations on mental health services for the homeless are clearly needed, and indeed they have been strongly encouraged (Morrissey and Dennis, 1986; NASMHPD, 1985; Talbott and Lamb, 1986). Yet studies of client outcomes in this area have only recently appeared, and have typically been based on non-experimental designs (Barrow, **1988a,** First and colleagues, 1988; Morse and colleagues, 1985, 1986; Rosenheck and colleagues, 1988). These studies have yielded some important data on mental health services for the homeless, but the strength and validity of their conclusions are limited by a number of methodological weaknesses, including short follow-up periods, and an absence of randomized, and sometimes any, comparison groups. Experimental designs typically provide the most valid conclusions about the effectiveness of a treatment program, but only two such studies have been reported in the literature (Lipton, Nutt, and Sabatini, 1988; Morse and colleagues, 1988). The study by Lipton and colleagues randomly assigned 52 hospital inpatients who had been homeless at time of admission to one of two conditions: (a) a supportive housing project, which includes a therapeutic milieu day environment and individualized case management assistance; or (b) a treatment-as-usual hospital discharge control. Lipton and coworkers reported that for a **12-month** follow-up period experimental clients spent less time homeless than did control conditions clients, lived in better housing conditions, as indicated both by consumer satisfaction ratings and interviewer ratings. No differences between the two groups were found for psychiatric symptoms or for **rehospitalizations** following the initial discharge, This is a landmark study, both for its substantive findings, and because it is the first experimental design in the area of

homelessness and mental health. The study is also limited in several respects, including (a) clients were selected from an inpatient rather than a literally homeless environment (i.e., shelter, streets); (b) outcome assessment was limited to a few variables; (c) follow-up was limited to one year.

The project by Morse and colleagues is currently in progress, but preliminary experimental results have been reported (1988). The study advanced the experimental method to psychiatrically disturbed clients who are literally homeless, selecting and randomly assigning individuals who were living in homeless shelters or the streets. Clients who met eligibility criteria (see Appendix) have been randomly assigned for primary service responsibility to one of three treatment conditions: (a) the CASA program, an adaptation of the PACT (Stein and Test, 1985) model which has been modified to meet the needs of the homeless; (b) a day program specifically designed for homeless mentally ill persons; and (c) the outpatient clinic of an inner city mental health center. The design, therefore, tests the comparative effectiveness of the first condition, the experimental CASA program, against the effectiveness of the latter two conditions, which serve as treatment-as-usual comparison groups. This study has been conducted in two sampling waves: an initial cohort of 90 clients randomly assigned to the three treatments, and a subsequent sample of 80 persons randomly assigned to the three groups. Clients are being followed for 18 to 24 months and data collected by trained interviewers for a broad set of outcome measures in ten domains. Preliminary results for the first cohort of 90 clients for the first six months on a subset of outcome variables indicated significant differences in favor of the experimental condition on three of five variables. Specifically, CASA clients, as compared to the treatment-as-usual controls, had improved social stability, spent less time homeless / more time housed, and had highest level of consumer satisfaction. No differences were found in this analysis on income or level of psychiatric symptoms.

To summarize, a number of services of untested treatment effectiveness have been implemented for the homeless. Although effectiveness research is clearly needed, there is currently a paucity of experimental outcome studies. While much research remains to be conducted, prior studies demonstrate that it is feasible to apply experimental methods to test the effectiveness of mental health services for homeless persons sampled both from hospital settings (Lipton et al., 1988) and from shelters and the streets (Morse et al., 1988). This limited body of knowledge provides initial substantive findings indicating that supportive housing arrangements (Lipton, et al.) and continuous treatment teams (or intensive clinical case management approaches) (Morse et al.) are effective for helping and housing the homeless.

## Obstacles and Issues in Conductinn Experimental Research on Mental Health Services to the Homeless

A number of obstacles and issues may arise in conducting experimental research in field settings (see Cook and Campbell, 1979). Based on experience from the St. Louis project (Morse and colleagues, 1988), it is evident that certain issues are particularly salient in applying experimental methods to homelessness. Those obstacles and issues requiring special consideration are discussed within the following four categories: (a) ethical, (b) sampling and external validity, (c) variables and measures, and (d) threats to internal validity. (Unfortunately, some of these follow-up points were not discussed at the NIMH workshop due to a time shortage and other constraints.)

Ethical. Within field research settings, objections to withholding treatment from the control group are common, although the creation of a non-treatment control is desirable for measuring the absolute effectiveness of an intervention (Cook and Campbell, 1979). Objections to non-treatment controls are particularly strong in the area of homelessness because of the tremendous and obvious needs and suffering of homeless people. No-

treatment controls are also practically difficult if not impossible to form in many areas because of the rapid development of a range of mental health and other human services for the homeless in recent years. A solution to this problem is to test new programs against treatment-as-usual controls (more generally, as Dr. Hargreaves also emphasized in his comments, the "usual care" community service standard is typically the appropriate comparison group in mental health services research). This design allows for an evaluation of the comparative effectiveness of new programs and of existing usual-treatment approaches, many of which have been previously untested.

Other concerns may also be voiced to using randomization as a method of assignment of homeless people to treatment groups. Several points can be made to counter such concerns, including (a) that while it is obvious that assistance needs to be provided, the effectiveness of various service approaches are unknown, and (b) that if certain treatments are deemed more desirable, demand is likely to far outstrip available resources and that randomization, as a variation of the lottery method, provides the fairest way of distributing scarce resources (see Cook and Campbell, 1979).

**Sampling** and External **Validity**. The external validity or generalizability or a study is enhanced as the sampling of clients is broad and representative. Two characteristics of the homeless population pose problems for maximal generalizability, however. First, the severity of the psychopathology of some homeless persons, particularly those with extreme paranoia or psychosis, is so severe that they may be unwilling to cooperate or unable to provide reliable and valid self-report data. Experience from the St. Louis study suggests that many homeless individuals who are initially paranoid or wary of outsiders can often be successfully incorporated into a research study, if sampling and subject recruitment procedures are designed to slowly develop rapport with potential subjects. This requires a labor intensive approach, with interviewers initially spending time "just hanging out" in shelters to engagement for the homeless (see **Axlerod** and Toff, 1987; Morse, 1988). The St. Louis study experience also **suggests** that many homeless individuals who are quite severely disturbed are still able to participate in the study although others who are decompensated to a greater degree have been excluded from the study because of their inability to provide reliable and valid data. Future researchers may be able to include greater numbers of decompensated individuals, relying on key informant data and interviewer ratings; however, this will require extensive training and clinical expertise of interviewers, and missing data will still occur on other important variables that rely on self-report measures.

A second issue to consider in selecting a sampling involves homeless mentally ill persons' patterns of prior and existing service usage. In urban areas mental health services for those with severe and persistent psychiatric disorders tend to be organized, and delivered in a fragmented and uncoordinated fashion, and consumers may have irregular patterns of service usage. These service patterns need to be carefully considered in determining client eligibility criteria, and may be problematic for experimental designs. Specifically, clients assigned to a treatment condition may have some prior or current exposure to that service or another treatment condition, particularly for usual care treatment conditions. This situation is particularly likely to exist in studies of mental health services for the homeless, where outreach and drop-in center programs are common and highly utilized, with an open-door policy for serving clients who enter, leave, and re-enter such services. This situation needs to be controlled in order not to confound study period treatment effects with prior service or other treatment conditions. Maximum internal validity would be achieved by considering as ineligible clients with prior or current treatment histories. However, this would greatly limit the generalizability of results by eliminating a great number -- probably the majority -- of the homeless who are or who have experienced other services. A solution, as applied in the St. Louis study, is to balance the conflicting needs for internal and external validity, and to set client eligibility standards that disqualify from study only those clients with intensive and recent contract with any of the treatment conditions.

**A** third problem in external validity concerns the lack of information that exists on the population characteristics in most areas. Greater external validity is achieved if random and representative sampling is used, but such methods are quite rare for treatment studies (Cook and Campbell, 1979). The absence of a sound data base on the population characteristics of homeless people with psychiatric disorders makes it even more difficult to compare the representativeness of samples used for treatment studies. Researchers should strive to collect information on treatment samples on variables and measures that have been used in other, more representatively-sampled studies to provide a rough basis of determining the representativeness of the treatment sample.

**Variables and Measures.** Service effectiveness studies should include not only variables of mental health and social functioning, as are commonly included in outcome research for persons with serious psychiatric disorders, but should also include variables specifically salient to homeless people. It is suggested that, in general, researchers studying services for the homeless sample a broad domain of outcome variables, including the homeless-related variables of housing, income, resource utilization, and substance abuse, as well as mental health, social functioning, and consumer-satisfaction. Even more comprehensive assessments may be desirable, given the multiple service needs of the homeless; the St. Louis study, for example, includes outcome variables in ten domains (see Exhibit 2.2).

Measurement of outcome variables for homeless people is problematic for at least three reasons: (a) psychometrically-tested instruments have not been previously developed in certain areas uniquely important for homeless samples (e.g., housing, income, resource utilization); (b) there is generally a lack of information and instrument development for the general population of those with severe and persistent psychiatric disorders; (c) instruments developed for non-homeless populations may not necessarily be appropriate, reliable, and valid for homeless samples. More generally, only minimal attention has been paid to the reliability and validity of measurements for the homeless. The lack of reliable and valid measures poses threats to the statistical validity of treatment effectiveness studies. Given the scope of the problem it is recommended that studies be funded and undertaken specifically in the areas of instrument development, reliability, and validity. In the meantime, researchers may carefully examine and consider selecting measures applied in prior outcome studies with the homeless (e.g., Barrow, 1988a, 1988b; Morse and colleagues, 1988) and should strive to conduct at least simple checks of the reliability of key outcome measures.

**Special Threats to Internal Validity.** Random assignment rules out many but not all threats to a study's internal validity (i.e., being able to determine whether a causal relationship exists between a treatment and observed outcomes) (Cook and Campbell, 1979). **A** review of Cook and Campbell's discussion in light of field experience in the area of homelessness suggests the following pose special threats to the internal validity of experimental studies: (a) compensatory equalization of treatment, (b) treatment diffusion, imitation; and (c) mortality/treatment-related attrition. Each is discussed below.

a. **Compensatory** eaualization of treatment. This treat **to internal validity** occurs when an agent, outside of the experimental conditions, attempts to compensate for the inequity in desirable services or resources that exists between control or experimental groups (Cook and Campbell, 1979). For example, shelter providers, out of caring and compassion for the needs of the homeless people, may intensify their efforts to help homeless people in a treatment-as-usual control condition, providing extra one-to-one attention, counseling, financial and housing assistance resources. In the St. Louis study, this tendency to attempt to compensate and equalize services has appeared not only among shelter providers but also among interviewers who have on occasion, again out of compassion, provided extra assistance (e.g., social work activities) to treatment-as-usual control clients. Such situations are probably quite likely to occur in homeless service

EXHIBIT 2.2

OUTCOME VARIABLES AND MEASURES

| | Variable | Measure/Source |
|---|---|---|
| A. | Homelessness | Time homeless/house<br>Adapted from MESS (Morse, 1984) and from (Barrow and Lovell, 1985) |
| B. | Mental Health | |
| | 1. Psychiatric Hospitalization | MESS (Morse, 1984) |
| | 2. Psychiatric Symptoms (Interviewer) | BPRS (Lukoff, et al., 1986) |
| | 3. Psychiatric Symptoms (Self-report) | BSI (Derogatis and Spencer, 1982) |
| | 4. Self-esteem | RSE (Rosenberg, 1979) |
| C. | Economic Status | |
| | 1. Income | Adapted from MESS (Morse, 1984) and (Barrow and Lovell, 1985) |
| | 2. Occupational Status | (Duncan, 1961) |
| | 3. Days Employed | MESS (Morse, 1984) |
| D. | Social Relations | |
| | 1. Interpersonal Adjustment (Self-report) | Adapted from Clark (1968) |
| | 2. Interpersonal Adjustment (Interviewer) | Adapted from SAS-II (Schooler, et al., 1979) |
| | 3. Social Support | Adapted from ASSIS (Barrera, 1981) |
| | 4. Alienation | (Bahr and Caplow, 1973) |
| | 5. Social Isolation | PSS (Spitzer, et al., 1970) |
| E. | Independent Living Skills | |
| | 1. Independent Living Skills | Adapted from ILSS (Wallace, et al., 1985) |
| | 2. Time/Leisure Impairment | Adapted from PSS (Spitzer, et al.,1970) |
| F. | Substance Abuse | |
| | 1. Alcohol Abuse | Quantity / Frequency Index, Adapted from NIAAA (1979) |
| | 2. Drug Abuse | Klett, 1979 |
| G. | Resource Utilization | |
| | 1. Service/Resource Utilization (Self-report) | Number of Services / Resources Received (New). |
| | 2. Service/Resource Utilization (Key Informant) | Number of Services Provided / Referred (New) |
| H. | Quality of Life | Adapted from SLDS (Baker and Intagliata, 1982) |
| I. | Consumer Satisfaction | Adapted from Larsen (1979) |
| J. | Social Stability | Attrition from Study |

MESS: Missouri Emergency Shelter Survey
SCID: Structured Clinical Interview DSM-III-R
PSS: Psychiatric Status Schedule
BPRS: Brief Psychiatric Rating Schedule
ASSIS: Arizona Social Support Inventory Scale
SLDS: Satisfaction with Life Domains Scale
RSE: Rosenberg Self-Esteem Scale
ILL&Independent Living Scale Survey

studies, given the extreme poverty, the high level of needs, and the suffering of homeless people -- all conditions which tug at individuals' sense of compassion and responsibility. Compensating equalization among shelter staff and other actors on the homeless scene is also exacerbated by the availability of greater resources recently released in the system through the McKinney Acts and other initiatives. Although these activities are beneficial to clients receiving such resources, they threaten to minimize or mask real differences that may otherwise occur between service approaches.

b. Treatment diffusion or imitation. This treat occurs when subjects receive the treatment intended for the comparison group. This may occur in several ways, including when subjects cross over and directly receive services from providers of another condition; when a provider from one condition receives knowledge about services from a different condition, and then modifies their original services in a way that imitates the other condition; and when an agent outside of the treatment condition initiates a new services that mimics one of the treatment conditions, and then delivers services to experimental subjects. Treatment diffusion and imitation is another likely threat to homeless services studies, and the likelihood of this occurring increases as (a) services exist within or outside of the treatment study that have unrestricted, open-membership client policies, many outreach and day programs, in fact, operate in this manner; and (b) new services become available within the system; this situation is also common in the field, since funding for the homeless from federal and other sources has been rapidly increasing.

Strategies for dealing with compensatory equalization and treatment diffusion or imitation are similar. In general, it becomes important to exert as much control and influence as possible to minimize these threats. This includes exerting direction to those research and service personnel under the researchers' direct control to eliminate compensatory or diffusion activities; for these reasons, the greater the researchers' organizational authority over service personnel, the more likely these threats can be minimized. For those agents outside the researchers' control, such as shelter providers, it may be useful to attempt to enlist their cooperation in the study.

It is likely, however, that compensatory equalization and diffusion will still occur to some extent. It becomes important, therefore, to measure and analyze treatment contact and the extent that various services, intended and unintended, were received by subjects in all conditions. Treatment diffusion, imitation or compensation may weaken or mask treatment effects, but is still possible to analyze outcomes within the experimental design, as long as differences in treatment contacts and services occur.

Mortality/Treatment-related attrition. Random assignment typically controls for initial client selection biases, but differential mortality between treatment conditions may pose a validity threat (Cook and Campbell, 1979). Attrition tends to be high in studies of the homeless and researchers need to take steps to minimize its occurrence. Strategies for reducing attrition rates include (a) paying subjects for interviews, (b) scheduling frequent follow-up interviews, with only short intervals between contracts, (c) obtaining and maintaining a "tracking" file on each subject, that includes updated information on: aliases, contacts for support networks, locations the individual is likely to frequent, (d) establishing a community interview office easily-accessible to shelters, (e) deploying interviewers who are mobile and assertive in conducting outreach contacts, and (f) employing a tracking specialist, perhaps a person who was formerly homeless, who is knowledgeable about homeless people and settings and who will focus on trying to locate difficult-to-find subjects.

Despite these strategies, some attrition is still likely to occur. Differential attrition may be interpreted as a treatment effect, but other treatment differences may be difficult to interpret (Cook and Campbell, 1979). Researchers need to conduct statistical analyses to

determine if attrition is related to treatment, and, if so, if subject selection biases result (see Cook and Campbell, 1979, pp. 360-363 for a discussion of analyses).

In conclusion, the field of homelessness and mental health poses special obstacles and threats to conducting valid experimental outcome research. Field research, in general, is much more difficult to conduct in controlled fashion than laboratory research, in part because systems are open, with multiple and contingent causes operating (Cook and Campbell, 1979). Mental health and homelessness involves a system that is not only wide open, but also fluid and dynamic, with changes occurring rapidly as public policy and practice shift. This makes controlled study difficult. Still, recent studies indicate experimental outcome research on homelessness and mental health is feasible, although certain obstacles and threats need to be carefully considered, and, in some circumstances, may impose limitations upon interpretations.

## Additional Research Considerations

In addition to the specialized considerations discussed above, researchers planning effectiveness studies of mental health services to the homeless need to also be mindful of more general issues relevant to treatment studies. In his presentation (see Appendix), Dr. William A. Hargreaves, contributed to the discussion of issues relating to the rationale and ethics of treatment studies, and to issues of "usual care" treatment controls and attrition; he also highlighted two additional topics that should be considered here.

Sample Size. Dr. Hargreaves emphasized the importance of determining the appropriate sample size for treatment studies. He suggested basing sample size estimates on four factors:

1. Variable associated with each outcome measure, with greater variance requiring larger sample sizes

2. Risk of falsely concluding an effect is present

3. Statistical power, which should be set at .8 or .9

4. Postulated effect size

Measurine Interventions. Dr. Hargreaves also emphasized the necessity of measuring the control and treatment interventions to aid in the interpretation of findings and for replication of the study. In order to document intended and actual interventions, he suggests collecting (a) management information system and other unit of service data, (b) assessments of program practice and style from both clients and staff, and (c) qualitative, key informant, and ethnographic data on program effects and critical ingredients. He also urges (a) collecting cost data and, with the assistance of an economist, conducting a cost effectiveness evaluation, and (b) developing a program manual for innovative programs to assist replication efforts.

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# Experimental Approaches to Service Delivery Research

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## Effectiveness: Standards of Evidence

Psychotropic medication is illegal to market without randomized controlled trial evidence of efficacy. The methodology of controlled trials is well established and relatively easy and inexpensive. There have been over 1000 randomized trials or psychotropic drugs.

In the case of psychosocial treatments in mental health, unproven treatments are marketed routinely. The methodology for controlled trials of psychosocial treatments has developed over the past 20 years, but is more difficult and expensive than for drug trials, primarily due to the greater difficulty of establishing adequate controls, greater difficulty of measuring the dose and various qualitative aspects of the treatment, the greater length of time for treatment delivery, and the need for follow-up outcome assessment after the termination of treatment. It is now accepted that the efficacy of psychosocial treatments should be studied. There have been hundreds of randomized trials of psychotherapies and other psychosocial treatments in mental health.

For mental health services, only in the past five years has investigator skill and research funding reached a point of some services research momentum. The methodology builds upon psychosocial treatment research and adds some demanding new features: primarily the dictum that policy relevance requires knowledge of cost effectiveness, not just effectiveness at any cost. New methods are also needed for specifying the nature of the service to be studied and measuring the fidelity of service implementation. Services research is not only more difficult than psychosocial treatment research, it can be much more expensive when multiple sites are needed to separate site-specific context from service organization and financing effects. The world literature only reveals about 50 controlled mental health services effectiveness trials.

## Effectiveness of What?

Any innovation that can be shown to be feasible and promising is fair game for a controlled trial. “Assertive Community Treatment” is feasible for the subset of mentally ill homeless who will accept services offered by an outreach screener. ACT will probably be studied widely in the next few years, since it is the subject of intense scrutiny in community treatment generally. One can expect service effectiveness research to address a series of “frontiers” that progressively attempt to address homeless subject groups previously inaccessible to or unaccepting of services, or for whom previous service strategies have been shown to be ineffective. When several single-site controlled trials have indicated that a particular service mode is cost effective, it may be useful to consider a multiple-site study to examine the interaction of service mode and site context in influencing cost effectiveness.

## Compared To What?

What is the appropriate control condition for a service innovation? The most common control is the current local community service standard (“usual care”). Sometimes another innovation, usually a less expensive one, is the control, or both an inexpensive innovation and usual care. The latter choice gives a chance to study both the relative cost

effectiveness of the innovation of primary interest, and the effectiveness of an inexpensive implementation of some component of the primary innovation. It is important to note that the **effectiveness of the (untested) "usual care" community standard cannot be directly studied,** due to ethical and political constraints.

## Design: When Not To Randomize

One cannot randomize **subjects** when the structure of the innovation makes a larger unit of observation, such as a geographic site, the necessary unit of observation. Some educational effectiveness studies use classrooms as the unit of observation and randomization, but many mental health service organization and financing innovations, by their nature, must be applied to whole communities rather than individual clients. Such studies may require two comparative samples of communities -- not for beginners! In fact, there is yet essentially no experience with mental health services research in which innovations are randomly assigned to some communities and not others. Weaker designs will probably need to be used in studies of community-wide innovations until we have accumulated a body of evidence and methodological experience that can justify the type of experiment.

Some at the conference raised the question as to whether weaker designs may not still be the best choice even when a randomized trial is possible, since a full experiment may be politically less feasible in some locales. Some suggested **very** weak designs, such as pre-post comparisons where subjects serve as their own control and there is not even a quasi-equivalent comparison group. I will admit to having done such studies, and there may be situations in which they are the best way to go. In the competitive world of Federal project grant review, however, such designs get nowhere if there are competing applications with strong designs. For many year very little services research was funded at all, due in part to the scarcity of proposals with designs as strong as what reviewers were currently approving in treatment research. If you propose a weak design, arguing that a stronger design is not feasible in your site, reviewers will probably take your word for it. I have often heard reviewers argue, "Well, if it's not feasible, it's not feasible" -- and vote disapproval.

## Ethics of Randomized Trials

Three principles govern most of the ethical issues regarding randomized trials:

1. Usual care of known efficacy may not be withheld for research purposes.

**2.** If an innovation is a scarce resource and cannot be given to all who quality, then even if it is seen in the community as probably effective it may be randomly assigned **among** those who auality, since that method is arguably fairer than any other, so long as the desired resource remains scarce.

**3.** Uncoerced, informed consent and freedom to withdrawn is required in every randomized trial except in unusual circumstances involving negligible risk to subjects.

## Politics of Randomized Trials

**Again, three principles cover most of** the cases:

1. The community standard of usual care, even if of unknown efficacy, cannot be withheld for research purposes unless a convincing argument can be made that it is potentially harmful.

2. The research group must control the service resources to be randomized. This sometimes means that the public agency administering the service program must be a full partner in the research (Public-Academic Liaison).

3. Service enrichment funding that is contingent on study participation (e.g., a CSP demonstration tied to a research grant) usually provides adequate control, since Ss can be admitted to the innovation only if they agree to participate in the research, and drop-outs from a usual-care control condition may not demand to enter the-enriched program.

## Recruitment

Inability to recruit the planned sample size is the **single-most** common reason for failure of a controlled trial. Pilot work that enables you to estimate recruitment rate is almost essential to argue that your proposed trial is feasible in your site. Any data that allow you to estimate the rate of arrival of persons meeting your screening criteria and their rate of agreeing to join the study will help. **Then divide your estimate by SIX!** If possible, use whatever pilot study resources you can muster to do a very small, simple version of your proposed randomized trial. The practical experience and approximate estimates of several factors bearing on your study design (as noted below) will enable you to make a much stronger grant proposal. Controlled trials are expensive research projects that answer one specific research question, and not many are viewed as a reasonable gamble by reviewers without pilot data.

## Attrition Is A Fact of Life

Selective exclusion of Ss prior to randomization limits generalizability of results (altering the hypotheses being tested in the study), but is otherwise not a problem. Selective attrition after entry biases the comparison and is a serious problem. There are several tactics for coping with attrition:

1. Try to minimize attrition (it may take money for intensive follow-up tracing of subjects).

2. Record the reason(s) for loss of each subject. It is important to distinguish reasons that are possibly treatment related from other reasons.

3. Try to retain all drop-outs from services in the follow-up measurement through the final evaluation time point (more money).

4. Compare baseline variables on completers versus the various classes of attriters, to test not only for: (a) a different **rate** of attrition in each cell,ut (b) whether attriters differ from stayers, and (c) whether attriter-stayer differences are the same across treatment groups.

5. Get statistical consultation on various adjustment methods in the analyses, in case you detect biased attrition.

## Sample Size

Estimate the attrition rate (the pilot study again!), since statistical power depends on the number of completers in each cell. Four factors determine needed sample size per cell:

1. Variability on each of several outcome measures (the pilot study again!) -- greater variability implies larger sample sizes; compute sample size based on each of the outcome measures and choose the larger sample estimate.

2. Risk of wrongly concluding that an effect is present (i.e., the conventional significance level, usually .05).

3. The statistical power to detect a population effect that is really there. This probability is usually set at 0.8 to 0.9. Why would you want to waste your time on a study that had only half a chance to detect an effect even if it is really there (power of 0.5)?

4. The postulated effect size, or the smallest effect size that would be meaningful from a policy perspective (get some statistical consultation on setting this value, which is usually expressed as a mean difference between groups that is some fraction of the error variance, or as a proportion of variance accounted for. Again some pilot results or previous work by others will give you guidance estimating probably population effect size).

