Practical Lessons :

The 1998 National Symposium on Homelessness Research

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FOREWORD

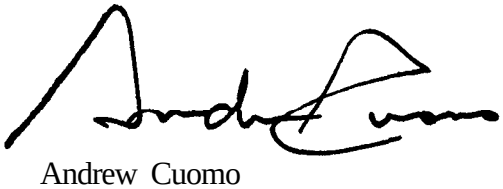
Homelessness in America affects a diverse population: families with children, people with disabilities, and others who flee from domestic violence or simply lose a job and cannot afford decent housing. Despite substantially increased funding and attention by government agencies, nonprofit groups, and thousands of volunteers, homelessness is still too common.

Much remains to be done. In the past few years, Federal, state and local agencies have created partnerships that use a comprehensive approach to the housing and support services needs of homeless adults and families with children. This new 'continuum of care' and other efforts to coordinate and integrate government and local services have successfully restructured service-delivery systems and improved our ability to respond to homelessness.

There has been a wealth of research over the past decade on homeless issues, including the nature of homelessness and characteristics of the homeless population; the special needs of homeless persons with disabilities; critical support services and other assistance homeless people need to become more self-sufficient; and new approaches to the problem. This is a broad range of important topics, and it is appropriate to review these findings carefully.

HHS and HUD collaborated to draw practical lessons from the studies. Leading researchers, program managers, practitioners and consumers commented on, reviewed, and synthesized knowledge about how to design continuums of care and how to provide services to homeless persons most effectively. As a result of this work, we have developed ***Practical Lessons: The 1998 Symposium on Homelessness Research,*** a set of summary papers and topics for further examination.

We are pleased to make this publication available to those concerned with and working to solve these problems, with the hope that it will help us all reach our goal of ending homelessness in America.