You will usually find that effect size, and therefore, the required sample size for acceptable power, depends on the type of comparison being made (although there are plenty of exceptions to this rule of thumb). Comparing an active treatment to no treatment (e.g., drug vs. placebo), which is rarely done in services research, requires 30 to 40 Ss per group. Comparing two active treatments, or services that involve differences right at the "front line" where clients will experience big intervention differences, requires 60 to 80 Ss per cell. Service system organization or financing comparisons, where effects are loosely coupled to direct care differences, are likely to show small effects, though they may be very important when the effect is spread over a large target group. The latter studies are likely to require 150 to 300 Ss cell.

## Outcomes

Outcome measures should be selected to cover the range of desired effects and the potential undesired side effects. Measures should be standard measures with documented psychometric properties whenever possible, or you should have done some psychometric work on necessary new measures you need to create yourself. It is advantageous to use measures that have been used in other studies of services to the homeless, to facilitate comparison of results across studies. The following domains of outcome will be needed in most studies.

- Housing status and income (brief interview by RA)

- Symptoms (e.g., BSI and RA interview, BPRS by clinical using the anchored BPRS and a 30-minute partly structured interview)

- Social functioning (60-90 minute structured interview by RA, using one of the standard instruments such as the Social Adjustment Scale II)

- Societal costs, This requires a health economist as a collaborator, although the information can be gathered by research assistants and from management information systems.

**Measuring** the Interventions

Without measuring the interventions, including the control intervention, the findings of the study cannot be interpreted and they study cannot be replicated. A considerable range of data may be necessary to adequately document the intended and actual interventions:

- MIS data on units of services for mental health and case management activity. Even a good mental health MIS probably does not have enough detail within case management procedure codes, so you will need to supplement with work logs, at least on a sampling basis. If possible, record source of payment. Many programs engage in grossly unreliable completion of MIS input forms, so validity checks are required (probably in your pilot study as well!).

- Units of service by other social, health, and law enforcement agencies; gather by interview from client and other informant (where available), and get permission to follow-up in agency records, and do so for at least a sample.

- Attach costs to units of service, which requires some additional data collection by **RAs,** but can be done once. Here's where the economist must help you distinguish societal costs, public costs, private costs, and charges.

- Staff ratings of program practice and style (e.g., a scale we are developing for assertive community treatment research).

- Client ratings of program practice,needs they would like (or would have liked) programs to serve, client satisfaction with response to each of these perceived needs.

- Qualitative description of the impact of the innovative program on the treatment system, and crucial elements seen by key informants as affecting the impact of the program on clients. Based on key informant interviews or other ethnographic methods; may require a social scientist with experience in this area.

- A program manual for the innovative program(s), so a program that your findings suggest is promising can be reproduced elsewhere for replication studies. If at least the beginnings of a manual can be submitted as an appendix to the grant application, reviewers will have a better idea of the nature of the intervention to be studied, as well as the level of documentation you can eventually provide.

Data **Analysis**

Statistical analysis strategies are often altered from those planned when preliminary analyses show that different statistical models are more appropriate. Nevertheless, a grant application should include a discussion of your data checking and verification approach, data entry and database management software, and the typical or representative statistical analyses that you expect to perform for each of the hypotheses or specific aims of the study. Analyses of attrition such as those mentioned above should be described, and analyses of service implementation. Key tests of comparative costs and outcome should be described, including the methods you will use to deal with missing data. Using such variables as baseline predictors, service assignment, individual implementation

characteristics that you hypothesize mediate service effects, and key outcome variables, propose a regression model for examining those aspects of the service comparison that you hypothesize will account for cost-effectiveness differences, if they are present.

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## Ethnographic and Qualitative Approaches

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While much of value has emerged from recent efforts to understand homeless individuals with chronic mental health problems, our understanding of the homeless mentally ill remains superficial at best. Surveys in many American cities have shed light on socio-demographic characteristics, the prevalence of chronic disorder, and rates of service utilization, but we have yet to arrive at a real sense of the human beings whose experiences underlie the percentages offered in these studies. We know little, for instance, about how homeless mentally ill people actually live their day-to-day lives. We know even less about how they perceive their experiences, and how those perceptions combine with their beliefs and values to affect their behavior in given situations. And we know almost nothing about issues which demand a processual perspective--how people make it from one day to the next, the kinds of crises they face, the situational factors that perpetuate their condition, the oscillations in their life circumstances, and the causal relationships among the many strands which make up the fabric of their lives.

These gaps in our understanding of homelessness are very much tied to the way we have pursued information on homeless persons. To date, cross-sectional designs featuring structured interviews with individuals at one point in time have overwhelmingly dominated the field. With rare exceptions (e.g. Baxter & Hopper, 1981; 1982; Martin, 1982; Morrissey et al., 1985; Schiller, 1984; Snow et al., 1986; Stark, 1984) approaches that rely on ongoing observation of individuals within and across the varied contexts in which they interact--approaches that are uniquely capable of achieving the longitudinal, contextual, and attitudinal understandings we currently lack--have been strikingly absent. This is true for many reasons, not the least of which is that lingering debates over whether such methods are sufficiently "scientific" has led to an entrenched bias against such methods on the part of funding institutions. The result is a distressing paucity of careful ethnographic research on contemporary homelessness, in spite of calls for such research (Spaniol & Zipple, 1985; Wittman, 1985).

This workshop sensitized participants to the ways in which an ethnographic approach offers a unique perspective on homelessness and mental illness, and increased their awareness of the problems inherent in conducting ethnographic and qualitative research with this population. This was accomplished by (1) highlighting the distinguishing features of ethnography; (2) describing how an over-reliance on survey research methods has limited our understanding of the homeless mentally ill, and how a very different sense of homeless mentally ill individuals emerges when ethnographic methods are employed; and (3) examining, through the work of the workshop presenters, the challenges inherent in conducting ethnographic research and the rich, contextual understandings that emerge.

### What Do We Mean bv the Term "Ethnography"

Because the term "ethnographic research" has recently been used to refer to any research effort that includes even the most minimal amount of qualitative data, the

workshop first focused on what ethnography is, how it is pursued, and how its worth should be measured.

Ethnography, most fundamentally, involves the documentation of a way of life, including how people behave and why. While its roots can be found in the efforts of anthropologists to understand behavior in vastly different cultural settings, time has revealed that it is of no less value closer to home. Just as different cultural groups lead ways of life characterized by different assumptions, values, beliefs, and rules for behavior, so do smaller groupings within our own society. Subcultures, complex organizations (such as medical schools), social settings (such as bars), or socially and/or economically marginal individuals (such as substance abusers or homeless individuals) are thus all grist for the ethnographer's mill.

In this sense, ethnography is an end in and of itself, toward which any number of methods can be used. In fact, ethnographers do draw upon a myriad of tools in addition to those traditionally used by qualitative researchers, including censuses, structured interviews, and projective tests. Ethnography is distinguished, however, by two unique aspects, both of which form a yardstick against which to measure the validity of ethnographic research.

The first of these is its reliance on participant-observation as a primary research strategy. Participant-observation is a time-worn method that features the immersion of a researcher into the lives of a particular people. Participant-observers live with the people with whom they are interested, learning their language, accompanying them through their daily rounds, and recording what they see and hear. They spend months, even years, in the field, correcting erroneous first impressions, developing close relationships that yield increasingly private information, building on what they have already discovered. They not only listen but watch, weighing what people tell them against what they themselves observe. In the end, they find themselves in the advantageous position of being able to grasp social life from the point of view of those who live it, while at the same time piecing everything together into a holistic understanding that members of the social group in question might not recognize.

The second distinguishing feature of ethnography is its focus on the actor's as well as the observer's point of view. At the heart of ethnography is the attempt to understand the meaning that behavior and social life hold for a people--how **they** see the world and make sense of it. In this sense, ethnography is the godchild of Max Weber and others who recognized.that people are unique as objects of study because they think and feel, and because what they think and feel affects how and why they behave as they do. Ethnography, then, is the documentation of a way of life that (1) emerges from long-term participant observation (and other methods, but always participant-observation), and (2) that highlights the meaning that social life holds for a group of individuals--that seeks, in other words, to understand the values and beliefs through which a particular world is seen. **Ethnographies** that are based on intensive participant-observation over long periods of time and that focus on beliefs and values as well as behaviors and accounts are more likely to produce richer, more detailed, more explanatory accounts. As such, these features are critical indicators of a study's validity.

## Gaps in Our Existing Understandinn of Homelessness

While carefully designed survey research must be an essential part of the effort to understand homelessness and mental illness, an exclusive reliance on survey research may leave us with a very incomplete, and perhaps even misleading, appreciation of the homeless mentally ill. This second workshop section focused on what we do **not** know about the

homeless mentally ill and how this is tied to the manner in which research on homelessness and mental illness has been conducted. Essentially, five points were made:

1. Descriptive material on the homeless mentally ill is scarce. We currently rely on snapshot impressions of people as viewed through middle class lenses, captured on the basis of fleeting contact. We lack rich descriptions of their ongoing existences and have little sense of what they believe and value.

2. Existing research reflects a preoccupation with pathology. One hears much about disorder but little about adaptation and the process of manipulating scarce resources to maximize one's chances of survival.

3. Most of what we know about the homeless mentally ill is based on single interviews. Very few studies have examined behavior over time.

4. Likewise most of what we know about the homeless mentally ill is based on self-report rather than observation, this in spite of the longstanding recognition that what people say and what people do can dramatically diverge.

5. Research to date has focused exclusively on individuals, ignoring the contexts in which individuals are found. Our explanations of behavior, as a result, center around individual, rather than contextual, factors.

## Applying an Ethnoeranhic Perspective to the Homeless Mentally Ill

The foregoing suggested that if we are to understand homeless mentally ill individuals and design viable intervention strategies, we must understand their belief systems and their adaptation in context and over time. This section of the workshop detailed how critical aspects of the ethnographic method and perspective could help fill identified gaps in our understanding, drawing upon examples from the available ethnographic literature on homelessness to illustrate these points.

The ethnographic approach, for instance, assumes that behavior must be studied and understood in context. Behavior that is otherwise inexplicable, for instance, often becomes intelligible once viewed in context. To cite a popular example, Stark (1986) and Martin (1982) suggest that peculiarities in dress and personal hygiene observed in some homeless women may sometimes reflect not functional impairment but conscious strategies designed to protect them from the predatory intentions of others, particularly men. Extending this point further, behavior studied independent of context forces one to explain behavior as a function of individual attributes when in fact contextual variables may play a more telling role. For instance, while quantitative data in the form of numbers of referrals from the New York City shelter system and other selection points supported the notion that chronically mentally ill homeless men were unwilling to avail themselves of an underutilized shelter, qualitative data revealed that features of this program allowed only the highest functioning clients with the highest tolerance for traditional services to survive the obstacle course that had to be navigated before one could receive services (Dennis et al., 1987a, 1987b). A focus on context, then, allows one to move past such concepts as "treatment-resistant clients" and "disorders of person" to such concepts as "treatment-resistant service providers (Koegel, 1987) and "disorders of place" (Love11 et al., in press).

Other examples of the importance of examining and understanding behavior in and across contexts were offered, as were examples of the importance of studying behavior based on both accounts and direct observation, and the importance of studying behavior over time. In addition, attention was paid to how both ethnography's focus on an emic point of view and its reliance on the notion of adaptation as a guiding concept allow

behavior to be understood within a more positive framework. For instance, while it might be difficult for many to understand how a homeless mentally ill individual could choose the streets over the security of a board and care facility, an insider's point of view would highlight how such security carries a price, and how the autonemy and self-determination that one enjoys on the streets outweighs the risks of danger and privation that one faces.

Ultimately, it was stressed that in order to put together programs that homeless mentally ill jndividuals will use, we must first understand what their lives are like, why they behave as they do, what they need, what they want, and how they want it provided. Ethnographic research is uniquely suited to providing these answers, and as such stands as a necessary complement to the quantitative, cross-sectional designs that have dominated the field.

## How Can Ethnonranhic Methods Be Applied: Examples from Presenters' Research

In a final section, workshop presenters turned to their own research for examples of challenges of conducting ethnographic research and of what a finished product can reveal.

Dr. Koegel, who has recently initiated a project in which 50 homeless mentally ill individuals in the Skid Row area will be followed over a two year period of time using ethnographic methods, addressed four problems that arose during a first year of exploratory research:

1. ***Who does one include in a study of homeless mentally ill individuals?***

The homeless mentally ill population is extraordinarily heterogeneous, including those who lead relatively stable lives in shelters or programs and who can articulate their experiences in insightful ways as well as those who lead unstable lives on the streets and who are so psychologically disorganized that communication is a problem. While the former end of the continuum is more attractive, restricting oneself to high functioning people yields a hopelessly biased sample. Include people at the more impaired end of the continuum is desirable but makes a difficult task that much more difficult, since these individuals are less easily engaged, tracked, and understood. On the other hand, no other method is as well suited to understanding this segment of the homeless mentally ill population as ethnography.

Also highlighted was the difficulty of deciding who is chronically mentally ill and who is homeless. With regard to the latter, for instance, ethnographic research makes it clear that an individual's status as a literally homeless person can change repeatedly even over relatively short periods of time . At different points in time, then, the same person can be eligible or ineligible for inclusion in a sample, depending on what is going on in their lives at the moment that the sample is actually selected. Too narrow definition of homelessness is ill-advised in that one can inadvertently end up excluding those whose homelessness follow a cyclical course but whose fortunes are temporarily'on the rise.

***2. How does one track homeless mentally ill individuals over time?***

In an ethnographic endeavor, one's best chance of success in tracking individuals rests on the ability to meet people, engage them, and eventually learn enough about their habits and routines to be able to re-locate them by predicting where they would probably be at a given time of day. This technique is effective but is confounded by the wide-ranging geographic mobility, both intra-city and inter-city, that is commonplace among many individuals. Attrition is a perennial problem but is one that can be mitigated by intensity of contact and high levels of rapport. Moreover, many people follow a pattern of cyclical mobility, which means that those who leave often return at a later time.

3. How ***does one build and maintain rapport with homeless mentally ill individuals?***

Ethnographic research both challenges and confirms the prevailing notion that engaging and maintaining relationships with homeless mentally ill individuals is extremely difficult. Some individuals are engaged quickly and easily; others take months and months of patient work, at times because of how alienated they are from social contact, at times because of socio-cultural barriers. Not exceeding their capacity for interaction, offering something tangible, but above all, taking one's time are all strategies for engaging hard-to-reach people.

4. ***How does one handle informed consent issues in this kind of research?***

Perhaps the most welcomed piece of information provided in this workshop was the existence of Certificates of Confidentiality. These certificates, which can be obtained from NIMH, protect researchers against having to release evidence of any illegal behaviors they have witnessed as part of their research. Given the certainty that ethnographic research with homeless mentally ill individuals will involve the observation of illegal behavior and the recording of the names of research participants, ethnographic researchers are well-advised to apply for such certificates.

The consent process be a difficult experience for many individuals because consent procedures are designed with the most highly functioning members of a prospective sample in mind and may include requests for permission for procedures that one would never employ with lower functioning members of a sample. Researchers should negotiate with their Human Subjects committees for an evolutionary consent process that allows consent procedures to proceed hand in hand with a developing relationship.

Dr. Ovrebo's work provided findings from a completed ethnography of a third class residential hotel in San Francisco's Tenderloin, and was presented as an example of the kinds of understandings an ethnographic effort can yield. Her presentation revealed that the hotel is a social world that operates according to subtle and complex norms negotiated by the residents and under rules established by the management and outside authorities. Residents operated under a hotel ethos, to "stay out of trouble" and to "not hurt anyone". Three core concerns of hotel life were isolated: money, health, and the sense of self. Of these three, the sense of self is primary (see Exhibits 2.3 and 2.4).

The old-timers (residents aged **65+** who have lived in the hotel for at least 10 years) oversee the primary life form of the hotel--guilt culture wherein the world and destiny are viewed as within the control of the individual and one is totally responsible for all of one's life conditions. Guilt culture is held up as superior to street culture and shame culture, the worlds of non-social insiders, those who are most likely to violate the hotel ethos. The fourth pathway of meaning in the hotel is "logos" culture, the world of the artists, wherein the individual views him or herself as capable of making meaning and thus transforming the world, where problems are anomalies which push one to make new meaning.

Understanding these pathways of meaning enables one to understand apparent anomalies of hotel life, for example the cycles of miasma and catharsis and the pattern among old-timers of refusing medical services. These findings also offer insights into the relationship between low class residential hotels and homelessness, revealing the threats homelessness poses to hotel dwellers and the ways in which hotel life compares with life on the streets.

**EXHIBIT 2.3**

**PRINCIPLES FOR EXIT FROM THE HOTEL:**

**THE ROLE OF MONEY, HEALTH, AND THE SENSE OF SELF**

| | Money-Related | Health-Related | Identity-Related |
|---|---|---|---|
| **Voluntary Exit: Moving Up** | Get a job<br><br>Save enough to move out<br><br>"Windfall" | Move around to other cities and hotels<br><br>Go home to die | Change name and/ or identity<br><br>Get married<br><br>Get a job |
| **Involuntary Exit: Moving Down** | **Non-payment** of rent: evicted or move out before evicted | Health declines: unable to care for oneself and it is discovered<br><br>Death | Lose one's sense of self and/or control |

**EXHIBIT 2.4**

**COMMON VIOLATIONS OF THE HOTEL ETHOS**

| | Don't Get into Trouble | Don't Hurt Anyone |
|---|---|---|
| Money | Not paying rent<br>Not repaying loans<br>Running out of money | Borrowing money<br>Not repaying loans<br>Stealing money |
| **Health** | Unable to leave room / get out of bed<br>Unable to protect self in and out of hotel<br>Not eating well; going on alcohol / drug binges | Asking others to help with daily needs<br>Hurting someone else physically<br>Selling / giving drugs and alcohol to other hotel residents |
| Sense **of Self** | Acting without pride and dignity<br>Revealing one's skeletons in the closet<br>Losing control of oneself or becoming disoriented | Attacking someone's character (stigma pain)<br>Gossiping (stigma contests) |

## Conclusion

Concluding comments, which stimulated a lot of discussion, focused on the fact that review committees tend to frown on ethnographic proposals, making the task of obtaining funding an extremely difficult one. Workshop participants felt very strongly that it is not simply enough for NIMH to voice an interest in ethnographic research and to include ethnographic methods in a list of acceptable research strategies that appears in RFA's. Rather, NIMH has to work to ensure that the composition of initial review groups and special committees include individuals who understand, and are capable of evaluating, ethnographic proposals.

One practical suggestion on increasing the likelihood of obtaining funding for ethnographic research was to combine ethnographic and quantitative approaches, allowing the strengths of each to complement the weaknesses of the other. This is perhaps the best formula not only for getting ethnography through a review committee but for reaching as full an understanding of human behavior as possible.

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# Longitudinal Designs

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and

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## Introduction

This workshop was divided into four sections. The first section consisted of an introduction and overview by Robert Rosenheck of recent longitudinal studies of the homeless and of specific issues central to such studies. Next, Pam Fischer presented the follow-up component of the Baltimore Homeless Study. Then, Dr. Rosenheck described the longitudinal outcome studies being conducted within the Veterans Administration's Homeless Chronically Mentally Ill (HCMI) Veterans Program and Domiciliary Care for Homeless Veterans (DCHV) Program. The workshop concluded with a group discussion highlighting the controversial issues involved in longitudinal studies of the homeless and the experiences of other workshop participants in conducting such studies.

## Background and Review of Issues

Longitudinal studies are of critical importance to understanding both 1) the current circumstances and future prospects of homeless persons, and 2) the effectiveness of interventions on their behalf.

**Discussion of Previous and Current** Loneitudinal Studies Longitudinal studies can be divided into two broad **categories;** studies of clinical programs and studies of **non-**clinical homeless samples. Studies of 'clinical programs can be further divided into three types. The first type are **clinical case studies,** descriptions of prolonged clinical work with homeless persons. Unfortunately only a small number of such case studies have been published thus far. These studies are needed to inspire and instruct clinicians working with the homeless in the community, every day. Studies of **comparative** treatment outcomes use similar follow-up methods for study participants in contrasting clinical programs. The pioneering studies of Barrow, Love11 and Struening, on five clinical programs in New York are of this type as is the VA study comparing the treatment of homeless veterans in an outreach program with contracted residential treatment (HCMI) and in a VA Domiciliary program (DCHV). Finally studies-using an experimental design were discussed. Dr. Gary Morse's study of three treatment alternatives is the principal ongoing study of this type, at present, and was presented in detail in another workshop.

Non-clinical longitudinal studies can be divided into those that examine the natural course of homelessness and its accompanying difficulties, of which the Baltimore study, to be discussed in detail below, is the most developed example; and **ethnographic** studies in which relatively small numbers of homeless persons are followed intensively using primarily, although not exclusively, qualitative field methods.

**Issues Central to Longitudinal Studies.** The following issues were suggested to be central to the types of longitudinal studies mentioned above and were targeted for discussion in this workshop.

First, it is crucial to articulate the goals of longitudinal studies and of the sponsors of those studies. Current studies of the homeless involve both the pursuit of new knowledge and advocacy. There is urgency in the plight of today's homeless and studies have been, and will continue to be driven by the need to both identify the best approaches to helping the homeless and to articulate honestly their needs, so that both service technology and public awareness can be expanded.

Second, on a more technical level the most challenging features confronting those who would conduct longitudinal studies of the homeless could be summarized under four headings.

1. Extended time frames. Such studies must take place within extended time frames. Unlike pharmacologic studies, for example, which can yield a result in 2-6 weeks, clinical or biographic studies of the homeless require months, or more likely, years, to yield significant findings.

2. **Instability/Unpredictability.** The homeless are geographically unstable and often unpredictable in their behavior, and are thus difficult to track.

3. Narrow vs. Broad Definition of Taraet **Population.** In an effort to minimize attrition, target populations may be narrowly defined. This will, however, reduce the generalizability of findings. Such tradeoffs are central to strategic planning of longitudinal studies of the homeless.

4. Methods of Minimizina Attrition. Because of these difficulties, special attention and effort must be paid to engaging the homeless in outcome studies and motivating them to follow through over long periods of time.

Third, and finally, two issue were identified that were not focused on in this workshop. The first of these issues involved selecting instrumentation appropriate to collecting data that would be valid and reliable, but that would also be practical for use under the field conditions involved in studies of the homeless. The length and complexity of such instruments is central to this concern. Issues of analysis are also noted to be critical but were not discussed here.

## The **Longitudinal Component** of the Baltimore Homeless Study

Dr. Fischer reviewed the background of the Baltimore Homeless Study. The Baltimore Homeless study has sought to determine rigorously the prevalence of mental disorders and other socio-demographic and health status measures among the urban homeless of Baltimore. In the plan for the longitudinal component of this study, one third **(N=100)** of the 150 males and 150 females in a detailed baseline clinical study were to be followed weekly for 6 months to determine the evolution of their mental health, general health and basic social circumstances. The follow-up was to be conducted using a minimum of resources and in such a way as to avoid having a major impact on the homeless persons studied. A certain emphasis was placed on not encouraging the follow-up interviewers to provide assistance or to get involved with the subjects.

In setting up this study subjects were asked to come to a drop in center that would be open at specified times during the week, or to call the research team on the telephone (collect, if necessary). Subjects were remunerated $1 for each weekly contact. More specialized arrangements were made for the remuneration of homeless persons in jail who were in the study. A major consideration in designed this tracking method was to find settings that were both easily accessible on foot to the homeless respondents and that did not jeopardize the safety of the interviewers. It was thus essential that interviews be

conducted is office space used for other purposes so that other people and telephone access would be available should the need for assistance arise. A room in a church and a community center were selected as suitable locations. All participants were given plastic cards to remind them of the phone numbers to use, where to go and when the interview settings were staffed. In addition to these drop-in arrangements, informed consent was obtained to inquire with shelter providers and other specified key informants as to the whereabouts of subjects.

During the first week of the follow up 67.3% of those involved dropped out of the study and were not heard from again during the six month period. At the end of the six months, only a small number of participants remained. Comparison of those who showed up with those who did not showed little differences on almost all of the major clinical and socio-demographic dimensions.

This study illustrates the substantial difficulty in conducting longitudinal studies of non-clinical samples of homeless persons, even in the face of a completely thought out strategy in which financial incentives and a variety of other mechanisms were used to maximize ease of access and motivation to participate for those involved in the study.

Discussion. In the discussion that followed Dr. Fischer's presentation attention focused first on the effectiveness and ethics of remuneration as a way of encouraging study participation. One participant described the experience of a study in which up to several hundred dollars were offered to reluctant informants, without successfully obtaining their participation. The thought was expressed by several participants who had themselves been involved in longitudinal studies, that in this population that was resourceless along many dimensions, personal contact and involvement seem to be more of an incentive to participation than financial remuneration.

## Lonnitudinal Evaluation of Two National VA Pronrams for Homeless Veterans

Dr. Rosenheck then presented the background and some preliminary findings from the evaluation of the Veterans Administration's Homeless Chronically Mentally 111 (HCMI) Veterans Program and Domiciliary Care for Homeless Veterans (DCHV) Programs. The evaluation of these programs was undertaken originally, to document and closely monitor the implementation of these large national programs, each of which includes 6 stages of treatment; (1) outreach, (2) medical and/or psychiatric assessment, (3) initiation of treatment directly or (4) through linkage, (5) residential rehabilitative treatment and (6) continuing case management. In the first phase of the evaluation baseline clinical data were collected on almost 16,000 homeless veterans as they entered the two programs, and then again at the time of discharge from the residential treatment components (contract community residential treatment, in the case of the HCMI program, and domiciliary care provided by the VA in the DCHV Programs.) Because the focus in this evaluation is on the conduct of community based outreach and treatment, all veterans who had an intake assessment are included in the evaluation. For the first group of assessed veterans, subsequent service use will be monitored through computerized VA data systems.

In an effort to gain additional information on the comparative cost and effectiveness of these two treatment programs, an outcome evaluation was initiated at just under a fifth of the sites in each of the programs (3/20 in DCHV; 9/43 in HCMI). At these sites veterans are re-contacted by an evaluation staff member at 3 month intervals for 1 year. During each quarter, data is gathered from 1) VA clinicians, 2) from the veterans themselves in a face to face interview, and 3) from the follow-up evaluation assistants.

The clinicians complete the 97-item Outreach Clinical Process Form (OCPF) on which they are asked to present their characterization of the treatment relationship, the

services they have delivered, the number and location of contacts and presumed reasons for the veteran's discharge from the program, if that has occurred, during each three month period following the intake assessment. Since the OCPF relies on clinician, not patient, availability, it is not surprising that the completion rate has been over 95% for this form.

Information is also collected through face to face interviews with eligible veterans who had at least one intake contact using the Homeless Veterans Follow-Up Battery (HVFB). While these VA outcome studies are in the middle of their data collection phases, so far about 29% of those eligible for the program (e.g. those who were validated veterans, were homeless and chronically mentally il or substance abusers **and** who had had at least the brief screening interview) have been re-contacted for a face to face follow-up interview. In view of the fact that all veterans contacted at least once by the program are included in the follow-up, this capture rate is quite high. At present almost 2,200 veterans are participating in the follow-up.

Further data are collected from the evaluation assistant on what was done to re-contact the veteran, on what was successful if the re-contact **was** established and on why the veterans was not interviewed if that proves to have been the case. A **29-item Follow-**Up Procedure Form (FUPF) has been developed for this purpose.

Since no remuneration is offered to any of these subjects, the re-engagement of these veterans is based largely on the personal value they place on the program and on the clinicians and evaluation assistants they have come to know. This no doubt will skew the data towards representing a higher percentage of those who have been clinically engaged in the program.

A review of 1,585 follow-up attempts showed that 37.9% of homeless veterans were successfully re-interviewed; 28.2% could not be located; 14.1% were not pursued for a variety of reasons; 13.1% had moved away; and 5.9% either refused or were incapacitated. Information on efforts that were made to re-contact these veterans showed that VA health service networks, personal networks and key locations (eg shelters and soup kitchens where previous contacts had been made) were all used to relocate homeless veterans. Interviews were conducted **(N=602)** in VA Outpatient Clinics **(35.8%),** VA Inpatient Units or Domiciliaries **(18.5%),** Residential Treatment Centers **(14.5%),** by telephone **(10.9%),** at community locations **(10.8%),** and at other locations (9.5%).

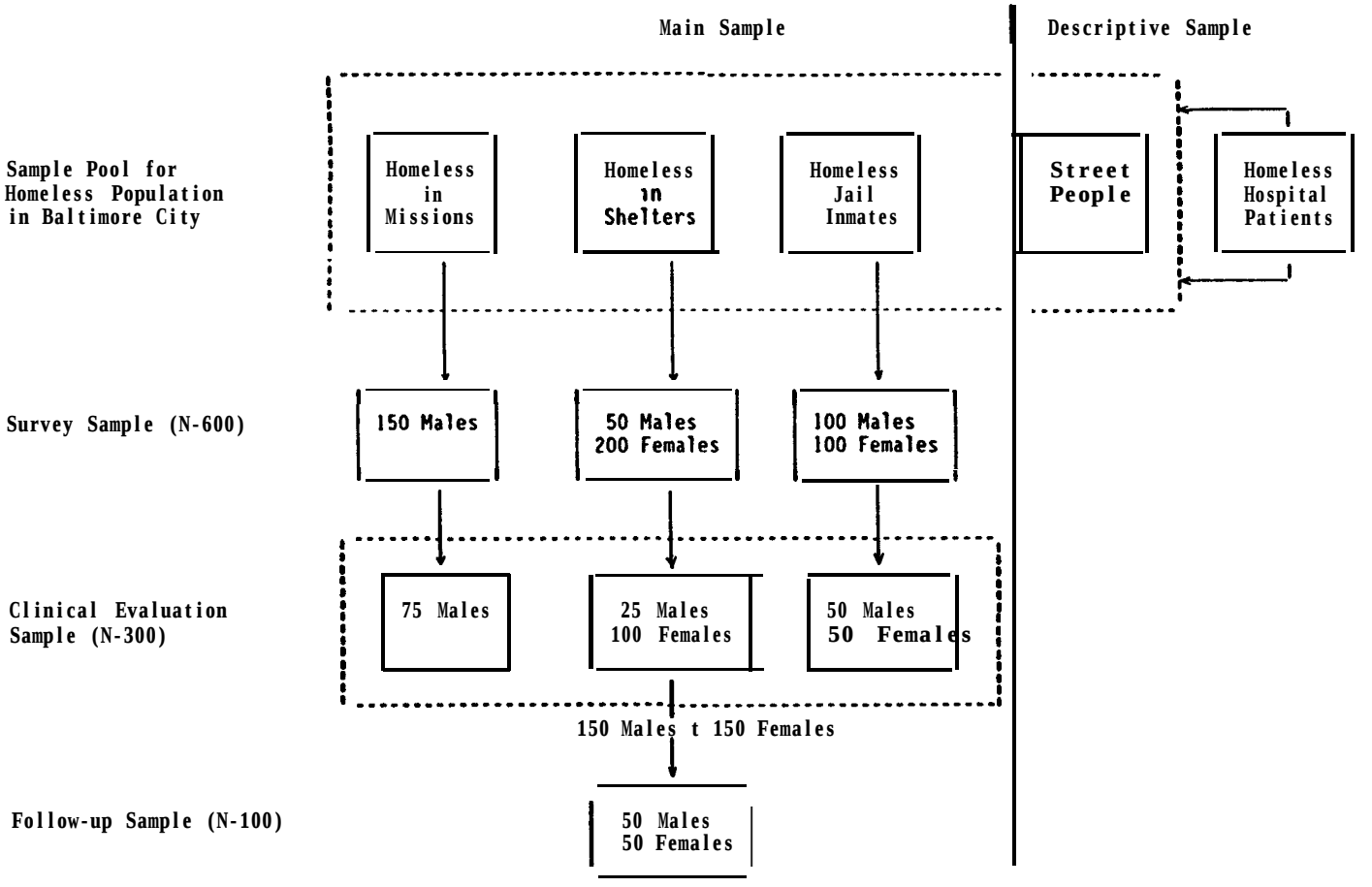
The methods and design use in this large VA study are suitable to its specific purpose of describing the actual process of care in a national outreach and residential rehabilitative programs for the homeless mentally ill and may have wider applicability for others conducting similar studies.

## Discussion

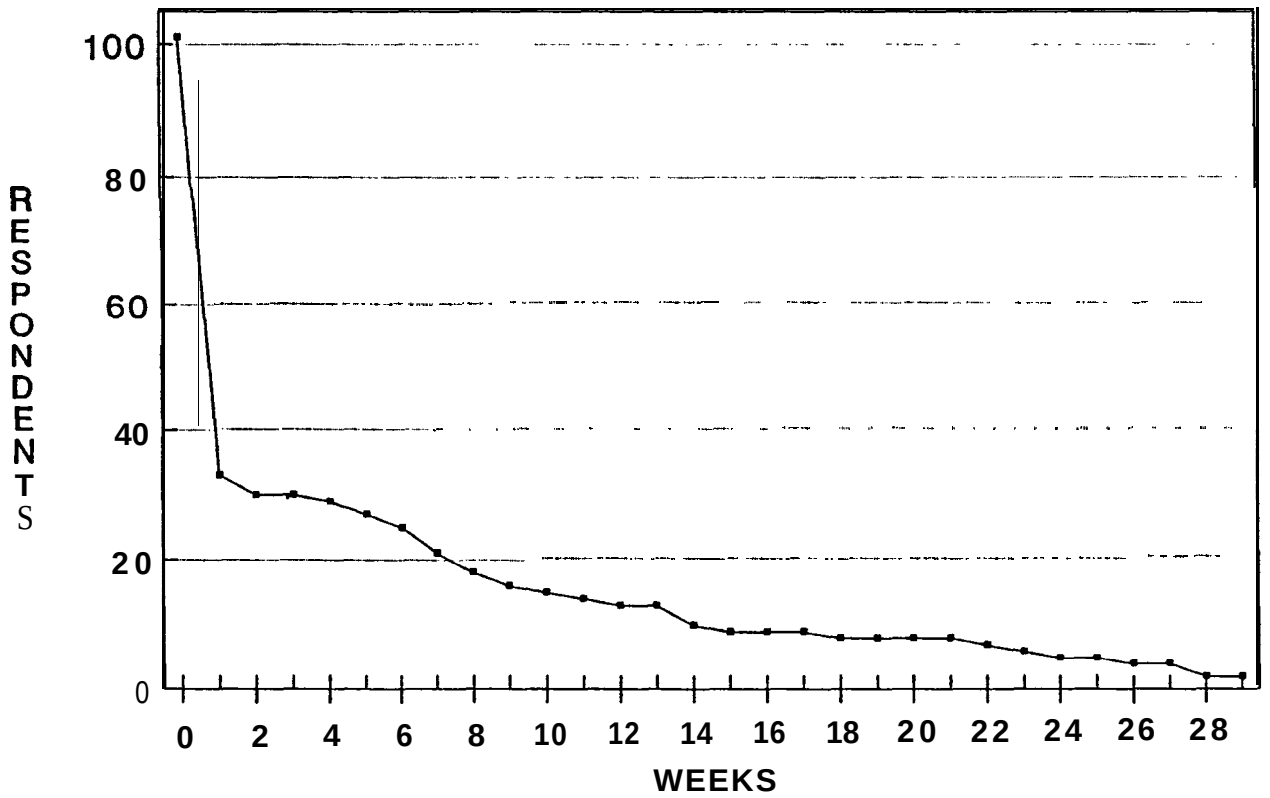
In the general discussion following the presentations two central issues were discussed: (1) how to successfully re-contact homeless participants in outcome studies and (2) the ethical considerations involved in speaking to other service providers,.family members or friends in an effort to relocate veterans. It was generally felt that personal contact was critical to making follow-up contacts but that remuneration played a key role as well. Various concerns were expressed about how both of these approaches could distort study findings. On the second issue, it was felt that it would be of value to present empirical data to **IRBs,** particularly as such presentation could show a non-coercive pattern participation of homeless persons with little control over their fates. Unfortunately space does not permit a review of the many other studies that participants described as a whole or in part. It seemed there was widespread commonality of experience among those conducting these studies both in the difficulties encountered in re-locating and re-engaging homeless persons in follow-up assessments, and in the role of financial and inter-personal incentives for participation.

# APPENDIX

SAMPLING FRAME FOR THE HOMELESS PROJECT



# The Baltimore Homeless Study
# Retention in Follow-Up



## APPENDIX

## SIX STAGES OF CLINICAL CARE AND DATA COLLECTION

| Stages of Clinical Care | Evaluation Instruments |
|---|---|
| **&e-Line Assessment** | |
| 1. Outreach | 1. The Intake Form for Homeless Veterans (IFHV) |
| 2. Intake Assessment | 2. The Intake Form for Homeless Veterans (IFHV) |
| 3. Psychiatric and Medical Specialty Examinations | 3. Psychiatric Data From (PDF) Medical Data Form (MDF) |
| 4. Psycho-Social Assessment | 4. The Homeless Veterans Evaluation Battery (HVEB)<br>► Addiction Severity Index<br>► Social Network Measures<br>► Brief Symptom Index<br>► Vietnam Experience Questionnaire |
| **C tinuing Case Management / Follow-Up Assessment** | |
| 5. Residential Treatment | 5. The Discharge from Residential Treatment Form (DRT) |
| 6. Continuing Case Management | 6. The Outreach-Clinical Process Form (OCPF)<br>Homeless Veterans Follow-Up Battery (HVFB)<br>Follow-Up Procedure Form (FUPF) |

SERVICE NEEDS OF THE HOMELESS
FOLLOW-UP QUESTIONNAIRE

STUDY NO.: ___ ___ ___ ___ ___ - ___
SITE: INTERVIEWER: ___
DATE: _ - ___ ___ - -

I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT WHAT YOU'VE BEEN DOING THIS LAST WEEK, FROH LAST (DAY) THROUGH TODAY.

1. Have you found a place of your own to live?

No(Q3) ..... 1
Yes ..... 2
DK(Q3) ..... 3

PROBE: exclude missions, shelters

2. IF YES: What kind of place is this?

SPECIFY OTHER:

Own room ..... 1
Own apsrtment ..... 2
Own house ..... 3
Hotel ..... 4
With family ..... 5
With friend ..... 6
Other(SPECIFY) ..... 7
DK ..... 8
NA ..... 9

3. Where did you usually sleep last week?

SPECIFY:

___ ___

OK ..... 98

4. In the past week, did you stay one night or longer in . . .

| | No | Yes | DK |
|---|---|---|---|
| General hospital..... | 1 | 2 | 8 |
| Mental hospital..... | 1 | 2 | 8 |
| Alco/drug program..... | 1 | 2 | 8 |
| Jail or prison..... | 1 | 2 | 8 |

S. In the past week, have you had any problems with . . .

| | No | Yea | DK |
|---|---|---|---|
| Getting enough to eat..... | 1 | 2 | 8 |
| Place to stay..... | 1 | 2 | 8 |
| Honey..... | 1 | 2 | 8 |
| Health..... | 1 | 2 | 8 |
| Alcohol or drugs..... | 1 | 2 | 8 |
| Emotions or nerves..... | 1 | 2 | 8 |
| OTHER: Other(SPECIFY)..... | 1 | 2 | B |

6. In the past week, have you traveled out of town?

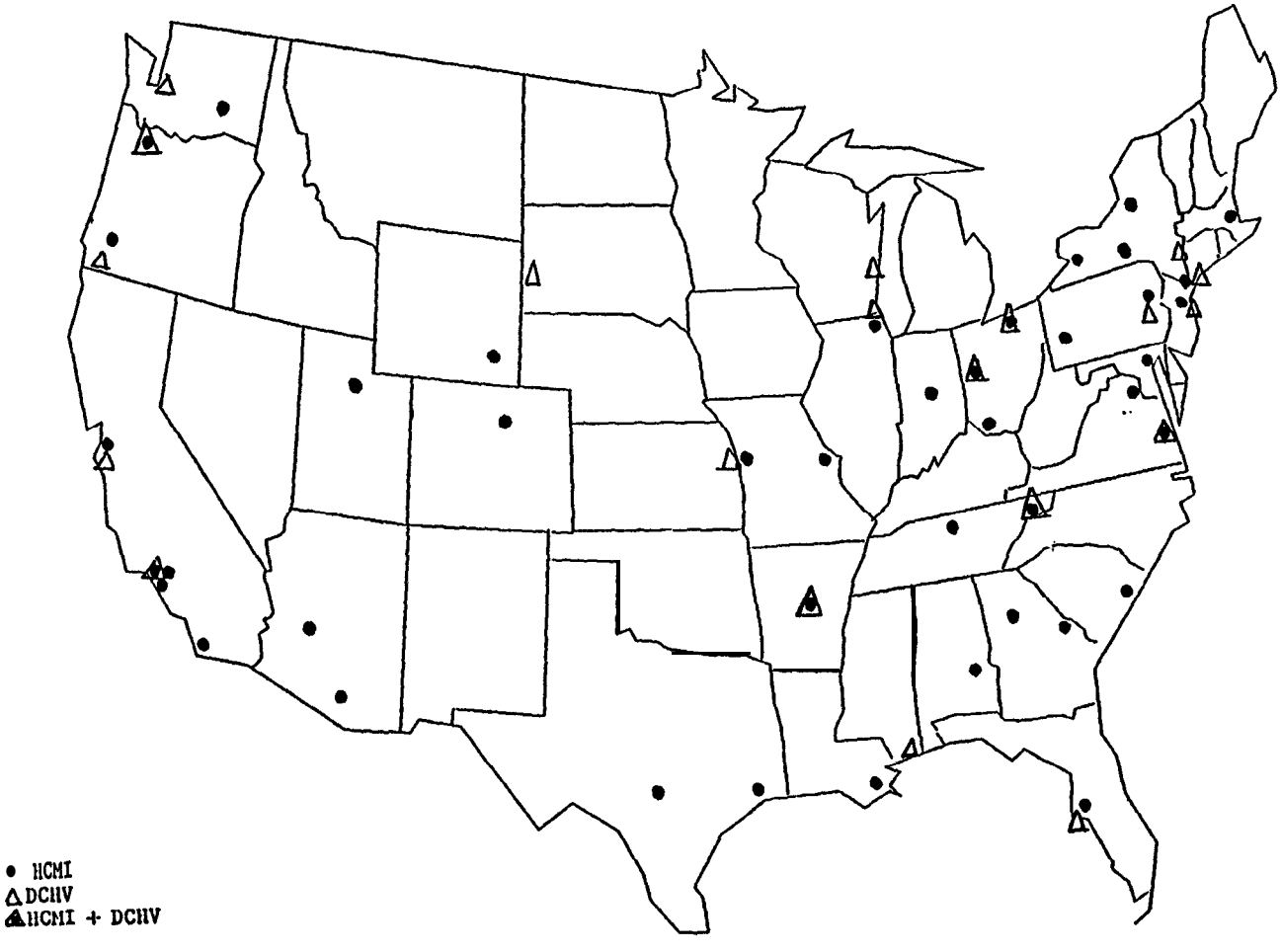
No ..... 1
Yes, out of town..2
Yes, out of state.3
Yes, out of U.S...4
DK ..... B

WHERE:

7. Did you receive help from any agencies or clinics this week?

| | No | Yes | DK |
|---|---|---|---|
| Social Services..... | 1 | | 8 |
| Social Security..... | 1 | 3 | 8 |
| Health Clinic..... | 1 | 2 | 8 |
| Mental Health Center..... | 1 | 2 | 8 |
| Alcohol/Drug Program..... | 1 | 2 | 8 |
| Employment Office..... | 1 | 2 | 8 |
| Probation Office..... | 1 | 2 | 8 |
| Day Program/Day Shelter..... | 1 | 2 | 8 |
| Other(SPECIFY)..... | 1 | 2 | 8 |

VA PROGRAMS FOR HOMELESS VETERANS



# Section III

# SPECIAL POPULATIONS

# Assessing Mental Health Status Among Adults Who Are Homeless

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and

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Decisions concerning which measures and instruments to use for assessing mental health status depend in part upon the purposes to which the assessments will be put: basic social science research, clinical treatment decisions, service delivery, program evaluation, planning, or policy development. The appropriateness of a particular instrument to a research project will also be determined by the characteristics of the individuals or groups under study and the context in which the assessments are made.

During the period from 1980-89, homelessness research, whether funded by NIMH or through other sources, sought mostly to understand who homeless persons were, to count them, and to estimate the prevalence of psychiatric disorders among them. Perhaps because of the urgent need for responding to widespread homelessness, little attention was paid to the quality of the methodology used for mental health. In addition, the early studies tended to emphasize individual level-data, rather than to acknowledge systems issues or the interaction of individual characteristics with context.

The new generation of studies, beginning in 1989, will address a different set of questions, and mental health assessments will be made with new objectives in mind. The instrumentation used will have to be applicable to the emerging characteristics of new populations of homeless persons, for example, to reflect the presence of more women with children; comorbidity with serious physical illnesses, such as tuberculosis and especially AIDS; and new types of substance abuse.

This discussion will be divided into two sections. The first will review critically the assessment of mental health status in the early studies of homeless adults and suggest improvements for future studies. Some issues raised by new research objectives will also be discussed. The second section will present a different type of assessment strategy, which relates individual-level clinical characteristics to environmental indicators, such as service-system characteristics.

## Individual-Level Mental Health Assessments

### *Critical Review of the Literature'*

From 1980 to 1989, at least seven types of measures were used to assess mental health status in surveys and other studies: self-report of treatment history or of the need for treatment; a service provider's brief assessment; an interviewer's observation; past history of psychiatric treatment or hospitalization; a scale measuring symptoms, impairment and/or level of functioning; diagnosis based on a clinician's evaluation; and

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[1] The information in this section draws upon three reviews: Lovell, Barrow, and Struening (1984), Lovell, Barrow and Struening (in press), and Love11 (in press). References and further information on instruments and studies mentioned in this section are contained in the three papers.

diagnosis based on a standardized, structured or semi-structured clinical interview. Most of the instruments were being used on homeless populations for the first time. Although reliability and validity measures were rarely reported, psychometric principles and research experience suggest that reliability of these measures increased as one moved from the least structured method (self-report) to the most structured (diagnostic interview), and from a single item or measure to several questions or especially combined measures.

Brief Measures. In the next generation of homelessness research, the first three types of assessment -- self-report, brief assessment, and interviewers' observations -- will probably be used less often, given their lack of methodological rigor. However, as they often comprise the only measures possible when time and money are scarce and people are moving about frequently, as in a street outreach situation or large shelter, they will be discussed here briefly.

While several instruments have been developed based on these types of assessments of homeless adults, virtually no validity studies exist to date demonstrating their potential as screening instruments. The most stigmatizing questions, such as whether someone has ever been hospitalized for a psychiatric problem, will probably provide less reliable answers, leading to underestimation. On the other hand, a variable based on history of hospitalization presents the advantage of measuring the same phenomenon across disparate studies.

Field experience suggests that screening items should be kept very behaviorally-oriented and descriptive. They should also be problem-oriented, combining mental health assessment questions with needs assessment questions that are closer to the concerns of homeless persons. If possible, information should be collected over time, using multiple contacts, even if brief. Detailed glossaries and manuals, training, and monitoring of interviewers or workers are essential for assuring reliable data-gathering.

**Symptom and Other Behavioral Rating Scales.** In surveys of mental health, symptom scales are useful, as they are cheaper to administer and usually require less training than a diagnostic interview. At least six symptom scales were used in the earlier studies.

Almost half of the homeless persons in most of these early studies scored above the cut-off points for "normal" populations, even though the instruments and sites where the instruments were administered vary. Care must be taken, however, in interpreting the meaning of these results. For example, are they reflecting psychiatric disorders, environmental conditions, or both?

First, most of the items on these scales are subject to environmental contamination, or the inability to tease out the signs of psychopathology from the effects of the environment. For example, in a factor analysis of the SADS-C on 101 homeless persons with severe psychiatric disorders, items concerning sleep and appetite disorder, considered to be vegetative symptoms of depression, did not correlate with one another or with depressed mood. Unsafe living conditions, scavenging, or eating only institutional food may affect sleep and eating patterns that have usually been associated with psychiatric disorders (Barrow, Hellman, Lovell, et al, 1989).

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[2] The Psychiatric Epidemiology Research Interview (PERI) psychoticism scale, the Schedule for Affective Disorders and Schizophrenia - Change Version (SADS-C), the General Health Questionnaire (GHQ), the Center for Epidemiological Studies - Depression scale (CESD), the Brief Symptom Inventory (BSI), the Psychiatric Evaluation Form (PEF), and Psychiatric Status Schedule (PSS) (See Lovell, Barrow, and Struening, in press, for more detail).

Furthermore, symptoms that are maladaptive in one context may also be signs of strength or survival strategies in another, as anthropological work suggests (Stark, 1986; Schiller, 1984; Lovell, 1984). For example, noncompliance with medication may assure alertness when one is living in the streets or in large, unsafe shelters. Paranoia may also be a healthy response in such situations. In a survey of New York City shelter users, interviewers were asked to indicate, for items on the PER1 psychoticism scale, which positive answers might be qualified by situational or cultural factors. Situational qualifiers were checked 75% of the time for two items, feelings about people wanting to harm the subject and feelings that "something odd or unusual was going on around him". Interviewers also checked the qualifier in at least half of the cases for all items (Susser and Struening, in press).

Secondly, neither internal consistency reliability, interrater reliability nor validity has been reported for these behavioral instruments (for exceptions, see Roth,Bean, Lust, et al, 1985, for the PSS; Barrow, Hellman, Lovell, et al, 1989, for the SADS-C and Scales for Level of Functioning, or SLOF; Baumann, Beauvais, Grigsby, et al, 1985, for the Global Assessment Scale, or GAS). Persons who are temporarily or long-term homeless differ from both general populations and from the clinical populations on which these instruments were developed. As persons who are homeless are under extreme stress, higher cut-off points may be necessary to determine "caseness" than in community studies.

Third, the construct validity, or phenomenon that the instrument purports to measure, may not be clear. For example, the high rates of symptomatology mentioned above may be the effect of the temporal dimension of the instrument. Most symptom and functioning scales are anchored in the past week or some unspecified "present". Yet, scores above a cut-off point are interpreted as indicators of mental disorders, regardless of whether the condition is short-lived. Other measures must be used to validate these results. For example, in a survey of New York City's adult shelter system, 33% of first-time shelter users scored 30 or more on the CESD (16 is the cut-off score for depression in general populations). This percentage was over twice as high as that for the shelter users surveyed as a whole (Susser, Struening, and Conover, 1989). This suggests that the CES-D may be measuring an extreme nonspecific distress related to specific stressors rather than depression.

The early studies also point to the inadequacy of single measures of mental health. In Ohio, Roth, Bean, Lust et al (1985) found that history of psychiatric hospitalization had a very low correlation (.03 to .14) to behavioral symptoms. In 10% of the cases, it would not have predicted current mental health problems. Similarly, in the New York City shelter study neither interviewer ratings of such behavior as withdrawal, unusual ways of thinking and flat affect, nor scores on the PERI, were good predictors of psychosis. In a subsample of male shelter users who were administered the sections of the SCID concerning psychotic symptoms, scoring above the cutoff on either the interviewer ratings and/or the PER1 did predict psychosis on the SCID (Susser and Struening, under review).

**Diagnostic** Instruments. Symptom scales cannot generate diagnoses, although they are too often treated as if they did. In earlier studies, clinicians diagnosed homeless persons on the basis of an unstructured interview, using DSM III criteria. However, without a structured clinical interview, variation in the information obtained by different clinicians cannot be controlled. Hence, reliable studies that used semi-structured or structured standardized psychiatric schedules, such as the Diagnostic Interview Schedule, based on DSM III, or the Schedule for Affective Disorders and Schizophrenia, based on

Research Diagnostic Criteria (RDC), achieved more reliable diagnoses.[3] These instruments still fall prey to problems of temporality and environmental contamination. For example, the prevalence rates of Antisocial Personality Disorder in the Los Angeles Skid Row study dropped by one-third when characteristics more common to homeless than to non-homeless persons - not having a regular place to live, not working for six months or more, having held more than three jobs in the past five years -- were eliminated from the definition (Koegel and Burnam, in press).

The DIS is shorter, can be administered by lay interviewers and hence is less expensive and more adaptable for surveys. It is typically administered in one setting. It is yet to be demonstrated, however, that a one-shot psychiatric interview produces a valid diagnosis in a homeless population, given interview conditions, some of which are similar to those that make emergency room assessments difficult (Chafetz, 1985). Both the SADS-L and the SCID, by allowing information to be collected from multiple sources over a period of time, enable the interviewer to modify earlier judgements based on information gathered under less than optimal conditions. Collecting information over time also increases the likelihood of being able to include in a study persons usually excluded because they are "too withdrawn or delusional..." to be interviewed at first encounter, because they are not taking medication that might abate symptoms or because of deterioration from months and years on the streets.

### *Instrumentation for the New Generation of Homelessness Research*

The newer research, if we are to judge by recent proposal announcements, will be more concerned with specific subgroups of homeless persons, comorbidity and service delivery systems, as well as with the interface of mental health treatment with other types of services. With the earlier studies to draw upon, a higher quality of methodology can be expected, including demonstrations that instruments used are reliable and valid.

Co-morbidity of substance abuse with other psychiatric disorders presents a serious methodological problem for assessing adult mental health status. Its prevalence is suggested by findings such as that alcoholism among homeless persons is far more likely to be coupled with another DSM III diagnosis than is the case for household controls (Koegel and Burnam, 1988a). To our knowledge, no scale exists that teases out symptoms of psychopathology from signs of alcohol or drug use. A temporal perspective is absolutely necessary to determine the history of illness and abuse; that is, whether the signs of substance use or the symptoms of psychopathology appeared first. Probes, such as those used in the DIS ("was _____always the result of alcohol, drugs, or medication..."), should also be incorporated into symptom scales or diagnostic instruments, when comorbidity is at issue.

Although it is acknowledged that non-whites are disproportionately represented among homeless persons (Martin, 1986), until now no attention has been paid to how well instruments tap specific cultural and ethnic categories. The pretest stage of any study should be used to assure that instruments cover the symptoms, disorders, and categories relevant to the group being studied. This may involve including culture-bound syndromes, such as somatization disorders or the more vegetative symptoms associated with depression in certain cultures (Kleinman and Good, 1985). However, for major diagnoses, the criteria1 symptoms -- those necessary to the diagnosis -- may not differ across ethnic groups

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[3] The DIS was used by Fischer, Shapiro, Breakey et al, 1986; and Koegel and Burnam, 1988a and b. The SADS-L was used by Barrow, Hellman, Love11 et al, 1989. Studies using the Structured Clinical Interview for DSM III-R (SCID) in its entirety are currently underway but not yet completed as of this writing.

(Fabrega, Mezzich, and Ulrich, 1988); therefore, prevalence rates within subgroups would not be changed by the symptom clusters. Within scales, symptoms may cluster differently and contrast among ethnic groups (Kleinman and Good, 1985; Rubio-Stipec, Shrout , Bird et al, 1989). A more complicated issue is the **cultural meaning** of any behavior or symptom, which will in turn affect actions.'

**The Need for a Social Diagnosis**. Psychiatric characteristics of homeless persons are too often interpreted as indicators of need for mental health treatment. Using only or primarily mental health assessments to describe homeless persons deflects attention from the multiplicity of needs homeless persons may have, and from the one characteristic all of them share, regardless of their psychiatric status, i.e. lack of housing. When used alone, psychiatric indicators reinforce a circularity whereby the service system defines demand by what it can supply, namely psychiatric interventions. Thus, psychiatric services become the social goal, legitimized by the categories of mental health status-as-need and preempting the possibility of other types of responses.

An alternative would be a truly social assessment, in which mental health status is but one element of classification examined, along with the ability to negotiate everyday life, degree of community ties, and the needs identified by potential consumers of services themselves. This might also give new meaning to certain behaviors, such as anger or noncompliance, which may be structured by the lack of suitable services or constant humiliation and deprivation of institutions and poverty, rather than simply by an internal pathological state. The challenge of future mental health assessment among homeless people should begin with the question: how can we develop a relevant social diagnosis?

## A System-Level Approach to Mental Health Status

While first generation studies concentrated on the enumeration of the homeless mentally ill population and highlighted questions regarding how best to measure mental health status in this population, second generation research may reflect this work through a more detailed and sensitive characterization of homeless mentally ill individuals. Additionally, second generation work should begin to focus on the characteristics of service programs and of the service systems in which these programs are embedded. As such, the research may progress from a concentration on validly and reliably identifying the mentally ill subgroups in the homeless population to understanding the differential outcomes of services for differing types of homeless mentally ill individuals who receive differing types and amounts of services.

In this section, we would like to present an approach that may be useful for organizing second generation research projects. The approach integrates system and outcome characteristics within one model and is currently being employed in an NIMH sponsored longitudinal service system research project that is underway in Denver (Coen, Wilson, Shern et al, 1989). While the project focuses on the severely and persistently mentally ill (SPMI) population in public treatment (a small minority of whom are homeless), the structure and much of the content of our approach should generalize to research on the homeless mentally ill population.

In Figure 1, we present a conceptual approach for planning and evaluating services to an SPMI population. The model has three components -- client characteristics, services needs, and client outcomes -- that are the focus of the study. The variables are logically arrayed such that client characteristics are hypothesized to be related to needed treatment,

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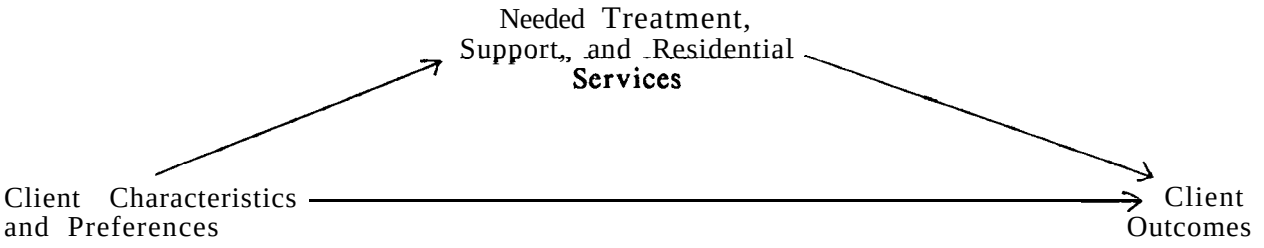
[4] These issues are beyond the scope of this summary. The reader is referred to **Kleinman** (1989) and to the references in this paragraph.

support, and residential services. The differential receipt of these services, in turn, is hypothesized to result in differing client outcomes. This model suggests that variables should be measured from three domains to adequately understand the client in relation to the service system.

**Figure 1**

**Conceptual Model for Planning and Evaluating Services**




**Client Characteristics.** Much of the discussion in the first part of this paper has focused on the most appropriate characterization of clients in terms of their symptoms, diagnoses, felt needs, and functional characteristics. These discussions regarding instrumentation may provide helpful suggestions about the appropriate selection of instruments for research among homeless persons. In the example from Denver, the Colorado Client Assessment Record, or CCAR (Ellis, Wilson, and Foster, 1985), was employed as the primary instrument for collecting client characteristic data. The CCAR is a rating form completed by clinicians in which a problem checklist composed of approximately 75 items is included in addition to nine level of functioning judgements which parallel the content of the problem items. The clinician problem ratings were used in a cluster analysis where four types of SPMI individuals were identified: the Young Adult, Extremely Disabled, Personally Distressed, and Adapted Clients. Each of these client groups is characterized by a distinct profile of problem items.

**Treatment Support and Residential Needs.** The second component of the model involves assessing the client's needs for services. In the Colorado project, a set of approximately 50 items was developed, addressing particular service needs in seven service domains: crisis stabilization, case management-advocacy, psychotherapy, employment, substance abuse (both drug and alcohol), medical and basic needs. Scales scores are calculated for each of these areas, reflecting the degree of met and unmet need in each service domain. An additional set of items relates to residential needs and preferences as well as to the support services that will be required in order for the client to live successfully in his/her preferred residential setting.

Consistent and significant relationships are obtained between the client typology and the pattern of service and residential needs (Shern, Bartsch, Coen et al, 1985). Using these relationships and data on client characteristics that are routinely collected as part of enrollment in the public mental health system, it is possible to type any group of clients (e.g. at a given clinic) and estimate the service needs of this group. While this approach has important practical benefits for system planning, it also may be employed to structure our approach to service system research by concretely identifying heterogeneity within a target population and the resulting heterogeneity in their need for service.

Client Outcomes The final component in the model involves outcomes experienced by clients. In terms of the conceptual model, outcomes are presumed to be related to differential receipt of needed services as well as to the characteristics of clients. In the Colorado research, outcomes are being measured in five major areas: client functioning and subjective quality of life, symptomatology, self-esteem, satisfaction with and engagement in services, and use of intensive, highly controlled environments like psychiatric hospitals or jails.

In this research project, then, the researchers have sought to integrate these three major content areas within one project in order to more completely describe the population, their needs and treatment outcomes measured across time. As such, the researchers feel that they have achieved a relatively comprehensive assessment of the target population that should both enhance our general understanding of issues related to serving this population and provide data that are immediately relevant for system planning.

Importantly, this project involves the use of multiple perspectives. Based upon their earlier findings that clinicians frequently attribute unmet needs for services to client's unwillingness to participate in treatment and to the reasoning associated with the "treatment resistant" client, the researchers felt that it was critical to incorporate client, clinician (case manager) and collateral data within one design. By using multi-perspective data, it will be possible to both assess the differences between needs and outcomes as seen from each perspective and to determine the areas in which and degree to which professional judgement may be relied upon in planning mental health interventions and evaluating their effectiveness.

The project also involves collaboration with researchers from the Robert Wood Johnson national evaluation and other university based researchers. The project's colleagues are investigating the inter-organizational effects of the Denver service intervention, the total social costs of clients served by the system, as well as completing parallel outcome studies in other settings. Through this collaboration other effects of the service system intervention have been included that otherwise could not have been included within one sponsored project.

The project may therefore provide a model for second generation research in terms of both its conceptualization and measurement of problems, its longitudinal nature, and the collaborative team that has been assembled to complete the work - e.g. Public/Academic Liaison. Bringing this approach to homelessness research may result in a better understanding of problems of and effective interventions for homeless individuals with serious mental disorders.

The Colorado model is based on data about treated individuals. Because many psychiatrically vulnerable homeless individuals do not participate in any treatment system, let alone the state-run one, additional strategies would have to be developed for including the nontreated ill. One possibility could be intensive sampling at programs that are not included in the state system, such as privately-run drop-in centers, sit-ups, soup kitchens and other services. Another would be to sample street people and shelter users in targeted areas, using substudies to determine what percentage actually used state services. While such data are not easily obtainable, the above-mentioned data-gathering methodologies are feasible, if properly carried out.'

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[5] See random sample surveys that have included street dwellers (Koegel and Burnam, 1988a and b) and in-depth studies of street and sheltered homeless adults with severe psychiatric disorders (Barrow, Hellman, Love11 et al, 1989).

Application of this model may be more feasible in states with smaller mental health systems. Nevertheless, as a conceptual model, it pushes us to thinking about ways to link individual-level mental health characteristics and the broader context of social needs and environmental factors with which they interact. Homelessness and its effects are so pervasive and complex that responses can no longer be built only around the characteristics of homeless individuals.

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# Assessing Mental Health Status Among Children Who Are Homeless

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In this workshop we review some of the instruments and issues in assessing the mental health of children, with a special emphasis on the development of empirically strong diagnostic instruments. Empirical findings illustrating prevalence, age differences and risk factors relevant to the population of children in homeless families are given. We then review some of the related assessments of functional level that should be considered for research on children in homeless families. Finally, we review some of the special issues and problems encountered in research on this population, with recommendations for coping with these problems.

## Symptom Checklists and Screening Measures of Children's Problems

A major issue in the assessment of children is from whom the information regarding children's symptoms, impairment, and functional level will be collected. As shown in a recent comprehensive review by Achenbach, et al (1987), the various sources of this information - parents, children, teachers, or mental health professionals - usually agree rather little, especially in populations not actively seeking treatment. The most widely recommended solution to this problem of disagreement is to seek information from as many sources as possible. Which sources are in fact available will be, of course, partly a function of the age of the child as well as of the particular population being studied. In early childhood parents are the primary source of such information, and it is fairly well established that mothers are more likely to note and report problems than are fathers. For children in middle childhood it is widely agreed that data from teachers should be used to supplement reports from parents. By late childhood and adolescence reliable and useful information can and should be obtained from the children themselves, as well as from parents. As children enter junior, and especially senior high school, it is less and less likely that detailed description of symptoms and problems will be obtainable from schools.

One important consideration in the selection of assessment measures is the availability of some kind of normative data based on the instruments. Table 1 presents scaled or screening measures of psychopathology in children as reported by parents or teachers. These may be described as established instruments in the sense that at least some normative information is available. It should be noted that these measures cover the youngest age groups of children, an issue likely to be relevant in research on homeless families. The Richman scales have been used in epidemiological studies both in the US and in the UK, and as can be seen by their relatively few items, cover a broad spectrum with little room for discrimination of specific types of problem. The other measures include more specific measures of types of problems, as well as an overall score. The Child Behavior Checklist has been developed with special forms for the preschool age groups, and is the single most thoroughly normed instrument.

Exhibit 3.1 also presents some of the most commonly used instruments for children's self-report of problems. In administering these measures to younger children it is generally necessary to have an interviewer or teacher read the items aloud. Only two measures attempt to cover more than a single domain of problems, the CBCL and the Children's

EXHIBIT 3.1

CHECKLISTS AND QUESTIONNAIRES

| | Age of Child | | |
|---|---|---|---|
| | Parent Report | Teacher Report | Self Reoort |
| Behavior Screening Questionnaire<br>Richman and Graham (12 items) | 2 - 5 | | |
| Preschool Behavior Questionnaire<br>Rlichman, Stevenson, and Graham | 3 - 6 | | |
| Behavioral Problems Checklist<br>Quay and Peterson (89 items) | 5 - 17 | 5 - 17 | |
| Conners Parent (Teacher) Rating Scale<br>C.K.Conners (93 and 39 items) | 6 - 14 | 4 - 12 | |
| Child Behavior Checklist<br>Achenbach and Edelbrock<br>(138 and 126 items) | 2 - 18 | 6 - 16 | |
| Revised Children's Manifest Anxiety Scale<br>Reynolds and Richmond (62 items) | | | 6 - 19 |
| Children's Depression Inventory<br>Kovaks (27 items) | | | 8 - 17 |
| Short Children's Depression Inventory<br>Carlson and Cantwell (13 items) | | | |
| Children's Inventory of Anger<br>Nelson and Finch | | | 9 - 13 |
| Child Behavior Checklist - Youth Report<br>Achenbach and Edelbrock | | | 11 - 18 |
| Children's Self-Report Psychiatric Rating Scale<br>Beitchman et al. (33 items) | | | 7 - 12 |
| Self-Reported Antisocial Behavior<br>Loeber et al. (33 items) | | | 6 - 14 |

Self-Report Psychiatric Rating Scale. The CBCL covers material approximately parallel to that covered in the parent and teacher report versions. The Beitchman et al scale is more global, having been developed to discriminate broadly between community and mental health treatment samples. A recent volume on the assessment of children (Rutter, Tuma, 1988) is recommended for more detail on most of these instruments, as well as a discussion of issues to be considered in their selection.

## Diagnostic Interviews for Children

Over the past decade or two much work has been carried out in the effort to develop psychiatric diagnostic instruments for the assessment of disorders in children by parental and child interview. These interviews have several properties that commend their use: (1) They emphasize problems at the severe end of the distribution, (2) The probes for functional significance, severity of distress, frequency and duration, and associated impairment incorporated into these interviews should improve the quality of the responses, (3) They permit the counting of children with problems, and thus can be more immediately translated into service needs, (4) They encourage identification of risk factors in an epidemiological framework, thus allowing for relevant indices such as attributable risk, (5) They allow fairly fine differentiation on the nature of the problem, and (6) Because they can yield scaled measures as well as diagnoses they permit flexible analytic models. Perhaps their greatest drawback is that they are relatively time-consuming, ranging between 45 minutes and two hours for different interviews in different populations, if given in their entirety.

Alternative approaches to interview construction and characteristics of these instruments can be understood by examination of the dimensional scheme given in Exhibit 3.2. In this exhibit, five commonly used interview schedules are compared according to the degree of structure of the interview. The more clinical interviews, e.g. the K-SADS, are the least structured, while those designed for administration by lay interviewers in epidemiological studies, e.g. the DISC and DICA, are highly structured. The degree of structure is determined by the intended purpose of the interview and, of course, reflects the training of the interviewers (Exhibit **3.3),** and consequently the expense involved. Clinicians who are accustomed to apply judgement and make discriminations on the basis of their experience prefer a more semi-structured format, whereas lay interviewers usually rely on the questions in the interview itself for these discriminations.

## Criteria for Assessing the Adeauacv of a Diagnostic Instrument

In the development of these measures, methodological studies are required to determine the inter-rater reliability, test-retest reliability and validity. Inter-rater reliability is commonly assessed by having two interviewers rate a videotaped interview that they have not previously seen or conducted. This type of reliability is usually sensitive to training, and if inadequate, can often be improved through further interviewer training. Test-rest reliability is generally lower than inter-rater reliability, and is influenced by a number of factors: (1) true change in clinical state, (2) length of retest interval, (3) testing effects (modification of responses based on experience with the interview), and (4) boredom leading to nay-saying. In comparing test-retest characteristics across instruments, it is important to consider such factors and how they may differentially influence the reliability results reported. Validity is problematic to assess for these diagnostic interviews, since a true diagnostic standard is lacking. Designs comparing a new measure against a single clinician interview have yielded disappointing results, which are probably attributable as much to error in the clinical evaluation as to lack of validity of the measure in question.

EXHIBIT 3.2

CHILD PSYCHIATRIC DIAGNOSTIC INTERVIEWS

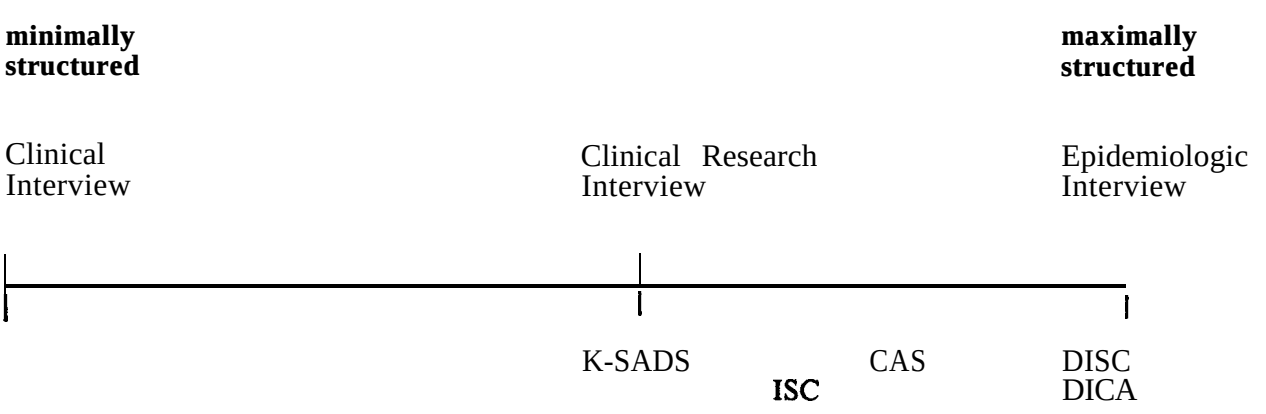


EXHIBIT 3.2

DIAGNOSTIC INTERVIEW CHARACTERISTICS

| | K-SADS | CAS | DISC |
|---|---|---|---|
| Type | Semistructured | Semistructured + | Structured |
| Ages | 6 - 18 | 7 - 17 | ? - 17 |
| Time | 60 - 90 | 60 | 60 - 90 |
| Interviews | Clinician | Clinician | Lay |
| Training | Extensive | Moderate | Moderate |

## The Development of the DISC

The Diagnostic Interview Schedule for Children (DISC) is an epidemiologic measure that has been in development for almost 10 years. It has been subject to several revisions and field trials at Western Psychiatric Institute (Pittsburgh), Columbia University and Yale University. The most recent revision project, conducted at Columbia, involved an item-level examination of the previous instruments with rewriting of unreliable and non-discriminating questions. The product of that effort (DISC-Revised) was tested in a test-retest design on a clinical sample of 11 to 17 year olds and their parents. Results of that study indicate that:

1. It is more reliable over time than clinical assessments.
2. It yields clinically reasonable diagnostic frequencies.
3. It demonstrates excellent inter-rater reliability.
4. It is acceptable to subjects.
5. It can be used with a deprived, poorly educated sample.

Unresolved issues involve:

1. Correspondence to clinical diagnoses
2. Applicability to children under 11 years.
3. Diagnostic performance for rare disorders.
4. Optimal methods for eliciting information about symptom duration and onset.

Plans have been made for further methodological studies to address these issues. A copy for distribution will be available from the Epidemiology and Psychopathology Research Branch of NIMI-I later this year.

Current developmental work on the diagnostic algorithms accompanying the DISC and other instruments. Interviews have traditionally used a variety of different methods of combining information from different sources to arrive at diagnoses. The K-SADS calls for a single interviewer to interview both parent and child, and to arrive at a decision with regard to the child's true status on each diagnostic criterion. Some interviews produce independent diagnoses from child and parent interview, combining them (as either or both) subsequently as necessary. More clinical instruments may not formally specify the way that the interviewer should combine the information. Most structured interviews, and increasingly the semi-structured ones as well, use computer algorithms to determine diagnoses from interview responses. Current empirical work on the DISC is being carried out to produce diagnoses based on a combination of all available evidence for each child. These diagnoses will also specify the degree of diagnostic certainty and severity.

## Some Empirical Fiodioes Based on the DISC Relevant to Research on Children in Homeless Families

**A brief** review of three areas of recent research using the DISC may serve to illustrate its potential utility. As shown in Exhibit 3.4 (adapted from E. Costello, in press), despite variations in estimated rates of certain specific diagnoses in populations differing in age span, geographical location, and other characteristics, there is fairly close agreement

EXHIBIT 3.4

PREVALENCE OF DISORDER IN GENERAL POPULATION SAMPLES

ESTIMATED SEVERE CASES PER 100 CHILDREN*

(N = 776 - 789)

| STUDY: | Anderson et al. | Bird et al. | Cohen et al. | Costello |
|---|---|---|---|---|
| SITE: | New Zealand | Puerto Rico | Upstate New York | Pennsylvania (HMO) |
| AGES: | 11 | 4 - 16 | 9 - 18 | 7 - 11 |
| Attention Deficit Disorder | 7 | 10 | 4 | 2 |
| Conduct Disorder | 3 | 2 | 4 | 3 |
| Oppositional Disorder | 6 | 10 | 5 | 7 |
| Separation Anxiety | 4 | 5 | 5 | 4 |
| Overanxious Disorder | 3 | NA | 2 | 5 |
| Depression | 2 | 6 | 3 | 2 |
| Any Severe Diagnosis | 18 | 18 | 18 | 22 |

*Adapted from Costello, E.J.

on overall rates of any diagnosable severe disorder (18-22%). These findings strongly suggest that serious disorders will be found at readily detectable levels in any population, and are particularly likely in high-risk populations.

Recent analyses of a large epidemiological sample originating in upstate New York show that rates of disorders should be assumed to vary for youth in different age and gender groups. Diagnoses used in these figures were made at either the moderate or severe symptomatic level, and thus illustrate the potential utility of assessing rigorously defined diagnostic groups at multiple levels of symptoms and impairment. These figures also suggest a problem in any research design that relies on normative data for comparison to a sample differing in proportional representation of age-gender groups.

Data from our study of over 800 families sampled from upstate New York provide evidence of differential rates of conduct disorder, attention deficit hyperactivity disorder, and major depression associated with low income, single parent families, and welfare status. In general, these findings are consistent with those of other contemporary investigators, showing that children who are poor or from single-parent families, or from families supported by welfare are two to four times more likely to suffer from diagnosable mental disorder.

Recommendations Reeardine Measurement of Adantive Function and Assessment of Degree of Imnairment

In general, it is highly desirable that in addition to assessing mental disorder in children, measures of the levels of adaptive functioning, or conversely, impairment in adaptive functioning should be assessed. It is likely that no single measure will be sufficient to cover all aspects of adaptive function relevant to the aims of a given study, however two widely used and relevant measures deserve special mention here. The first is the set of revised Vineland Adaptive Behavior Scales. These measures, designed for semi-structured interviews of mothers, cover activities and skills of children virtually from birth through adolescence. They are organized according to domains of functioning, e.g. communication, daily living skills, and they yield scores in these individual domains, as well as an adaptive behavior composite score.

Another widely used, albeit more specialized measure is the Social Competence section of the CBCL. This measure covers the child's participation in jobs or chores, sports, hobbies and arts, and organizations, along with an estimate of the level of performance in these activities. As is true for the CBCL more generally, an advantage of this measure is the careful collection of norms for individual age and sex groups.

It will probably always be crucial to collect information on the level of school achievement, as poor achievement is consistently one of the highest correlates of serious emotional or behavioral problems in childhood. In addition, three other aspects of school function are likely to be particularly relevant to children in homeless families. First, school attendance or truancy is very often an issue, and may also be related to problems of changing schools when becoming homeless. Second, it will be important to record whether the child has been in trouble with the school authorities to a degree that has resulted in school suspension, expulsion, or other disciplinary action, or in placement in a special class. A third aspect of the adaptation of the child to the school may only be obtained by self-report. This aspect reflects the attachment or alienation of the child to the school, with potential associated feelings of low school-related self esteem, low aspirations, and poor connections to other students.

Another very important risk factor for mental disorder in childhood and adolescence is peer rejection or neglect. The best way to obtain this information is

probably through sociometric measures obtain from the child's school class. Unfortunately, this kind of data is extremely difficult and expensive to obtain unless the targets of the investigation attend relatively few schools. Obviously it is very important to gather such data from classes (and teachers) blind to the study objectives and target children. When sociometric data are not feasible, information from parents, teachers, and youth may be pooled to provide reasonably good estimates of social integration of children.

The presence of a constructive relationship with at least one parent or other adult is another potentially important aspect of adaptive function. It may be difficult to separate problems in this area that are attributable to parental stress or psychopathology from those attributable to problems originating in the child. Nevertheless, the potential importance of this factor in predicting long-term outcome recommends its use.

Another aspect of child adjustment that may not be reflected in measures of symptoms or diagnoses is morale. There is now accumulated evidence that good morale and an optimistic outlook are indicators of positive mental health, even when optimism is clearly not warranted.

## Some Special Problems Encountered in Research on Children in Homeless Families

Our pilot work interviewing children and mothers in temporary residences for homeless families has led us to identify a number of areas requiring special attention. Although many of these issues are appropriate considerations in any research on children, some are especially difficult in this population.

The first problem we encountered was in locating a quiet, safe, private, and comfortable place to carry out interviews of mothers and children. At least in our urban setting, homeless families are not likely to participate on a broad scale if you require them to come to you. On the other hand, unless all children are in school, it will be very difficult for you to interview even the mother in the single room that the family typically occupies. It is essential that children and parents be interviewed separately if uncontaminated data are to be obtained. Therefore, it will generally be necessary for you to arrange for a suitable setting as part of the research plan, and very often babysitting arrangement must be included as well.

Do not try to plunge into the assessment of the child at the beginning of the interview. These families are under stress, and are unlikely to see your targeted concerns as their most pressing problems. Begin the interview with questions that allow them to air their problems as they see them. Begin the section on the child with a description of the child's day, activities, and problems as seen by the (child or parent) respondent.

It is likely that most of the time it will be difficult or impossible to cover the entire diagnostic spectrum in addition to assessing the other aspects of child and family function that are needed. Select specific diagnoses most relevant to the aims of your study.

Information on children obtained from mothers in such high-stress situations is likely to be less valid than under more ordinary conditions. Our impression in pilot interviews was that mothers were so involved in problems connected with the logistics of daily living, in addition to their own experienced feelings of stress, fear, and boredom, that they were not likely to be attuned to nuances of their children's emotional state. In addition, mothers may be motivated to hide the child's behavior problems, and perhaps accent or project high levels of emotional problems. Even when parents are assured that their responses will not bear on the timing or nature of housing availability or any other services they may well not believe you, or may still be inadequately motivated to respond objectively. These problems with what is usually considered the single best source of

information make it highly desirable that information is also gathered from both teachers and children. When teachers are interviewed it will also be important to keep them blind with regard to the targeted study aims and population, whenever possible.

We also found that children in homeless families were very often somewhat developmentally delayed, including language functions. These problems mean that you will need to pilot the measures to be collected from children on members of this population to be sure that they will be able to cope with materials developed for more general populations of the same age. These various problems with the usual sources of information also imply that it would be highly desirable to build in checks on the reliability and validity of the assessment procedures, rather than relying on such data from normative samples.

As noted, it will virtually always be important to include data on school performance and adjustment. In addition, it is likely to be desirable to develop indicators of when and how children are able to cope adaptively with this unfortunate family situation. One common pattern we found in our pilot work was role reversal between mother and child, where children take responsibilities mothers aren't up to, and serve as confidante to the mother.

One problem with measures designed to tap symptoms and other indices of problems is that the interview can be quite depressing for the respondent. Data are likely to be much improved when questions with neutral or positive content are interspersed to break up response sets. It is especially important to include positive material at the end of the interview, both to improve morale and to increase the likelihood of agreement to participate further.

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# Research Issues for Homeless Families

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Mental health researchers and many observers of the homelessness problem in America share a common problem -- they are both prone to making the fundamental attribution error (cf. Ross, 1977). The error has to do with differences in perspective when viewing one's own versus another's behavior. It is the assumption that others are responsible for what happens to them, while what happens to ourselves is a function of the situation. In the case of observers of homelessness, the mistake often is to blame the victims of homelessness for their problem, rather than the situation of poverty, lack of housing, and health status (cf. Brickman et al., 1982). Researchers (particularly those interested in gaining government support for their research), make the opposite error. Each of us -- particularly if unsuccessful in obtaining support for our ideas and research -- believe that the review process and "system" is at fault. The goal of this presentation is to help you avoid the need to make such attributions and develop successful proposals.

There are two components to this discussion of what makes a good research proposal for studying family homelessness. The principal ingredient of a superior proposal is a good question/idea. Although it is perhaps trite to suggest that the question is essential, it is not always clear that in developing a proposal one gives appropriate attention to the alternative ways in which the question might be formulated. Our focus here is on refining your questions so that they are both important (for understanding homelessness, as well as mental health conditions) and testable. The second ingredient of a fundable proposal is the quality of its methodology. Since methods need to be subservient to the idea being tested, the view expressed here will be that the appropriateness of the methodology can only be evaluated in light of the idea or construct being tested.

## Conceptualization

If the review process is functioning properly, the primary criteria used to evaluate your proposal will be how well you have formulated a specific problem associated with mental illness and homelessness, and how well you have developed a testable model of the processes that address your problem. Developing such a testable model is not an easy task and any evaluation of your conceptualization is, necessarily, subjective. There may be honest, and strongly felt, differences of opinion among scientists about the reasons for particular problems. As evidenced by the recent Institute of Medicine (IOM, 1988) report on homelessness, it is clear that there are competing views about the role of mental health factors. One hopes that reviewers, whatever their natural theoretical prejudices about these issues, can assess your ideas relatively objectively.

One way in which you can insure that your ideas will be given a "fair" assessment is to make as clear as possible the way in which you understand homelessness (the problem), the homeless who are your focus (the target population), the role of intervening variables, and your explanation of the process (the construct). An example of how a problem, target population, intervening variables and construct can be explicated is illustrated by some of our own recent research involving familial abuse and homelessness:

- Problem: Is a history of familial abuse (including physical or sexual abuse in childhood or adulthood) a psychological risk factor for homelessness among poor women with children?

- Target population: A random sample of homeless mothers located in a particular geographical region; and, a comparison sample of housed poor mothers matched on age, ethnicity, and number of children.

- Intervening variables: The psychological characteristics that might mediate between experiences of domestic violence in childhood and adulthood and homelessness include interpersonal difficulties (manifested as social isolation) and a sense of learned helplessness (manifested as manifested).

- Construct: This study would address the hypothesis that for poor women with children, past experiences of familial abuse, mediated by interpersonal difficulties and learned helplessness, increases the risk of becoming homeless. Research evidence indicates that victims of physical and sexual abuse often lose their ability to trust others or to feel that they have control over what happens to them. As a result, they sometimes become quite isolated and depressed. The theoretical construct underlying this study would be that those survivors of familial abuse who become socially isolated or depressed will have a great deal of difficulty accessing supportive mutual aid networks in times of extreme need. The absence of such networks, coupled with material poverty and the current housing shortage, place these women at risk for homelessness.

Although being clear about one's model and to whom it applies is probably essential for any research proposal, it is especially important in a new area, such as family homelessness. There are a host of competing explanations for the problem (including explanations that suggest that the problem does not exist) and the field is not mature enough for many of these ideas to have been subjected to rigorous testing.

It is not possible to present didactically the way in which one goes from one's understanding of a problem to a description that can be the basis of a research proposal.[1] Instead, one can only take one's ideas and try to insure that there are logical connections among the elements. Usually critical in this process obtaining feedback from others -- those both intimate with your program and those not familiar with it. Particularly valuable is feedback from others who do not share one's perspective on homelessness. Obtaining such feedback is, perhaps masochistic, but it is better than receiving the same type of response from an NIMH review committee.

## Methodoloev

No matter how flawless one's conceptualization of the problem and specification of a model explicating relationships among hypothesized variables, justifying research support involves demonstrating that your methodology has a reasonable chance of success in answering questions posed by your analysis. Although, to some extent, methodological criteria are universal and should be objectively applied to any research endeavor, in fact, "science in practice" is somewhat different than "science in theory". As with conceptual issues, this problem is exacerbated when conducting research in an area such as family homelessness, given the lack of widely used research protocols.

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[1] In the workshop, we conducted an exercise with participants. Several volunteers allowed their ideas about research proposals to be discussed and evaluated by the group. Instead of recreating that discussion in this document, we have "worked-through" our own illustration.

Limits of methodology. There is, unfortunately, considerable misunderstanding about the role of methodology in evaluating research proposals. There is, what we will characterize as the "good paint paradox". A belief exists that rigorous methodology can cover-up conceptual blemishes and that one's methodology can help to fix problems in how one thinks about the problem. The paradox is that not only is such a belief inaccurate, but good methodology often has the opposite effect --it helps to uncover the problems in one's thinking about a problem.

An extreme, but pervasive reflection of this belief is the emphasis on true experiments (cf. Cook & Campbell, 1979; Saxe & Fine, 1981) to evaluate ideas and interventions for the homeless. Randomized experiments are the sine qua non of research and, undoubtedly, provide the most unequivocal tests of hypotheses. They are not always feasible, however, and their use has to be matched with the needs of the problem. Given our state of understanding of homeless families, there will be many situations that are not yet ready for such methods.

Alternatives to true experiments are not, by definition, inferior and can often yield valid information about the problem and intervention. What is important to recognize is that the most serious inferential problems of quasi and non-experimental research can sometimes be overcome by collection of additional data. In fact, given the nature of some specific problems, this is often the only viable option. The relationship between validity and the amount of data/ design rigor can be expressed as: Validity = Design Rigor X Amount of Data. Valid research results when appropriate data and an appropriately rigorous design are used.

Research is typically divided into three groups, according to the type of design -- case studies, quasi-experiments, and true experiments. To illustrate the trade-offs and decision making necessary in selecting an appropriate design, the three types of research designs are discussed below in terms of studying family homelessness.

Case Studies. Assume that one was interested in understanding the mental health problems of homeless women and the impact of homelessness on their children. It would not be unreasonable to begin to study that problem by visiting, perhaps becoming a participant observer, in a shelter for homeless women. One could imagine research of this genre leading to detailed descriptions of the experience of homeless women and their children. If conducted by a psychologist, the descriptions would no doubt be different than those of a journalist (e.g., Kozol, 1988) and are potentially important in increasing our understanding of the problems and mental health needs of homeless families.

It is likely, however, that such a study would not be fundable by NIMH, at least as a standard investigator-initiated grant. One would have to make a very strong case that our understanding of the problems of homeless women and children is tabula rasa and that such descriptive, case study, research is essential. It is unlikely, though, that such arguments would be successful, as we do know a fair amount about the experience of these families (see, e.g., Bassuk, Rubin & Lauriat, 1986). Furthermore, even if one's description was exquisitely detailed (see, e.g., Hirsch, 1989), its general utility would still be considered low, since only one shelter and a very small group of homeless were studied.

The problem with case studies, is not that they are inherently inferior, it is that the data necessary to make them truly useful is probably beyond most investigator's ability. It is often too costly and infeasible to study diverse shelters and homeless populations. With only a single site and one type of family (homeless), it is difficult to understand the reasons for particular observed problems.

The "bottom line" is that there are other, more efficient, means to conduct research where the need is for generalizability. Limited case studies are probably most useful when our knowledge is nil. That situation, even in the case of family homelessness does not really exist and more focused and efficient designs are probably warranted.

Quasi-experiments. More likely to be fundable are quasi-experimental studies. Such investigations require a somewhat sharper focus than case studies and involve some type of comparative assessment. Thus, for example, a quasi-experimental study might be developed comparing homeless and housed children in terms of their cognitive development. The validity of such a design will depend on a number of factors; most importantly, how confident one can be about differences between the two groups of children.

There are probably a number of differences between a group of homeless and housed children. Potentially, they are markedly different in socio-demographic background, intellectual abilities, and history of mental health problems. The extent to which any of these factors invalidates the research is a central issue for the investigator to consider. Criticism can be muted by obtaining data that indicate, for example, that the prior to being homeless, children in this group were not poorer school achievers. Or, by providing data that the families in each of the groups are equally poor.

Although one cannot be entirely confident in attributing cognitive development effects to homelessness, there may be no alternative. Only in rare situations would one be able to assign children randomly to a homeless or non-homeless condition. There may, however, be creative ways of reducing validity threats and the non-equivalent control group method (such as a comparison of homeless and housed children) is only one means. There are a host of alternative methods, including the use of interrupted time series (collection of longitudinal data prior and post-homelessness) and the use of cross-lagged correlation methods.

It should also be recognized that validity is, in part, dependent on the strength of the construct. If one has a detailed model of the relationship among homelessness and various cognitive development conditions, it will be far easier to rule out alternative explanations. The better one's understanding of the problem, the easier it will be to collect information and draw inferences.

True Experiments. For some questions related to family homelessness, it is not difficult to conceive of the use of true experimental designs. For example, if one has developed a mental health program or service to aid homeless families, it is not difficult to think of randomly offering it to some families and not others. This may be especially appropriate if the funding available for the program is limited and it will not be possible to make it available to all those in need. It is an attractive possibility because it seems to afford instant respect in the scientific community and reduces the requirements for data collection.

The data collection issues are particularly important. Since we can assume equivalence in the groups, data to rule out alternative explanations is unnecessary. Although significant issues of statistical power exist, especially for variables which are effected in subtle ways, the number of subjects and sensitivity of instruments probably have less strict requirements in true experimentation.

The use of randomized designs is not, however, without problems. Perhaps most importantly, they may not allow one to do the most important theoretical tests of the etiology and maintenance of family homelessness. If, for example, one is interested in examining the relationship of violence to homelessness and the degree to which pathological conditions play a role, it may simply be infeasible to conduct such research as a true experiment -- random assignment to conditions of violence is not possible, It may

not be until one has developed an intervention to deal with homeless individuals who have histories of violence that a randomized test (although not necessarily a field test) of its efficacy is needed and possible.

In addition, although true experiments allow a mechanical testing of two different approaches, if one does not have a good conceptual sense of the differences between the approaches, such a test may be of limited value. In some cases, if one does not understand the precise relationship between the independent and dependent variables (including mediating factors) it may not even be possible to conduct the study successfully. For example, if one has designed a program to improve the self-concept of homeless children, the study can only be conducted if you have a relatively precise understanding of how many children, and in what circumstances, exhibit self-concept problems. The intervention may just not be applicable to the study population that you have selected.

## Developing Usable Knowledge

The goal of your research proposal should be to develop new knowledge about family homelessness. Hopefully, the information that will be generated by your study will be useful to other researchers and to practitioners struggling with how to aid this population. What should be clear from the present discussion is that developing a research program is a complex task involving the interweaving of a theoretical analysis of the problem with an appropriate set of methods. Unfortunately, it is not possible to specify precise criteria either for an adequate theoretical analysis or for appropriate methods. Both are a matter of judgment -- the "trick" is to maintain a focus on the distal goal (improving our understandings of the mental health problems of homeless families) while attending to the proximal goal of reviewing current knowledge and developing a specific research design.

What, perhaps, should be kept in mind as one develops a research design is the old adage that "today's confound is tomorrow's independent variable". That which confuses and makes difficult the present research study is often the variable that one must focus on in a future study. Understanding the mental health problems and the aid needed by families who are homeless is not going to be accomplished by a single research study. The problem is a multivariate one and will require concentrated programs of research, to understand. The benefits, both to those who are victims of this 20th century social failure and to the mental health sciences, are immense.

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# Section IV

## ORGANIZATIONAL AND SYSTEMS STUDIES

## **Financing and Reimbursement** Issues

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and

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In our workshop we divided our topic into two sections, one devoted to financing income support and health care services, including mental health services, and the other devoted to financing housing. Each section is presented separately, reflecting the workshop process.

There was little discussion and only some review of research design and findings in our workshop. The majority of the effort was focused on a review of the various financing mechanisms available to the homeless mentally ill. It was our hope that by becoming familiar with financing mechanisms and current policies, investigators would identify new topics for research and would better understand the financing policies that influence the lives of the homeless mentally ill. We reviewed programs, describing the incentives created by each, in terms of the supply and demand for housing and other human services.

Although the presentations were separate and distinct, the presenters are joined by a mutual interest in evaluating programs for the homeless mentally ill. In particular, both are involved in the National Evaluation of the Robert Wood Johnson Foundation - U.S. Department of Housing and Urban Development Program on Chronic Mental Illness, a demonstration program in 9 cities in the United States. The homeless mentally ill population is a special focus of the demonstration. The materials presented in our workshop form the information foundation of our research. We did not review analytic techniques, such as cost-benefit analysis, or the findings of our research. Our goal was to share a base of information with workshop participants to enhance their research capacity in the area of financing housing and other human services.

### Income Support, Health, and Mental Health Services

The two most important resources (other than housing) in the care of the homeless mentally ill are income support and health care services, especially mental health care services. Research focused on these resources must consider how they are financed. The focus of this presentation was on the public financing of income support and health care. As in the case of the discussion of housing finance, a presentation on income support and health services considers both demand-side and supply-side programs. By their nature, income support programs, such as the disability benefits programs described below, are demand-side supports, providing purchasing resources for individuals to meet their needs through demand in the marketplace. In contrast, although some health care finance programs, such as insurance, provide resources to beneficiaries to purchase (demand) services on their own, other health care financing programs place the resources in the hands of providers, placing them at risk (or making them responsible) for supplying care to the homeless mentally ill. Each approach creates its own incentives and has its benefits and limitations.

The brief discussion, below, reviews some of the most important finance programs affecting the homeless mentally ill, identifying some areas for research.

**Income Support · Disability Pronrams.** Both the Social Security Administration (SSA) and the Veterans' Administration (VA) operate disability programs providing income support to the homeless mentally ill. SSA manages the Social Security Disability Insurance (SSDI) Program, an early retirement program for disabled workers who have paid premiums through FICA withholdings, and the Supplemental Security Income (SSI) Program for the elderly and disabled poor who have not paid premiums into SSDI. The criteria for disability are identical for both SSA programs. The statutory definition of disability is quite strict, requiring a medically determinable physical or mental impairment of 12 months duration which precludes substantial gainful activity (ie, competitive employment). SSDI also entitles beneficiaries to coverage by Medicare, after two years of eligibility status; SSI immediately confers eligibility for Medicaid benefits in almost two-thirds of the States. The VA has a disability program that compensates partially and totally disabled veterans. VA disability status confers special privileges of access to VA health care and other services. [Several VA programs are discussed elsewhere in this volume (see Rosenheck) and are not the focus of the remainder of this presentation.]

SSDI and SSI pose several special problems for the homeless mentally ill. A number of potential solutions suggest research opportunities for investigators:

1. Many mentally ill disabled individuals who were entitled to benefits were removed from the SSA rolls or were denied benefits during the early 1980's. In spite of changes in policy and court cases in their favor, not all of them have been reinstated. Some of them have significant "back benefits" awards due to them. It is presumed that many of the disabled denied access to income support from SSA became homeless; many cannot be located. Efforts to assist this population have been offered by SSA and by advocacy groups. Perhaps foremost among them is the Mental Health Law Project, overseeing the settlement of a class action suit in New York City. Investigators may wish to study attempts to locate the homeless mentally ill beneficiaries of SSA, or they may study the use of their back benefits. In New York, assisted by a grant from the Robert Wood Johnson Foundation, the Mental Health Law Project is trying to help the homeless mentally ill become equity partners in their own housing. Study of these populations can tell us much about the natural history of homelessness and the role of the SSA disability programs in providing income support.

2. An SSA requirement that beneficiaries have a fixed address for receipt of checks represented a "Catch 22" for the homeless mentally ill, often homeless because they couldn't receive their SSA entitlements. Recent attempts to appoint "representative payees" to receive benefits on behalf of SSA beneficiaries have not been studied in any detail.

3. Work disincentives were created by SSA's regulations that denied benefits to individuals as soon as they tried to return to work; reinstatement was often laborious. New regulations reduce these disincentives with a "trial work period" of up to 15 months and rapid reinstatement policies. SSA has not uniformly implemented these regulations. This is another area for research.

4. It often takes a long time (120 days or more) from the time an individual applies for benefits and the time he or she is notified of SSA's determination. Special procedures have been developed by SSA and its State offices - to flag cases of the mentally impaired and to train case managers to provide relevant data for the determination process. Preliminary studies in Ohio suggest that the time can be greatly reduced (to an average of 45 days). Further study is underway as a part of the Robert Wood Johnson Foundation 9-city demonstration. Other sites may develop similar interventions and should be evaluated.

Health and Mental Health Services Demand-side benefits are provided by the public sector in the form of Medicaid coverage and Medicare outpatient benefits. (Medicare's prospective payment system for hospital services is a supply-side payment system.) The principal value guiding policy in these programs is cost containment. Preliminary evidence suggests that efforts to reduce the length of stay in hospitals for Medicaid beneficiaries has been successful but at the expense of increasing referrals to state mental hospitals (and perhaps into homelessness). (Frank and Lave, 1985) Medicaid and Medicare have favored inpatient over outpatient benefits, and alternatives to traditional medical office practice have not been uniformly covered. Changes in benefit design, especially waivers allowing case management services, off-site visits to homeless patients in shelters, and so-called "clinic and rehab option" services, have all been instituted in an effort to increase the flexibility in benefits to expand coverage efficiently. Considerable research is required to evaluate these efforts, to design rational benefits for the homeless mentally ill, and to define "efficient practice." Perhaps the most pressing problem in the era of cost containment is to be able to distinguish under-treatment from efficiency. Further investigation of the impact of cost containment policies on patterns of treatment and quality of care are critical for assessing current policy - both for demand-side as well as supply-side financing mechanisms.

The concern about under-treatment is even greater for supply-side policies than for demand-side policies, because of the incentives inherent in supply-side policies, such as prospective payment, to provide less care. Efficiency may simply be a disguise for inadequate care. Medicare's prospective payment system has been an important focus for this area of research. Little is known, although speculation abounds, about the extent to which homelessness among the mentally ill may have resulted from the strong incentives of prospective payment mechanisms. Much has been said about the potential benefits of capitation financing on reducing duplication of services and improving continuity of care. Equal concern, however, must accompany these expected efficiencies, concerns about the impact of limited resources on the adequacy of care provided to the indigent mentally ill, the homeless, in particular. Not only true capitation is a source of concern, but also program budgeted programs such as those offered categorically by State and county mental health programs. Community programs may be expanding at the expense of hospital care - or vice versa - given fixed resources shared between all service providing agencies. A new concern for policy-makers and investigators, alike, is the impact of the nursing home reform components of the Omnibus Budget Reconciliation Act of 1987. Provisions of this bill threaten to remove mentally ill residents of nursing homes and to deny access to others. There is widespread fear that these new regulations may result in increased homelessness among the mentally ill.

Although many of the policy problems and research questions associated with them are generic to the mentally ill, in some sense the problems that current policies pose for the homeless mentally ill sharpen the larger issues. The homeless are among the most disenfranchised of the mentally ill. They test the limits of financing policies and highlight their inadequacies. Investigation in this area can verify the scope and depth of the problems of the homeless mentally ill and may assess the efficacy of interventions designed to correct those problems. It is a fruitful area of research that may produce humane, as well as scientific, benefits.

## Housing

One logical approach for thinking about housing subsidy programs is to first identify the major costs of providing housing, and then assess whether there are subsidies potentially available to defray these costs, and the depth of these subsidies.

Costs vary depending upon whether housing is newly constructed, rehabilitated or acquired (rented). As shown in Exhibit 4.1, the major cost centers for housing producers or providers include land costs, "hard" costs (i.e., construction costs), "soft" costs, and operating costs; for housing consumers, the main costs are rents (or their equivalent for owners). This division provides a convenient tool for considering housing costs and housing market activities, namely, to categorize them into supply-side costs or activities, and demand-side costs or activities. Housing cost interventions on the supply side would provide attractive financing for those activities that are associated with getting housing units built and to support the costs of operating them; for example, low-interest loans or grants for construction or property rehabilitation, tax incentives that make investment in housing production competitive with, if not more attractive than, other investment options or guaranteed rent streams of sufficient quantity to assure that the property can be maintained and the debt serviced. In contrast, demand-side interventions would increase the consumer's ability to pay for housing, such as by rent subsidies or, in the case of homeowners, significant tax breaks. (See Exhibit 4.2).

Housing consumers have potentially much to gain from supply-side subsidies, as do housing suppliers from demand-side subsidies. The fact that a tenant receives a government subsidy which essentially guarantees a rental stream to the owner of the property over some period of time can also be viewed as an operating cost subsidy for the property. Similarly, housing consumers stand to benefit from subsidies that induce the production of housing, particularly if these subsidies are tightly targeted on market segments that are not currently well-served or not served at all, as in the case of the homeless.

A practical rule of thumb for distinguishing supply- from demand-side housing subsidies is by identifying whether the subsidy stream is attached to the structure or housing unit, or whether it is attached to the household. The former are generally subsidies for supply; the latter, for demand.

Until about 1981, the federal government subsidized both types of housing interventions. In fact, by the end of 1980, it had provided subsidies for the construction or rehabilitation of more than 2 million housing units. But since that time, the almost exclusive focus has been on the demand-side, through the Section 8 Housing Certificate Program and the Housing Voucher Program.

There are two additional features of federal housing subsidy programs that are fundamental to understanding how such programs operate, and for whom. First, unlike income support programs or health benefits, housing assistance is not an entitlement. Rather, a fixed budget is set by Congress to fund a set agenda of housing activities that translate into a projected number of individuals or households who can feasibly be served.

Second, although there are no hard data on the specific characteristics of housing program recipients (again, in contrast to income assistance and health programs), it is unlikely that many of the chronically mentally ill have been served by federal housing programs to date.

Federal Sources of **Funding for Housing for the Homeless Mentally Ill.** Despite the roughly 70 percent decline in the federal housing budget and the growing involvement of states and localities in housing assistance programs for vulnerable populations, the federal government still commands a sizable pool of housing resources. Reviewing the proposed FY1990 budget requests of the Department of Housing and Urban Development reveals an estimated $10 billion in requested subsidies that could conceivably be targeted to housing assistance. Just to establish differences in scale, if we assumed that this $10 billion were equally divided among the 50 states, each state would receive $200 million. In contrast,

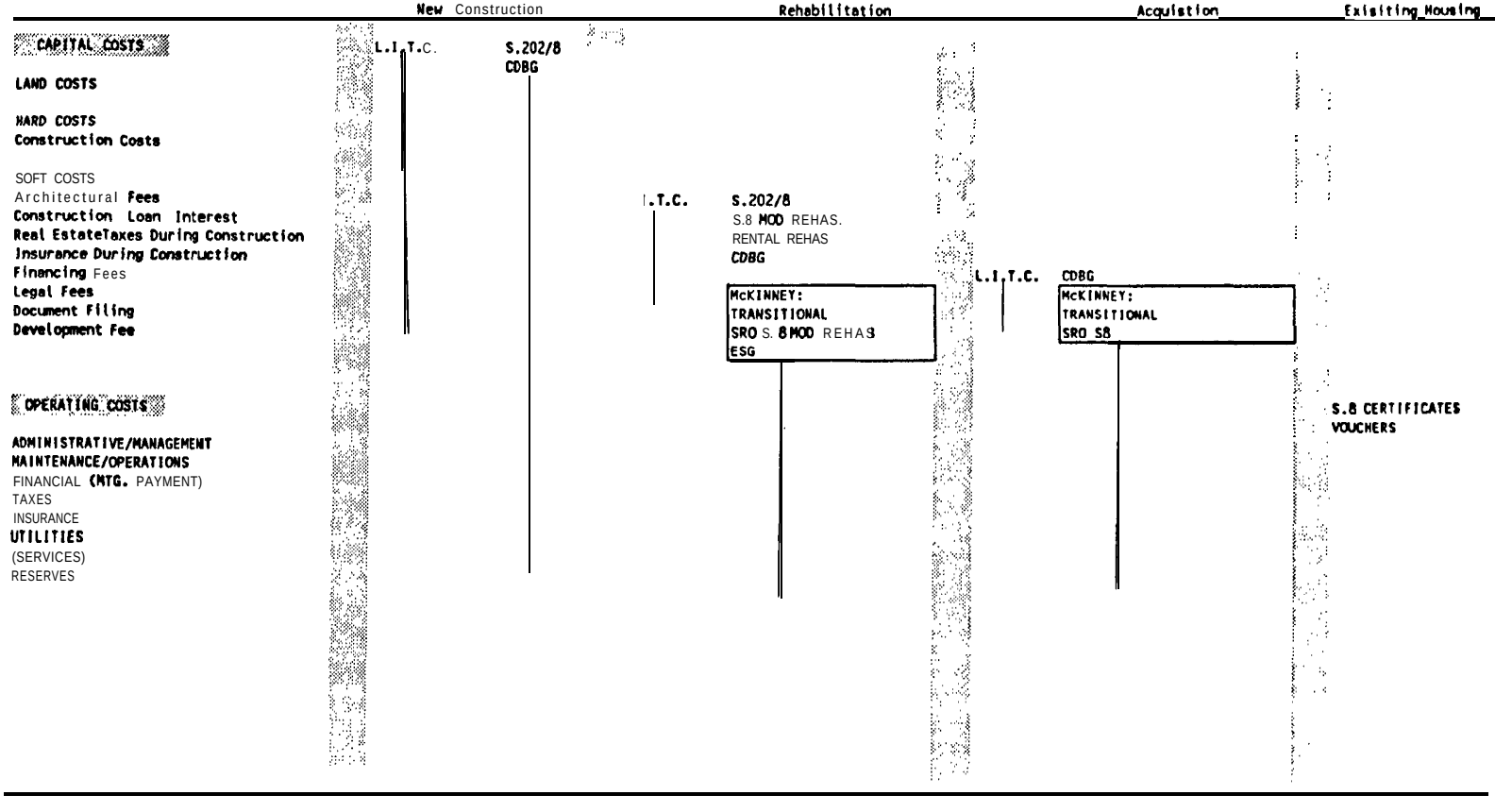
## EXHIBIT 4.1

## KEY HOUSING COST CENTERS

| | HOUSING PRODUCER/PROVIDER | | | HOUSING CONSUMER |
|---|---|---|---|---|
| | New Construction | Rehabilitation | Acquisitio | |
| **CAPITAL COSTS** | | | | |
| LAND COSTS | | | X | |
| HARD COSTS | | | | |
| Construction Costs | | X | | |
| SOFT COSTS | | | | |
| Architectural Fees | | X | | |
| Construction Loan Interest | | X | | |
| Real Estatefaxes During Construction | | X | | |
| Insurance During Construction | | X | | |
| Financing Fees | | X | X | |
| Legal Fees | | X | X | |
| Document Filing | | X | X | |
| Development Fee | | X | X | |
| **OPERATING COSTS** | | | | |
| ADMINISTRATIVE/MANAGEMENT | X | X | X | |
| MAINTENANCE/OPERATIONS | X | X | X | |
| FINANCIAL (MTG. PAYMENT) | X | X | X | |
| TAXES | X | X | X | |
| INSURANCE | X | X | X | |
| UTILITIES | X | X | X | |
| (SERVICES) | X | X | X | |
| RESERVES | X | X | X | |
| RENT | | | | X |

# EXHIBIT 4.2

**SOURCES** OF FEDERAL **HOUSING** SUBSIDIES



Ridgeway's recent review of state housing programs for the chronically mentally ill revealed roughly $300 million in spending by all states combined.

The $10 billion HUD request is comprised of the following components:

1. $6.6 billion for assisted housing, which covers the long-term budget authority for about 125,000 housing units nationwide.' This request covers funding for:

- 100,000 housing vouchers;
- 2,000 SRO units for the homeless under the Section 8 Moderate Rehabilitation Program;
- 7,000 units of Section 202 housing of which 3,000 units are specifically designated for the handicapped, and 400 are set aside for the homeless mentally ill.

2. $2.8 billion for the Community Development Block Grant (CDBG) program, which can be used to provide housing for the poor and disabled;

3. $130 million for the Rental Rehabilitation Program which provides funding for the renovation of residential properties;

4. $185 million of McKinney Act funding - other than the SRO units already noted - for transitional and permanent housing for the homeless and for emergency food and shelter grants. These dollars are split at roughly 2 food and shelter grant dollars for every 1 dollar for housing.

Other than the 400 units of Section 202 housing earmarked explicitly for the homeless CMI, the McKinney Act is the only stream of federal housing dollars whose use is restricted to this population. There are potentially four housing funding streams that comprise the McKinney legislation, which became law in 1987:

1. Emeraencv Shelter Grants Program (FY1990 budget request = $114 million) which, as proposed for FY1990, will represent a merger of the HUD-administered shelter grants and the Emergency Food and Shelter Program that has been administered by the Federal Emergency Management Administration;

2. Supportive Housing Demonstration Program (FY1990 budget request = $71 million) which provides subsidies for transitional and permanent housing. All monies are proposed for financing transitional housing, however, with no slots for permanent housing;

3. Supplemental Assistance for Facilities to Assist the Homeless (FY1990 budget request = 0) which theoretically provides advances or grants to buy, lease, renovate or convert buildings to assist the homeless with preference for: families with children; the elderly homeless; and the handicapped homeless;

4. SRO Section 8 Moderate Rehabilitation Program (FYI990 budget request = $74 million), to pay for the rehabilitation and provide rent subsidies for 2,000 SRO units.

There are some features that all of these McKinney housing financing streams have in common. First, starting in FY1990, they will all be administered by HUD if the FEMA Emergency Food and Shelter Program is merged with the Emergency Shelter Grant Program. Operationally, this means that HUD will establish the regulations for these

programs, review applications for funding, and monitor compliance. Second, the grantee must match federal McKinney dollars with state or local dollars under each of these programs. Third, the release of funds under each of these programs is contingent on the jurisdiction having filed a Comprehensive Homeless Assistance Plan (CHAP) with HUD and on HUD's approval of this plan. Fourth, any physical structure that is established with McKinney funds must be used for homeless individuals for some period of time ranging from 3 years for shelters that required no major physical rehabilitation to 10 years for transitional housing. Finally, eligible applicants to HUD for McKinney funding are states, local governments, and nonprofits.

There are two distinguishing features to the Emergency Shelter Grant Program. In contrast to the other housing funding streams, ESG dollars are formula grants; that is, the amount of money a jurisdiction can receive is determined by the Community Development Block Grant formula. In addition, this appears to be the only housing component of McKinney that can be used to prevent homelessness. While the regulations do not specify the maximum amount of ESG dollars that can be used for prevention activities, it appears that the cap is 20 percent of the total ESG grant. Preventive activities include emergency payments of rent arrearages, prevention of utility cut-offs, and payment for mediation services to resolve landlord-tenant disputes.

The Supportive Housing Demonstration Program is explicitly aimed at meeting the needs of deinstitutionalized homeless persons and others with mental disabilities. Funding is available for two classes of activities: (a) the acquisition and/or rehabilitation of structures to be used for housing; and (b) the operating costs of such housing. (New construction subsidies are available only under exceptional circumstances.)

Acquisition costs are subsidized through non-interest bearing loans or "advances" which must be repaid within 10 years. However, for each year the property remains transitional housing beyond 10 years, the payment is reduced 10 percent. Physical rehabilitation costs are subsidized through grants currently capped at $200,000 per property, with the possibility of appealing for a higher cap (up to $400,000) in high cost areas. Operating costs are subsidized through grants covering up to 75 percent of these costs.

Under current program regulations, "transitional" is defined as 24 months of residence. However, grantees can appeal to extend the time period.

From a research perspective, what may be of particular interest is the fact that this is a demonstration program. Therefore, the goals that are explicitly stated in the Act include determining the cost of establishing such housing, the cost of operating the housing, and the strengths and weaknesses of the different housing and service approaches pursued under this demonstration. Unfortunately, there are no funds set aside for this research. It may be that some jurisdictions will conduct their own evaluations or that HUD will use the monitoring reports it requires as a basis for intramural research.

The SRO rehabilitation grants available under McKinney must be structured under the Section 8 Moderate Rehabilitation Program. Thus, the public housing agencies or PHAs that exist across the country are the applicants for these "mod rehab" dollars. The PHAs then advertise the availability of these funds in their local jurisdictions, and the next round of competition occurs among those groups--both nonprofits and for profit organizations--that have an interest in these funds. Under the Section 8 Mod Rehab Program, the subsidy stream from HUD is in the form of rent guarantees, where the rents are set to cover both the base rent of the unit before rehabilitation plus the pro-rated share of the rehabilitation. The tenant pays no more than 30 percent of income for rent while living there, but if the tenant moves, the subsidy stays with the SRO unit and is therefore available for the next qualified tenant. Mod Rehab funds do not cover the costs of any

services that may be required. Therefore, the PHA, in the first instance, and the developer, in the second, must demonstrate that any services that are required by the tenantry will be available and funded from other sources.

As noted, the McKinney Act is in many sense a separate and quite different track of funding for housing relative to the "stock and trade" of HUD housing programs. Currently, the major federal housing assistance strategy for low income persons is rent subsidies that are attached to the person rather than the housing unit; that is, a demand-side intervention. There are currently two demand-side programs: the Section 8 Certificate Program and the Housing Voucher Program. To qualify for either of these programs, the household's income must be at, or below, 50 percent of the area's median income for comparably sized households. Housing units must meet housing quality standards, and the rent that can be subsidized by the federal government must be reasonable for the particular market area. The average cost of a Certificate or Voucher is about $3500-$4000 per assisted household per year. The Congressional Budget Office estimates that as of the end of FY1988, about 875,000 households had entered into Certificate contracts and about 184,000 had received vouchers.

The goal of these demand-side housing subsidies is to give the housing consumer as much freedom of choice and control as possible. But with these freedoms come important responsibilities: applying to the PHA for the program, searching for a housing unit, reporting back to the PHA that the unit is ready for inspection, possibly negotiating with the landlord regarding the rent, and the like. Program regulations currently allow the use of special lease provisions regarding the availability of appropriate supports to tenants to assure that they can live independently. One goal of the housing evaluation that is being undertaken as part of the Robert Wood Johnson Program on Chronic Mental Illness is to determine the strengths and weaknesses of such a demand-side intervention (in this case, the Section 8 Certificate).

The Section 202 Program has essentially been the only HUD program targeted to vulnerable populations, including the mentally ill. Section 202 is a supply-side program: direct below market loans for up to 40 years are available to nonprofit sponsors to cover construction and Section 8 rent payments are attached to all housing units and are set at a level that covers both the base rent plus the pro-rated share of construction costs.

One distinguishing feature of 202 projects is the requirement that they be designed to enable the provision of necessary services to occupants. These services must include congregate meals and may also include health, recreation, and transportation services. However, funding for these services is not covered by the Section 202 subsidy and must, therefore, be covered by other sources.

Unlike the Section 8 Moderate Rehabilitation Program or the Section 202 Program which are based on the premise that rent levels ought to bear some relationship to the rehabilitation or construction costs that have been expended, the Rental Rehabilitation Program separates the subsidy for rehab from the tenant rent subsidies. One-time, up front grants or loans are made to cover rehab costs which normally cannot exceed $8,500 per unit. These funds are allowed to cover up to 50 percent of total rehab costs; the remainder must come from another source. Allocations for rental rehab subsidies are made on a formula basis to states and local governments; property owners then apply for these limited subsidies. Properties must be located in low and moderate income neighborhoods and at least 70 percent of the funds must be spent on units in which low income tenants live. Any very low income tenants (defined by HUD as having an income at, or below, 50 percent of the area's median) living in the property before the rehabilitation are provided with a Section 8 Certificate or housing voucher. These individuals may use their subsidies either to remain in place in the newly rehabilitated unit, or to move elsewhere. Thus, the rental rehab program combines elements of both supply-side and demand-side strategies.

The CDBG program which provides formula grants to states and localities has as its purpose the promotion of viable urban communities and the assistance of low and moderate income persons. As implied by their name, these block grants give grantees fairly broad discretion regarding fundable programs. Eligible activities include acquisition and rehabilitation of properties to be used for housing, for example. Many of the innovative housing strategies currently being proposed or already funded by localities, including those for the mentally ill, use CDBG funding as part of a larger financing package.

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# Program Implementation Analysis

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As programs and models of care for the homeless mentally ill proliferate, the first question clinicians, administrators and policy decision makers will want answered is: do these programs work (Exhibit 4.3)? I have recently argued (Brekke 1988) that after nearly two decades of research on the effectiveness of community support programs (CSPs) for persons with chronic mental illness, we are becoming convinced that these programs can work. However, we have almost no systematic empirical knowledge about the programs we are delivering, the kinds of treatments used, how they can be replicated, or what ingredients account for their success.

This discussion will review strategies for monitoring program implementation, examine how they have been applied to various CSPs, and offer some suggestions for research on programs for the homeless mentally ill. The first section will briefly examine the methodology of monitoring program implementation.

## Imdementation Monitoring

Evaluations that monitor program implementation have been discussed as an essential element of complete evaluation research (e.g., Rossi and Freeman 1985; Scheirer and Rezmovic 1983; Honnard and Wolkon 1985). The monitoring evaluation is designed to provide: (1) an empirical description of the services delivered and the manner of service delivery, (2) data describing the population served, and (3) a comparison of these data to the intended service population and the intended intervention.

As can be seen, monitoring evaluations have both descriptive and evaluative functions. Descriptively, they result in an empirical profile of the types, or major components, of services delivered in a program (Exhibit 4.4). When data are collected over time they also provide a profile of the longitudinal form of service delivery. Other program processes can also be examined. The evaluative, or model testing, function is to provide an assessment of the degree to which the program being delivered matches the conceptual model on which it is based.

Without monitoring a program's implementation, it has been argued that we have no idea what the program consists of; therefore, if it succeeds we do not know what worked. Conversely, if it fails we cannot assess whether the program design was faulty of if the wrong program was implemented (Rezmovic 1984; Rossi 1978). Monitoring evaluations provide a way to describe programs, and therefore to compare and replicate them across sites. Finally, in combination with outcome data, monitoring data can be used to examine the relationships among client, program and outcome variables.

I have also argued that monitoring methods are particularly critical for CSPs, where the questions of replicability, efficiency, and "what works best with whom" are now pre-eminent. However, the use of these methods to examine program processes in CSPs has just begun (Brekke and Test 1987). In sum, the fact that monitoring plays a critical role in evaluation research and for research on CSPs is clear; however, it is equally clear that little of this monitoring has been done in any area of social service delivery.

I have offered a five step evaluative process that is called the model guided method of monitoring program implementation:

EXHIBIT 4.3

BLACK BOX MODEL - DID IT WORK?

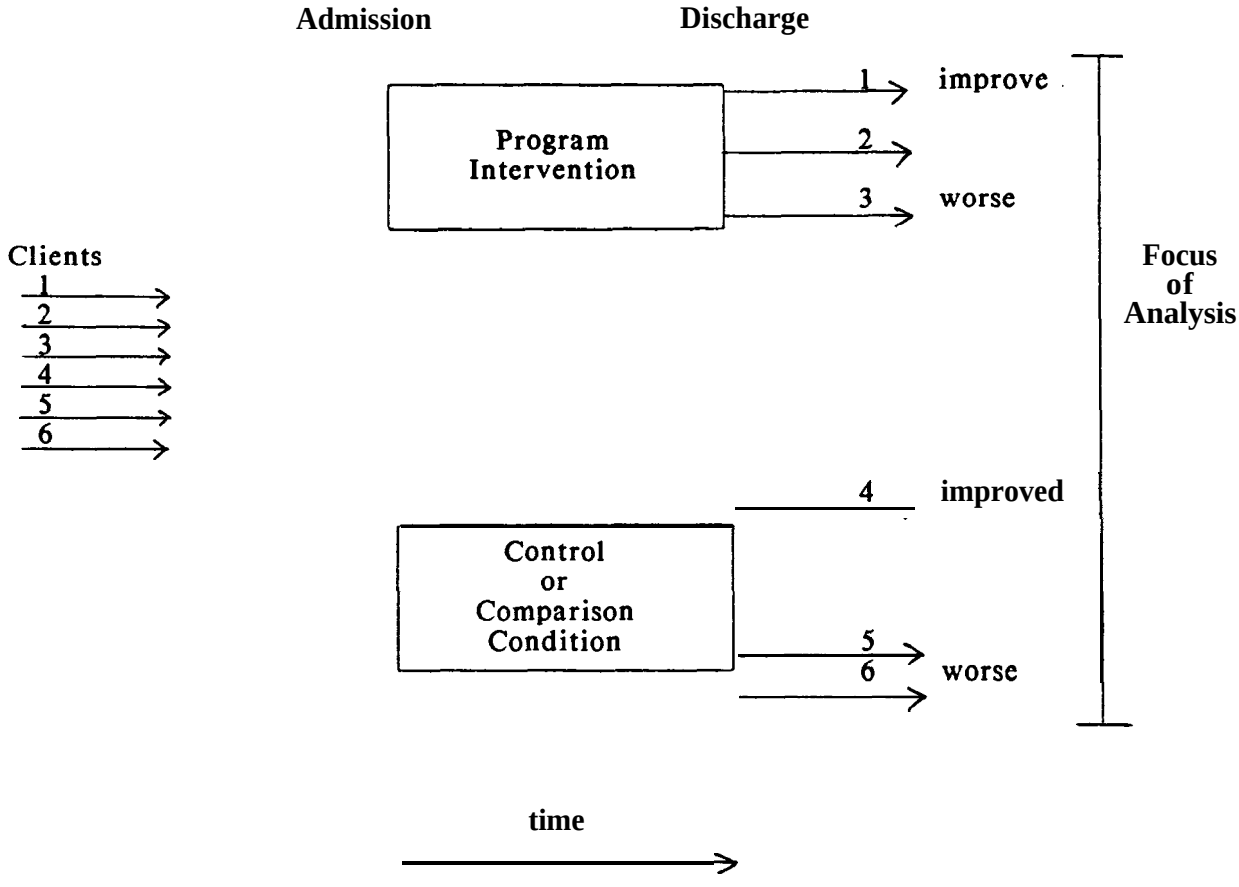

EXHIBIT 4.4

IMPLEMENTATION ANALYSIS - WHAT WAS IT?

A. IMPLEMENTATION MONITORED?

| | | YES | NO |
|---|---|---|---|
| Effective? | yes | It worked | Something worked but what? |
| | no | It didn't work (refine, study again) | Something didn't work |

B. IMPLEMENTED AS INTENDED?

| | | YES | NO |
|---|---|---|---|
| Effective? | yes | Continue to refine and replicate | Conceptual challenge can replicate |
| | no | Conceptual challenge falsification of model<br>No replication | No challenge, reconceptualize reimplement reevaluate |

Two conceptual domains

1. program model specifications
2. application of theory on which they are based, e.g., treatment, human behavior, or organizational

1. delineate critical elements of the intended program in terms of the population(s) served, and service components and their design--that is, how much of what to whom, when, and in what manner;

2. develop conceptual and empirical specifications of program design, that is, "hypotheses" about adequate implementation (see Exhibit 4.5);

3. collect relevant data;

4. describe the program's implementation and test hypotheses; and

5. recommend design or implementation changes.

This method results in an empirical description of a program's implementation along measured dimensions, as well as a test of the adequacy of its implementation (Brekke 1987).

If researchers on programs for the homeless mentally ill hope to see their studies contribute to the description, understanding, and replication of effective models of treatment and care, then implementation monitoring is crucial. Therefore the remainder of this discussion will focus on how these methods have been applied to CSPs, and will suggest ways to apply them to programs for the homeless mentally ill.

## Applying the Method

All programs, no matter what stage of development or implementation, rest on notions of service delivery. These notions may be formalized in a manual or program description, or may just exist as an implicit but binding philosophy among staff members. Therefore, the first step in implementation monitoring is to gather these notions from as many sources as possible: written, oral, clinical and administrative. The goal is to assemble or derive as accurate a picture as possible of the critical elements of the model of treatment that is intended to reach the clients.

At the three CSP sites we have investigated, this derivation of the model has been done in a variety of ways. First, is reading program descriptions from published or unpublished sources. Second, we have had discussions with program directors, developers, and program staff. Third, we have observed the program by attending clinical and administrative staff meetings, or by just being present at the program site or wherever services are delivered.

Having gathered implementation information, it can be summarized into a series of program specifications. These are then discussed with the major program players to see if they comprise an accurate picture of the critical elements of the program as it is intended. It is at this point that these specifications are formalized conceptually, and that empirical parameters are derived whenever possible (for examples concerning the PACT program see Brekke 1987).

Once the specifications are detailed, it is possible to select or construct a strategy to gather relevant implementation data. There are several sources of these data: (1) existing records or institutional data sources; (2) staff using specially constructed instruments; (3) direct observation; or (4) program participants. These data can be gathered through record or data searches, through interviews, or with self-report instruments or checklists.

**EXHIBIT 4.5**

**IMPLEMENTATION "HYPOTHESES": AN ILLUSTRATION**

**(A)** The Assertive Availability of Services

P.I. Each client will receive a percentage of staff contact that is delivered in locations other than the offices of PACT.

D.I. To what extent are services delivered in locations other than the offices of PACT?

**(B)** The Longitudinal Nature of Care

P.2. There will be no cessation of contact for any PACT client for as long as they remain at PACT.

D.2. What is the treatment dropout rate at PACT?

**H.1.** Within targeted component areas of contact for clients there will be a trend over time from high frequency and duration of contact to low frequency and duration of contact in the delivery of services.

**(C)** The Continuity of Care

P.3. Assessment -- each client will receive an assessment of functioning in each component area that will be documented in the client's records at PACT.

P.4. Treatment plan -- each client will have a treatment plan documented in his or her records referring to the following dimensions of treatment: social / interpersonal skills, vocational skills, activities of daily living, living arrangement, and psychiatric symptomatology.

D.4. Monitoring -- to what extent are client treatment plans updated?

**D.5.** What is the distribution of staff contact time among clients?

**(D)** The Components of Treatment

D.6. To what extent does staff contact with clients and staff allocation of time reflect the following seven conceptual components of client functioning: social / recreational, vocational, psychological, psychiatric (including medication), activities of daily living, residential and family?

**(E)** Individualization

H.2. Based on pre-illness levels of functioning, there will be significantly more staff contact over time with poorly functioning clients than with better functioning clients.

These data can be gathered on a continuous basis using all or selected program staff. Time period sampling can be done with all or selected staff. Finally, data can be gathered on a one- shot, cross-sectional basis. This decision will, of course, be based on the purpose of the study and the time and resources available.

Elsewhere, we have detailed the construction, use and psychometric properties of a daily staff checklist that has been used successfully at a number of program sites on a continuous basis as part of two longitudinal studies (Brekke 1987; Brekke and Wolkon 1988). Other noncontinuous data gathering strategies using existing records or staff interviews have been detailed by Hargreaves, et al (1984).

In considering how we can obtain the most useful and meaningful implementation data on programs for the homeless mentally ill, the recommendations I offered with regard to CSPs are applicable. First, the individual client and not the program should be used as the.unit of observation. This allows the client, a group or subgroup of them, or the program to be used as the unit of analysis. Important implementation questions can be asked at all levels, e.g., grouping clients by diagnostic or outcome categories in order to examine treatment delivery variables; or comparing programs on total units of service utilization across time.

Second, programs can change rapidly as they respond to idiosyncratic clients or emerging treatment populations; therefore, longitudinal designs with continuous data collection are advocated. Third, using formative evaluation methods that focus on evaluating a program as it develops can enhance program functioning and evolution in an ongoing manner. Fourth, data gathering strategies need to be able to capture the complexity of these programs along critical dimensions.

The variables considered critical for CSPs include the amounts and kinds of services (vocational, residential, medication etc.), the modalities used such as individual, family and group, and the setting of treatment, for example, the program site or in the community (see Exhibit 4.6). Additionally, the amount of advocacy work done on behalf of the client with other agencies, as well as milieu variables are important. There are other variables critical to programs for homeless mentally ill which will be suggested later.

Fifth, it is imperative that instruments be reliable, valid and easy to use. Finally, our experience suggests that the best implementation data come from methods that include staff utilization of data. This final issue will be discussed in more detail below.

## Some Monitoring Results. and Strategies for Getting Good Data

The following observations from our research using the Daily Contact Log at three sites are relevant to this discussion. First, the data functioned as designed. We were able to provide meaningful descriptions of the program investigated, and they were extremely useful for model testing purposes. Both administrators and clinicians were impressed with the results, and were dedicated to continuing and contributing to all phases of the research when preliminary data were presented. Second, our data gathering relied on staff using a specially constructed checklist on a daily basis. This turned out to be workable from staff and administrative perspectives.

Our experiences with getting and maintaining the participation and motivation of program personnel have resulted in the following suggestions for getting good implementation data. First, the plans for using these data should be made clear with staff before the data are collected, especially if staff will be involved in the data gathering. Second, staff should be included, whenever possible, in discussions of the appropriateness of the instruments used and any subsequent changes or improvements made in them.

EXHIBIT 4.6

TYPES OF CONTACT

1. VOCATIONAL: contacts associated with work training such as developing specific work skills, job-seeking skills or work habits; also includes activities associated with placing or maintaining clients in work, volunteer, or sheltered work experiences, and developing vocational resources for clients.

2. LIVING ARRANGEMENT: contacts specifically related to locating, moving into or maintaining a residence.

3. ACTIVITIES OF DAILY LIVING: contacts associated with budgeting money, cooking, house cleaning, personal hygiene, shopping, use of transportation, laundry, etc.

4. BASIC LIVING RESOURCES: contacts associated with getting and maintaining basic entitlements such as SSI benefits, Food Stamps, rent subsidies, bus passes or legal services.

5. SOCIAL/RECREATION: contacts associated with constructive use of leisure time, development of social skills, use of community recreation programs, general social activities.

6. PHYSICAL: contacts associated with non-psychiatric medical care such as making appointments or giving physical exams, also general health care issues such as nutrition or prevention of illness.

7. MEDICATION: contacts related to the use of prescribed psychiatric medication, e.g., anti-psychotic or anti-depressants, such as dispensing or prescribing medication, decision-making around compliance, etc.

8. CRISIS: contacts dealing with crisis situations in any aspect of the client's life.

9. CASE MANAGEMENT: this only covers regularly scheduled case management appointments that staff have with clients.

10. ONE TO ONE: this covers time spent with clients that has as its primary focus offering emotional support, building a relationship, or offering empathy, e.g., talking about favorite movies, chatting over coffee, or taking a walk together. All contacts have this element, but these contacts are just for this purpose.

11. OTHER: any contact that does not fit into any of the above categories.

* Remember the following definitions when logging family or group contacts:

| | |
|---|---|
| group = | 3 or more clients present |
| family = | only when client's family or significant other(s) are present |

* Also, when logging phone contacts, consider all parties present even though you don't have face-to-face contact.

Third, these data should be integrated into overall program functioning whenever possible. For example, we have used them in empirically-based clinical case reviews, and in administrative reviews on a monthly basis. In these reviews selected data are summarized and presented according to staff needs and specifications. Fourth, the data should be presented to the staff or used for program purposes as soon as possible after data collection has begun. This is also particularly important if staff are involved in data gathering. Finally, any use of these data for evaluating individual staff performance must be done only with full knowledge and cooperation of the staff involved; otherwise, the potential for misreporting the data increases.

## Programs for the Homeless Mentally Ill

The following thoughts are offered concerning the generalization of this discussion to programs for the homeless mentally ill. Clearly, the first suggestion would be to see implementation analysis as an integral part of all program research. Beginning this effort early will help in the effort to understand the mechanics and effectiveness of the models, as well as to determine the limits of their replicability. As I have argued elsewhere, an ineffective but well-monitored program is ultimately more meaningful than one that is effective but not adequately monitored.

Formative evaluation methods are particularly critical to an area that is emerging. There is no need to see implementation methods as useful only in the final analysis. In fact, they can be used to meet ongoing and multiple program purposes.

While the implementation variables considered important for CSPs can be well generalized to programs for the homeless mentally ill, procedures for engaging the homeless mentally ill need particular attention. Many program personnel argue that having services available is not at all sufficient for treatment to occur. They describe careful and sometimes elaborate methods for engaging this population in treatment. These methods need to be documented in terms of how, how much, in what manner, where, and with whom they are done.

Concerning patient characteristics, it is critical to begin describing subtypes of the homeless mentally ill. This can be done by using variables from clinical observation to distinguish categories of the population. Potential discriminators could be diagnostic and clinical status, physical and health status, length of time homeless, sheltering patterns, help-seeking behavior and degree of transience. This effort has relevance for differential patterns of treatment selection, implementation and engagement, as well as service outcome.

It is also important that a discussion begin concerning the various models of treatment available and the critical variables to study. Implementation monitoring not only contributes to the functioning and testing of individual programs, but to the development of models of care, and generalizable principles of treatment and service delivery. This can begin with program personnel providing written descriptions of the programs they offer and the principles that are embedded in them.

The following program domains are suggested as places to begin the discussion of variables critical to implementation analysis in this area. The types and amounts of staff to client contacts; the locus of treatment; milieu variables (quality of interaction) among staff, among clients, and between staff and clients; organizational factors such as lines of authority and the scope of staff discretion in treatment planning and daily program functioning; and staffing patterns and characteristics. With these discussions, the informed monitoring of program implementation can take place. Without these efforts, we are constrained to having programs that cannot be described, understood or replicated.

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# Interorganizational Systems Approaches

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## Introduction

We designed this workshop around two very basic questions: (1) How do you put together a proposal to study the mentally ill homeless, focusing on an interorganizational systems or network perspective? and (2) What are the questions and issues you need to consider as you develop such a proposal?

From an examination of the pre-registration forms of participants interested in this topic it was apparent that the audience for this workshop would be (and was, in fact) quite diverse. Their questions reflected a broad range of concerns, from practical issues in developing actual cooperative agreements between organizations to serve the mentally ill homeless, to questions on data analysis techniques and variable measures to study network transactions.

We decided not to attempt to answer all of these questions in this workshop; in fact, some of them are quite unanswerable at this point in time; our current state of knowledge on service delivery to this population doesn't provide such answers. As summarized by Richard Tessler in the Keynote Address, the first generation of NIMH-supported research on the homeless mentally ill focused primarily on individual and population-level characteristics; we are still in great need of research on delivery system characteristics. Although several of the first generation studies found that very often the homeless are not receiving mental health services, the reasons for this can only be inferred indirectly. In effect, all of the materials covered in this workshop can be considered gist for a "second generation" of studies, focusing on the determinants and consequents of system structure.

Another caveat: given time constraints and the range of backgrounds and interests represented by the audience, we did not present detailed instruction on very specialized techniques of either data collection or analysis, such as social network analysis. We did, however, structure the workshop so as to provide something of a "road-map" for turning participants' questions into researchable ideas appropriate for the NIMH RFA on the Homeless Mentally Ill. An outline was prepared as a handout which summarized a number of conceptual and research design issues to be considered, such as: historical and contextual factors affecting system development; major theoretical perspectives relevant to interorganizational service delivery systems; choice of level of analysis, types of linkages, networks structure variables; model building; choice of data collection strategies and sampling designs; longitudinal vs. cross-sectional designs; and special problems such as gaining access to data, recall, confidentiality, etc. We also provided a number of bibliographic references for each topic on the outline, as well as a reprint of an extremely useful article from the social network journal Connections, which summarizes the various computer programs available to do social network analysis, as well as their advantages and disadvantages.

The next section of this report summarizes three major approaches to the study of interorganizational systems for service delivery to the mentally ill homeless. Interwoven in

this discussion are examples from the research of the presenters, as well as suggestions for second generation research on the homeless.

## Overview of "State of the Art"

As we all recognize, the homeless mentally ill require a wide range of different services, from psychiatric evaluation, medication and therapy through general health care, job-search assistance, benefits assistance, alcohol/drug rehab, housing assistance and case management. This set of services is wider than the usual range of services needed by homeless persons, and wider than the usual range of service needed by typical users of community mental health centers.

Further, the organizational context in which this wide variety of health, mental health and social services is provided (or not provided) is very complex. Service fragmentation is widespread, with different agencies involved in the delivery of each service, and with different administrative structures or levels of government involved in perhaps multiple types of services. In effect what has developed is a hybrid, primitive system of service delivery that functions at the margins, or the interstices, of a number of different delivery systems, and has so far been every system's "bastard child," no one system's clear responsibility.

This is because the problem of service delivery to the homeless mentally ill is not one problem, but many problems. It is a problem of deinstitutionalization and of inadequate community care. It is a problem not just of unavailable mental health care, but of insufficient low-cost housing, and of low levels of welfare benefits. It is not just a problem of inadequate community mental health care, but of inadequate health care for the poor, alcoholism and drug abuse. It is also a problem of competing public and private priorities within a period of resource scarcity.

What all this means in trying to design a reasonable research program on service delivery to the mentally ill homeless is that it cannot be investigated as a discrete problem in service delivery; we should really be looking at it as part of larger interconnected complex of various service delivery systems, involving a number of institutions, organizations and interest groups, each with its own definition of service domain, and often with competing claims to a slim resource pie. This is clearly a problem of interorganizational and inter-system dimensions. Unfortunately, that's not easy to do, and there are no clear models in the interorganizational relations literature to fall back on.

In developing research in this area there are at least three sets of literature, three approaches, that warrant consideration. In fact, some of the most promising research will probably come from a combination of these approaches. These three sets of literature have developed fairly independently, although #2 and #3 have been somewhat more likely in the recent past to be used together. Each looks at the development of service delivery systems from a different foci:

1. From an examination of client needs and practitioner concerns;

2. From an examination of the resource needs of specific agencies and their development of ties to other agencies;

3. From a more macro perspective of examining the overall structural dimensions of multi-organizational sets or networks.

**The Client-Needs Perspective.** This perspective provides something of a "normative framework" for defining the critical elements needed in any system of service delivery for the mentally ill homeless. Building on the writing of Bachrach (1980, 1984) and Goldfinger and Chafetz (1984), four crucial elements have been identified: outreach, stabilization, linkage, and service provision. Outreach brings clients into the system; stabilization is the process of both responding to emergency needs of homeless persons and developing a stable interpersonal relationship with them; linkage is the process of making connections with service providers; and service provision occurs when actors in the system provide health, welfare and other services to the homeless.

Each of the elements is interdependent. For example, service provision is unlikely to be successful if clients have not achieved some modicum of stability. These elements are also generic system components that may appear in specific organizations: a single homeless shelter might provide some of each, or a separate agency may provide outreach and referral workers. However, the linkage element is critical for the system's success: "Although the separate elements of the continuum may be of high quality, well designed, and staffed with the best meaning of clinicians, the absence of an effective interagency network may render their work ineffective" (Goldfinger and Chafetz, 1984: p. 100).

The client-needs perspective can also be linked to the standard medical concept of continuity of care. Bachrach has developed such a model, with seven essential qualities corresponding to all four system elements, as summarized in Exhibit 4.7. Further, Bachrach's continuity of care features can be applied at several levels of analysis, from staff within agencies, to agencies themselves, agency-sets, or the community-system level of analysis.

Dockett's (1986) study of homeless services in the District of Columbia, derives from the client-needs perspective. Her exploratory research assumed a definition of the DC "network" of service delivery to the homeless which included providers in eleven different service areas (Exhibit 4.8), and she investigated how that service network processed homeless mentally ill clients. Her specific foci included an identification of: typical referral pathways for multiple-need clients; general patterns of resource utilization; the critical decision points within the referral network; and the factors that may influence referral decisions. Her most telling results concerned the dispersion of referrals across a wide variety of agencies for services where systemic authority and responsibility are unclear (i.e., housing and social/mental health rehabilitation). As indicators of discontinuity of care, both of these types of services are characterized by fragmentation of responsibility between providers, fragmentation of authority between systems, and conflicting/competing goals and objectives.

**Resource Dependence/Interorganizational Coordination.** Both of the perspectives listed in #2 and #3 come out of organizational theory, and both are more concerned with structural issues of organizational relations. They are thus both at least one step further removed from client-concerns and practitioner definitions of what service delivery systems should look like. They are also quite different in focus, however, in terms of what sorts of variables you usually use as dependent variables, and also in terms of what unit of analysis is employed. There also are multiple units of analysis in interorganizational research ranging from the simple to the complex, including: pair-wise or dyadic relations, organization-sets, networks, organizational clusters, and community or societal sectors (Exhibit 4.9).

The literature summarized in Section B is what's usually referred to as the IOR literature, or studies of interorganizational relations, which held sway in many organizational and sociological journals in the late 70's and early 80's. The dependent variable in much of this research is an explicit focus on coordination: what explains variation in coordination between organizations, and how do you get more of it? In the

## EXHIBIT 4.7

## SERVICING MENTALLY ILL HOMELESS

BARRIERS TO CARE IN A **DEINSTITUTIONALIZED** SERVICE SYSTEM *

- Lack of Comprehensive Care
- Lack of Continuity of Care
- System Misfits
- Preclusive Admission Policies
- Nonspecific Responsibility
- Geographically Determined Responsibility
- Inappropriate Expectations

7 ESSENTIAL QUALITIES OF SERVICE SYSTEMS **

1. Capable
2. Comprehensive
   - Mental Health
   - Medical
   - Social and Economic
   - Rehabilitation -- Social and Vocational
   - Housing
   - Case Management
   - Outreach
3. Continuous
   - Case Manager
   - Centralized Responsibility
   - Interagency Cooperation
4. Individualized Programming
5. Flexible Programming
6. Willing and Tolerant Staff
7. Meaningful Services

* Bachrach, 1984.
** Goldfinger and Chafetz, 1984.

EXHIBIT 4.8

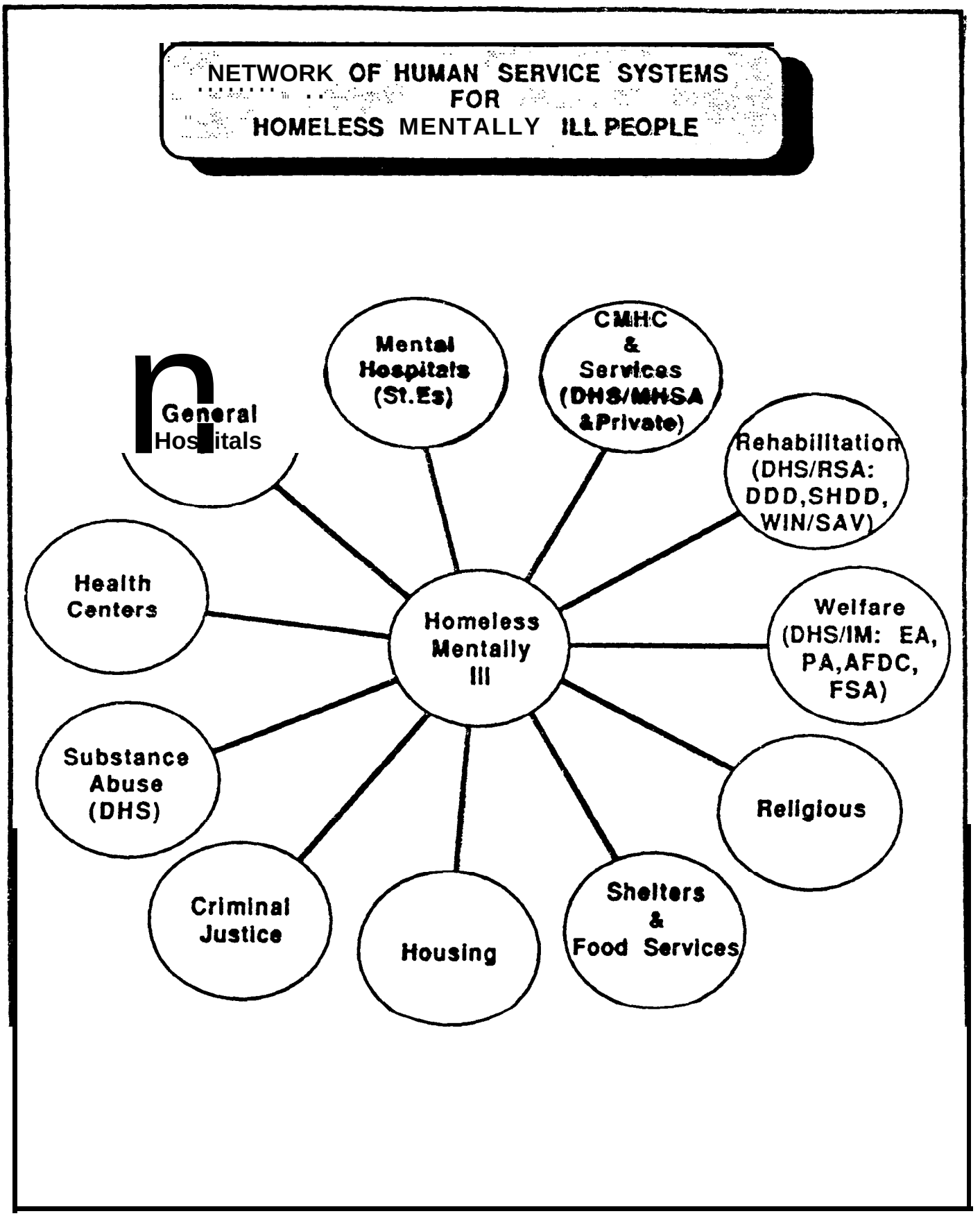
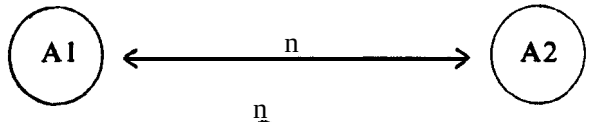

NETWORK OF HUMAN SERVICE SYSTEMS
FOR
HOMELESS MENTALLY ILL PEOPLE
General Hospitals
Mental Hospitals (St.Es)
CMHC & Services (DHS/MHSA &Private)
Rehabilitation (DHS/RSA: DDD,SHDD, WIN/SAV)
Health Centers
Homeless Mentally Ill
Welfare (DHS/IM: EA, PA,AFDC, FSA)
Substance Abuse (DHS)
Religious
Criminal Justice
Housing
Shelters & Food Services

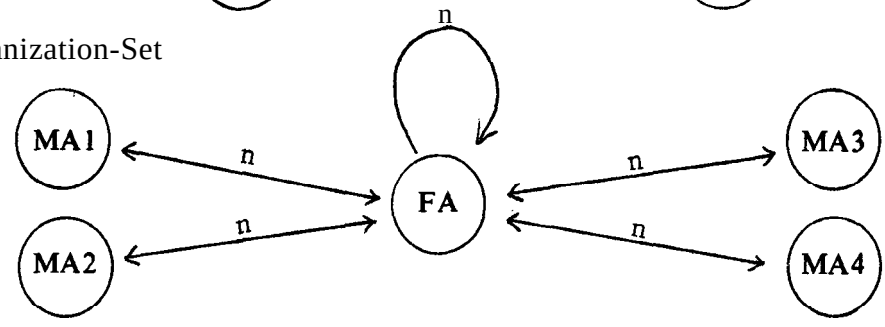
EXHIBIT 4.9

LEVELS FOR EXAMINING INTERORGANIZATIONAL RELATIONSHIPS

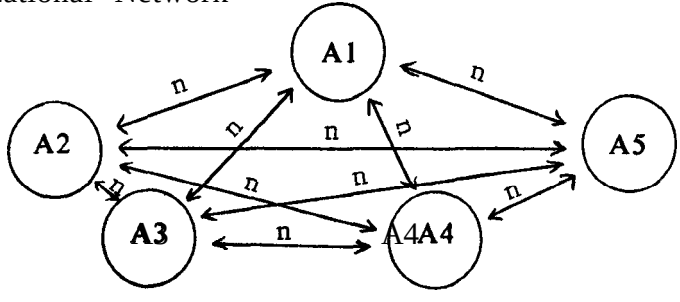
A. Pair-Wise Inter-Agency Relationship




B. Organization-Set




C. Interorganizational Network




D. Organizational Cluster

All organizations of a specific type located within a delimited geographic area, e.g., all homeless shelters within a city (Fennel1 1980, 1982)

E. Community Field

An examination of the horizontal ties among all types of organizations within a local community (plus, vertical ties to extra local agencies: Warren, 1972)

F. **Hierarchial** System or Societal Sector (Scott, **1983),** or Industry System (Hirsch, 1972)

All organizations involved within a particular "domain" (e.g., housing sector), plus organizations to which focal organizations are hierarchically linked (i.e., organizations which contribute to or regulate the industry/domain itself)

SOURCE: **Adapted from Andrew Van de Ven et al., "Coordination Patterns Within an** Interorganizational Network." **Human Relations 32, c** 1979, p. **21.** Reprinted by permission of Plenum Publishing Corporation, New York, New York.

Bibliography for this section, there is a volume by Rogers and Whetten (1982), which still, although nearly eight years dated, provides one of the best sets of essays on studies of interorganizational coordination. The last paper in this volume is by J. Kenneth Benson, and he neatly summarizes the underlying agenda of most of this research:

> "... the impetus for interorganizational analysis seems to come mainly out of a perceived need to reduce duplication and overlap of services, to reduce conflicts and tensions between agencies, and to enhance the articulation of services. In short, interorganizational analysis seems tied to a program of building a more smoothly operating division of labor among agencies. Different philosophies of and strategies of coordination . . . may have changed over time . . . for example, the disagreement over centralizations versus decentralization. Coordination, however, seems to be the ultimate dependent variable . .."

The value of this approach for studying interorganizational systems for service delivery to the mentally ill homeless is that one can fairly readily combine a focus on coordination with an emphasis on continuity of care and client needs. Indeed, much of the IOR empirical literature is grounded in studies of public sector, human service organizations. Much of this literature focuses on the nature of transactions or linkages between dyads of organizations, and model-building has emphasized figuring out what independent variables will maximize perceptions of coordination between agencies.

A major problem with this literature is that, indeed, most of the measures of coordination or consensus building between agencies tend to rely on the perceptions of organizational members, such as agency directors, as to what happens between two agencies and how smoothly their joint program run, or how important the other agency is to focal agency goals. The usual assumption made is that if agency directors think activities are coordinated, then they must be. There are obvious problems with validity in such an approach.

Another limitation of this literature is the lack of consistent results either explaining interorganizational coordination, or linking coordination to client-level outcomes. Partly this may be due to inappropriate measurement; partly it may be due to the difficult inherent in stretching the IOR emphasis on coordination between pairs of agencies to a meaningful analysis of multi-agency and multi-system level service delivery problems. It's not just translating from data on the "trees" to a full picture of the forest, but how do you use tree data to figure out what's happening in a forest with a number of different eco-systems?

For the most part, variables of IOR structure and process are perceptual measures concerning specific links between specific dyads of organizations. When system-wide measures are computed, they are usually averaged or aggregate indices of dyad-level measurements.

Interoreanizational Networks. This section summarizes some of the major directions taken by studies of interorganizational networks, most of which rely in some way on social network analysis. This approach is another level removed from the client-needs approach, so the concerns of Bachrach and Goldfinger and Chafetz are not as easily combined with an interorganizational network perspective. Also, by far most of these studies have used data on private sector firms and assumptions about for-profit firm behavior as motivating interorganizational linkages, especially studies of interlocking directorates. That makes them somewhat more difficult to apply to an analysis of human service delivery systems.

EXHIBIT 4.10

VARIABLES OF IOR STRUCTURE AND PROCESS

Interaction Formalization

Interaction Standardization

Transaction Importance

Transaction Frequency

Reciprocity

Perceived Power

Centrality

Cooperation

Conflict

Coordination

VARIABLES OF NETWORK STRUCTURE

Density

Multiplexity

Cohesion

Reciprocity

Structural Equivalence

Reachability

Centrality

Complexity

Nonetheless, a network approach does emphasize uncovering interaction structures for multi-organizational groupings, without necessarily emphasizing a particular focal organization or set of organizations. This is much more macro perspective than the IOR literature, and would be useful in tackling research on delivery systems where multiple types of service-sectors are involved, as with the homeless mentally ill.

Network analysis starts with two assumptions:

1. That any actor, whether an individual or an organization, participates in a social system involving many other actors, and that position in that social system will influence the actor's behavior.

2. That there are various levels of structure within any social system, and that groups of actors form social positions, which are linked to other social positions in particular patterns. The organization of social relations thus becomes a central concept in analyzing the structural properties of networks.

Network analysis has been applied to the study of organizations in a number of ways, including the three we've indicated on the outline: to study linkages across organizations that are represented by the personal ties of their professional employees; in conjunction with Resource Dependence Theory to examine how resource constraints can influence the development of different network structures; and most often, to study board interlocks among corporate firms. A potential direction for further study on homeless mentally ill service networks could be an analysis of homeless shelter governing/advisory boards and the existence of board interlocks across human service organizations and the private sector: what impact do such interlocks have on both the agency's service delivery strategy and linkage to other agencies?

Network structure variables (Exhibit 4.10) describe total network characteristics, using measure based on reports of actual contacts or linkages within the network. These can also be based upon perceptual data, but they are less likely to be. Also, the network structure variables are usually computed using matrix indices; they tend NOT to be averaged measures of dyad-specific data. Examples of computing network structure variables were presented in the remainder of the workshop.

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Section V

# UNDERSTANDING THE SOCIAL CONTEXT

**Analyzing the Social Context of Homelessness and Mental Illness**

Kim Hopper
New School for Social Research

and

Michael Sosin
University of Chicago

Division of labor in this workshop was fairly neat: Hopper attempted to contextualize homelessness within the field of poverty and housing scarcity, drawing chiefly on work done in New York; Sosin dealt with more particular issues of research design and causal inference as exemplified by work in Chicago.

## Overview of the Issue and Inventory of Relevant Variables

Hopper began the presentation with a brief commentary on the socially embedded nature of research. He reminded participants that our inquiries take place within a set of "givens" -- ideological, cultural, economic -- all of which affect the received version of "problem to be solved." He stressed the importance of understanding how the linkage between homelessness and mental illness is currently viewed, and used an recent editorial by Charles Krauthammer' to illustrate how narrow the bounds of inquiry can be drawn in clinical terms. He suggested that this carries particular weight in public and policy-making circles owing to the "cultural authority of medicine."[2]

Recent efforts to collapse the problem of homelessness to that of mental illness represent an "impaired capacity" model of homelessness, one that is open to criticism on epidemiological and historical grounds, as well as for weaknesses in the logic of causal inference. This is not, however, to slight the difficulties involved in specifying the social variables at work and in analyzing the mechanism of their action. Macro-micro linkages are but poorly understood at this stage. As a close approximation, we can pose larger "frameworks of plausibility" that will allow us to refine gradually what it means to contextualize not only the analysis of homelessness, but the evaluation of remedial efforts, demonstration projects, etc.

Hopper outlined an approach to the contextualization of homelessness that redirects attention to the role of mediating variables: those informal, often hidden, networks and resources that spell the difference between displacement and dispossession. This in turn shifts the focus of inquiry to homelessness as a problem to be solved by social actors in specific settings (see Exhibit 5.1). One can thus accept even a minimalist definition of homelessness -- as when Tessler and Dennis (following Rossi et al.) see it as "lacking customary and regular access to a conventional dwelling" -- and then go on to outline a variety of makeshift solutions to this problem -- ranging from street-dwelling to doubling up to residence in public shelters. More to the point, one can accommodate recent evidence from New York, Los Angeles, Chicago and Minneapolis that suggests that homelessness today is most commonly episodic in character, an observation with heretofore unexamined implications for intervention strategies.

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[1] Syndicated column, appeared on December 25, 1988.

[2] The phrase is Starr's, and is discussed in the opening chapter of The Social Transformation of American Medicine (New York: Basic, 1982).

EXHIBIT 5.1

PROBLEMS

1. Identifying and describing mechanisms of linkage between macro-order variables and micro-order variables.

2. The dimension of time: need for longitudinal studies of coping strategies/economies of makeshift.

3. The interpretation of strategic action: stated "reasons for" homelessness, observed norms of behavior, patterns of use over time. Intentional action and unintended consequences.

4. The ambiguities of "adaptation."

5. Integrating modes of analysis: systems-level study (political economy, macro-sociology), survey analysis, ethnographic inquiry, longitudinal studies.

6. Identifying appropriate control populations.

The logic is straightforward: pathology may indicate personal suffering, areas of impaired functioning, diminished social status, stigma, difficulties with sustaining social margins, as well as a higher probability of other problems (unemployment, substance abuse, disrupted family relations or childhood separation). Individual vulnerabilities of these sorts no doubt enter the homeless equation. The key contextual question is: under what circumstances do such personal difficulties become social handicaps and survival liabilities (see Exhibit **5.2)?**

The analysis begins by identifying populations at risk -- a determination that must go beyond the trait clusters of the "usual suspects" -- and moves to an analysis, explicitly inter-disciplinary in nature, of the local economy and ecology. Key variables in the latter include specification of locale (climate, "reputation," any peculiarities of location that affect influx of transients); state of the housing stock (availability, affordability, and barriers); and conditions in local labor markets, especially with reference to populations thought to be at risk of displacement. At the same time, recognizing that scarcity is a function of competing demand for a certain good, the analysis must examine changes in other demand streams and in the housing stock itself. Gentrification refers both to the "reclamation" of degraded or "undesirable" urban space and land, and to the amassing of new and more affluent demand. When coupled with a politically powerless or easily compensated resident tenant population, the result is the displacement of the poor, the transformation of formerly cheap dwellings, and the intensification of competition for what affordable space remains.

In keeping with the concern for unobtrusive resources noted above, the analysis must look not only at formal supply/demand dynamics, but at informal dwelling capacity as well. This means gaining an understanding of factors affecting the ability of support networks (friends and family) to take in additional household members, the likelihood that the displaced person will have such networks to fall back upon, and the burden of support he or she may be expected to pose. It also means appreciating that such resources are strategic goods, not inert stores, and that decisions of how, when, and for how long they may be used, may weigh considerations of personal cost and obligation that may not be at all apparent to casual observation.

Public policies, too, are part of the contextual picture, especially those changes in public programs that affect the quality and level of support for surplus populations (the dependent and/or disabled poor). Drastic changes, such as occurred with wholesale **deinstitutionalization** of psychiatric patients, are obviously relevant to the creation of new populations of people in need of housing and vulnerable to displacement. But income and in-kind support for the working poor is relevant, too, as it affects (1) the ability of marginally situated households to sustain additional members, and (2) the likelihood that they will be competing for low-quality but cheap housing. More directly, the terms and quality of emergency relief may encourage or discourage potential recipients from making use of it. If maintained in keeping with the traditional principle of "less eligibility," it will actively encourage needy individuals to seek assistance elsewhere, either making use of friends/family, or repairing to the street. Alternatively, should residence in an emergency shelter begin to function as an effective gateway to permanent affordable housing, then, in the absence of other such routes, emergency shelter could conceivably function as an incentive to households to "undouble," thus adding to the official toll of homelessness.

Finally, a range of "cultural" factors must be examined. Chief among these are the enduring American staples of racism and stigma, operating both directly (as expressed attitude) and indirectly (as institutional bias). Other factors include: (1) the meaning and utility of marginal space in urban settings, which directs attention to the transformation of "skid rows" in the postwar era; (2) particular strategies of survival in the shelters and on the streets, which seeks to apprehend the "native's point of view" for observed behavior; (3) customary or traditional economies of makeshift, which can accommodate periodic

EXHIBIT 5.2

HOMELESSNESS AND MENTAL ILLNESS: SPECIFYING THE LOCALE -- A ROUGH INVENTORY OF CONTEXTUAL FACTORS

I. Identifying Populations at Risk
   A. Effectiveness demand: the conversion of private distress into a public declaration of need
   B. Predicament of the poor: household incomes, household composition, rates of break-up, etc.
   C. Predicament of vulnerable populations: disabled groups, newly deinstitutionalized, refused hospitalization

II. Economy and Ecology: Locale, Dwelling Space and Work
   A. Locale:* e.g., season, climate, "reputation," utilities (port,transportation node, entry point)
   B. Habitat - what is the state of dwelling space? indices of available housing, affordability, quality and crowding; loss of units (especially of former choice), changes in rent levels, exclusionary policies; artificial market factors (zoning, warehousing, illegal eviction)
   C. Work: what is the state of the job market, local industry especially with respect to populations at risk of displacement? Labor demand: public sector employment; service economy, home-work, degraded manufacturing, part-time and pick-up work; how does the education system measure up regarding preparing new cohorts of skilled workers? Alternative sources of labor.

III. Competing Demand for Housing
   A. Demographic changes in the locale: especially in- and out-migration patterns; proportion of poor over time; household formation and composition.
   B. Gentrification: the reevaluation of degraded space and intensification of new demand.
   C. The displaced poor -- trickle-down poverty in a tight housing market.

IV. Diminishing Margins
   A. The accommodation capacity of friends and family.
   B. Burden of support posed by dependent member.

V. Public Policies
   A. Quality and level of support for surplus populations, especially dependent and/or disabled poor, and working poor.
   B. Emergency relief: deterrent conditions and policy vs. disincentives to cope with hardships/doubling up.

VI. Cultural Factors (special note: racism and stigma)
   A. Meaning and utility in marginal space: the transformation of skid row -- from zone of refuse/zone of discard to dispersed waste.
   B. Strategies of survival in the shelters, on the street: reasons for observed patterns
   C. Economies of makeshift: episodic homelessness as part of larger patterns of subsistence.
   D. Viability of extended support networks -- beyond near kin.
   E. A "culture of homelessness?" Resistance and recalcitrance of hard-won survival techniques; shelters as part of the problem.

*Especially pertinent to relative proportions of transient vs. local homeless.

homelessness as part of larger patterns of subsistence; (4) the structure and resiliency of extended support networks, which go beyond the usual inventory of kin or close friends; and (5) the question of a "culture of homelessness," whether resident in the hard-won survival strategies of the street-dweller, or enforced as part of the increasingly inflexible routine of public shelters.

In a brief set of closing remarks, Hopper turned to the question of service interventions and outlined a number of contextual considerations that might apply. These include: the achievement of legitimacy on the street and in the service delivery system; the question of the treatment resistance -- of providers to serving the population of interest; the feasibility of meeting basic needs as fundamental and prior to most therapeutic issues; the changing dynamics of neighborhood resistance; and the tricky question of "Rx: housing" -- seeing the provision of housing as a service need under a new and revivified clinical environmentalism.

## A Working Model: The Chicago Study of Homelessness

Sosin orchestrated the second half of the workshop by providing a fairly detailed and practical account of the research strategy he and his co-workers used in a study of the Chicago homeless poor. Of particular interest were the use of a comparative ("control") group and the definition and sampling of the homeless group. The upshot was a more refined account of what distinguishes those individuals who become homeless from their very poor but (for the time being) housed counterparts.[3]

Sosin began with a review of the difficulties in developing a causal model of homelessness, especially if one attempts to take account of social trends -- changes in the social context over time. Explanations of homelessness may be bracketed between the two poles of "alienation/pathology" and "environmentalism." Historically, adherents of the former stressed the "deviant" strain in homelessness: the view that this life style was associated with a "semi-voluntary" break with established social norms and institutions (family, work, church, civic life). In some variations, a new association -- with the street "culture" of the otherwise disaffiliated -- is posited. Often playing a role in the process was alcoholism or other pathologies. More recent variants have stressed the role of psychiatric disorder, and the "voluntary" aspect is considerably muted, if present at all. Consideration of social institutions in this approach tends to be restricted to helping or service agencies.

At the other extreme lies the view that homelessness is simply the extreme edge of poverty. Individual disabilities are not stressed, except as deficits in the "human capital" needed to take advantage of today's labor market. Instead, the emphasis is on resource scarcity, in jobs, housing and social services. Like its competitor, however, the environmental position does see long-term homelessness as carrying a burden of pathology or alienation. But it tends to view the condition less as a permanent "status" than as a transient or cyclic circumstance, subject to the buffeting of economic forces at large.

Research to date has produced evidence for both views, while sanctioning neither as a complete explanation. (This is true even for that classic period of the "disaffiliation" thesis, skid row research.) The most common shortcoming of attempts to inventory the distinctive traits of homeless populations was that most of the documented traits were true of the housed poor as well. Recent surveys have been hampered by the lack of appropriate control groups, by limits in types of questions asked, and by a failure to interpret findings

[3] One striking finding of the Chicago study is that nearly half of the extremely poor but housed sample had been homeless at some point in the past.

in the light of data about relevant social institutions. The Chicago study was an effort to correct these deficiencies. Its fundamental premise is that the homeless are best considered in the context of extreme poverty. The comparative design adopted takes the situation of poverty as a given and asks instead what features differentiate the homeless poor from their extremely poor but housed counterparts.

In constructing the design, a number of critical decisions were made. The most important and disputable were two: the definition of the homeless population and the selection of a control group. Three possible candidates for a control group were considered and rejected: the welfare population (rejected because failure to receive benefits may itself be a cause of homelessness); specific neighborhood (rejected because we don't know from which areas the homeless come, nor are there any white poverty neighborhoods in Chicago); and housing stock (again, we don't know from what type of housing the homeless come). Rather, a strict rule was adopted: the control group was composed of a sample of those housed individuals who obtain their main meal of the day for free. The definition of homelessness was similarly strict: individuals in shelters or living on the street; people who were "doubling up" but were not paying rent and had been there less than two weeks; and individuals in residential treatment programs for the indigent (alcohol, drug or mental illness) who faced discharge with no place to go. A total of 536 individuals was selected; two-thirds were currently domiciled, a third was currently homeless. (For details, see Sosin et al. 1988.)

The homeless and domiciled samples were compared with each other and with the Chicago poor population as a whole (corrected for race and sex composition - see Exhibit 5.3). In addition, the homeless sample was compared with that drawn by Rossi and his associates in an earlier study of Chicago's homeless population (Rossi, et al., 1986). Compared with their domiciled counterparts, the homeless in the study:

- were more likely to have experienced out of home placement as child (17% vs. 9%)
- were less likely to be receiving welfare (44% vs. 68%)
- showed lower monthly earnings ($51.51 vs. $91.77)
- were more likely to have had military experience (32% vs. 20%)
- were more likely to have had a history of mental hospitalization (20% vs. 12%)
- were more likely to live alone (71% vs. 42%)
- paid higher rent ($168.47 vs. $129.90)

The two samples did not differ significantly with respect to education, work or jail/prison experience, or current symptoms of psychiatric disorder. Regression analyses confirm and further refine the contributions of such factors.

In sum, the salient finding of the study was that above and beyond the contribution of individual deficiencies, a host of quasi-randomly distributed circumstances among the urban poor are the best predictors of homelessness: lack of relatives, poorly paying or no current work, higher rent payments, and non-receipt of welfare. Simply put, compared with other members of the sample the homeless were those who had fewer resources or higher costs or both. The probability of homelessness with all vulnerability variables rated high is nearly 100%; with all variables rated low, it is .4%.

These findings make it possible for researchers to begin to isolate social cause in the narrow, individualized sense and to generate new hypotheses about the role of social institutions in general. A subsequent investigation has revealed, for example, that the treatment system did not differentially handle homeless individuals; rather, those who became homeless tended to be more symptomatic and not receiving SSI.

Taken by themselves, Sosin concluded, the policy implications of these findings are ambiguous. They would appear to be compatible with either system-based reforms or individual-focused interventions.

**EXHIBIT 5.3**

**SELECTED CHARACTERISTICS AND COMPARISONS BETWEEN THE DOMICILED SAMPLE AND POOR ADULTS**

| Trait | Domiciled Sample | Chicago Poverty Comparison (or race/sex correction) |
|---|---|---|
| Age | 37.8 years | 42.1 (c) |
| Percent Black | 74.2% | 68.8 (a, c) (3) |
| Percent Male | 74.1% | 43.2 (c) (3) |
| Years of Education | 11.0 years | 10.8 (c) (estimate) |
| Percent of Adult Life Worked | 52.2% | 59.1 (c) |
| Prison Experience | 13.3% | 9.6 (b) (4) |
| Military Experience | 19.7% | 22.5 (c) |
| Childhood Out of Home Placement | 9.0% | 8.3 (b) (1) |
| Mental Hospital Experience | 12.1% | 10.7 (a, d) (3) |
| One Adult Household | 41.6% | 56.9 (c) |
| Jail Experience | 59.1% | 38.2 (b) (4) |
| GSI (mental distress) | .74 | .87 (e) (3) |
| Alcohol Symptom | 17.4% | 17.4 (d) (2) |
| Welfare, Other Income Maintenance | 68.1% | 70.8 (c) |
| Monthly Work Earnings | $91.77 | $117.43 (c) |
| Rent pays or paid | $129.90 | $167.70 (a) (3) |

a. Chicago b. Illinois c. Midwest pre-transfer poor, non-elderly household heads
d. National e. selected group

1. Only corrected for percent black in sample
2. Only corrected for percent male in sample
3. Only corrected for poverty
4. Corrected for sex and race composition of sample but not poverty

All other comparisons but those footnoted 1 through 4 are corrected for the sample's sex and race composition.

## Measures of Poverty Population Used in EXHIBIT 5.3

Percent Black

Percent Male

CPS Micro-data for 1986, midwest household heads. Race results also use information on Chicago published for the CPS, corrected (using the midwest data) for the inclusion of the elderly.

Average Age

Years of Education

Military Experience

One Adult Households

Welfare and Income Maintenance

Percent of Adult Life Worked

CPS Micro-data for 1986, midwest household heads. In the last case, we use weeks worked in current year and assume individuals are poor half the time and that they work 95% of the time when not poor.

Prison Experience

Based on 1983 Illinois admissions, assuming one-half of admissions are new offenders, one admission per year, and 20 years of exposure. Only blacks and whites by sex are reported clearly (U.S. Department of Justice, 1985).

Childhood Out of Home Experience

Uses national data from the mid 1970s, assuming ten years of exposure for each individual, year long stays, and an average of two stays in a lifetime (National Encyclopedia of Social Work, 1987). Race representation, for blacks, only, is contained elsewhere (Children's Defense Fund, 1978).

Jail Experience

Uses 1983 daily estimate, assuming three months average stays, that one-half of all stays are first time admissions, and 20 years of exposure. Uses prison data to correct for proportion male and black (U.S. Department of Justice, 1985).

GSI

Calculated from raw data on Wisconsin AFDC women, made available by Professor Sharon Berlin. See Berlin and Jones (1983) for details.

Alcohol Symptoms

Male and female figures as reported in National Encyclopedia of Social Work (1987).

Rent paid

Average rent paid by those with incomes below $3,000 and below $10,000 per year (Chicago Annual Survey of Housing, 1986), and assuming individuals pay 65 percent of the rent (rounded from data on the sample).

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# ABOUT THE AUTHORS

## ABOUT THE AUTHORS

Below are brief descriptions of the authors of the papers contained in this report. Complete addresses and telephone numbers are contained in the List of Participants which follows this section.

**John Brekke,** Ph.D., is Assistant Professor in the School of Social Work at the University of Southern California in Los Angeles. Dr. Brekke's main area of interest is mental health program evaluation. He has conducted studies of several case management programs including the PACT program in Madison, Wisconsin.

Patricia Cohen, Ph.D., is a research scientist with the New York State Psychiatric Institute and Co-Director of the Psychiatric Epidemiology Training Program at Columbia University. Dr. Cohen has developed and tested instruments to assess the mental health status of children; she has also conducted longitudinal studies of psychopathology and psychological development in children and adolescents.

Deborah **Dennis, M.A.,** is Project Director of the National Resource Center on Homelessness and Mental Illness, Policy Research Associates, Inc., in Delmar, New York. She has co-authored a number of reports and conference proceedings on homelessness and mental illness. She recently completed (with Richard Tessler) a synthesis of NIMH-funded research on homelessness and mental illness.

**Kathleen Dockett,** Ed.D., is Associate Professor in the Department of Psychology at the University of the District of Columbia in Washington, D.C. She has conducted one of the few studies to-date of referral patterns for and service utilization of homeless mentally ill individuals. She has also conducted a survey of the characteristics and service needs of homeless "street people" in the District of Columbia.

**Mary Fennell,** Ph.D., is Associate Professor in the Department of Sociology at Pennsylvania State University. Her major area of interest is health care organizations. She has conducted research on multi-hospital systems and is currently doing work on the interorganizational relationships among homeless shelters and mental health service systems.

**Pamela Fischer,** Ph.D., is Assistant Professor in the Department of Psychiatry and Behavioral Sciences at The Johns Hopkins University School of Medicine in Baltimore. She has written extensively about the mental health aspects of homelessness, substance abuse among the homeless population, and the criminal justice system involvement of homeless persons. She was recently awarded an NIMH grant to study the mental health needs and characteristics of homeless women and children.

Howard Goldman, M.D., Ph.D., is Director of Mental Health Policy Studies in the Institute of Psychiatry and Behavioral Sciences, University of Maryland School of Medicine. He is widely known for studies of mental health policy and financing. Dr. Goldman is the director of the National Evaluation Team for the Robert Wood Johnson Program on Chronic Mental Illness.

**Lisa Goodman,** M.S., is a doctoral candidate in clinical-community psychology at Boston University. She is currently completing her dissertation which compares the prevalence of domestic violence among homeless and domiciled women. She has served as a consultant to the Better Homes Foundation on the evaluation of programs for homeless families.

**William Hargreaves,** Ph.D., is Professor of Medical Psychology in the Department of Psychiatry at the University of California Medical School in San Francisco. He is known for his methodological and theoretical contributions to the mental health services literature, studies of case management, and experimental evaluations of county mental health systems.

**Kim Hopper,** Ph.D., Visiting Assistant Professor at the New School for Social Research and a research scientist at the Nathan Kline Psychiatric Institute. Dr. Hopper is a founding member and currently on the board of the National Coalition for the Homeless. He was one of the first researchers to draw attention to the plight of mentally ill homeless persons in New York City with the publication in 1981 of Private lives. Public Spaces (co-authored with Ellen Baxter). He has written extensively on the historical roots of homelessness and the policy implications of the various proposals to solve the social and personal problems associated with homelessness.

**Paul Koegel,** Ph.D., is Assistant Research Anthropologist in the Department of Psychiatry at the University of California Medical School in Los Angeles. Dr. Koegel's study (with Drs. Roger Farr and Audrey Burnam) of the homeless population in L.A.'s Skid Row is known for its ethnographically informed and rigorous sampling design and its in-depth analysis of mental health status. He was recently awarded an NIMH grant (with Audrey Burnam) to conduct a two-year panel study of 480 homeless persons with and without mental illness.

**Anne Lovell,** M.S.W., M.Phil., is a research scientist with the Epidemiology of Mental Disorders Research Department of the New York State Psychiatric Institute. She has written extensively on the methodological issues of studying homelessness and of assessing mental illness among homeless adults. Ms. Lovell conducted (with Drs. Elmer Struening and Susan Barrow) an NIMH-funded evaluation of outreach programs for homeless mentally ill individuals. She is currently conducting research on the social networks of homeless men and women in New York City.

Gary Morse, Ph.D., is a clinical psychologist and Director of Community Support Programs for the Malcolm Bliss Mental Health Center in St. Louis. He has created programs to meet the needs of the homeless mentally ill population in St. Louis, conducted research, and written extensively on the subject. He was recently awarded an NIMH research demonstration grant to study the effectiveness of different models of case management with the homeless mentally ill population.

**Joseph Morrissey,** Ph.D., is a sociologist and Deputy Director of the Health Services Research Center at the University of North Carolina in Chapel Hill. He has studied mental health service delivery and sheltering programs in New York City. His other work has focused on interorganizational studies of mental health systems and the policy implications of this research. He is a member of the National Evaluation Team of the Robert Wood Johnson Program on Chronic Mental Illness.

**Sandra Newman,** Ph.D., is Associate Director for Research at The Johns Hopkins University's Institute for Policy Studies in Baltimore. Her research focuses on housing consumption behavior, housing policy, and long-term care. She currently directs the housing subcomponent of the National Evaluation of the Robert Wood Johnson Program on Chronic Mental Illness.

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**Robert Rosenheck,** MD., is Director of the Veterans Administration Northeast Program Evaluation Center in West Haven, Connecticut. He is currently conducting a longitudinal evaluation of the Veteran's Administration's Homeless Chronically Mentally Ill Veterans Program at 43 sites nationwide.

**Alan Ross,** Ph.D., is Professor and former Chair of Biostatistics at The Johns Hopkins University School of Hygiene and Public Health in Baltimore. He helped design the sampling and statistical analysis plan for the Baltimore homeless studies conducted by Drs. William Breakey and Pamela Fischer.

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**David** Shern, Ph.D., is the Director of the Bureau of Survey and Evaluation Research for the New York State Office of Mental Health. His research expertise is in the areas of social indicator models of the need for mental health services and the cost of care for seriously mentally ill individuals. He is a collaborating investigator in the National Evaluation of the Robert Wood Johnson Program on Chronic Mental Illness.

**Jay** Sokolovsky, Ph.D., is Professor of Anthropology at the University of Maryland in Baltimore. He has been studying the social networks of men on the Bowery in New York City for the past eight years and has recently completed a book on the subject (with Carl Cohen). His expertise is in measurement issues related to social network analysis.

**Michael Sosin, Ph.D.,** is Professor in the School of Social Work and Institute for Research on Poverty at the University of Wisconsin. While a Visiting Scholar at the University of Chicago, he conducted one of the few studies to investigate the factors that differentiate homeless persons from other impoverished persons who remain domiciled. This study, which used a wide variety of data sources to incorporate social indicators as well as individual characteristics, is a model for future research on homelessness and mental illness.

**Richard Tessler,** Ph.D., is Professor of Sociology at the University of Massachusetts in Amherst. He is widely known for his research on chronic mental illness and mental health services. He recently completed (with Deborah Dennis) a synthesis of NIMH-funded research on homelessness and mental illness. He is currently conducting an NIMH-funded study of family burden and chronic mental illness in several cities participating in the Robert Wood Johnson Program on Chronic Mental Illness.

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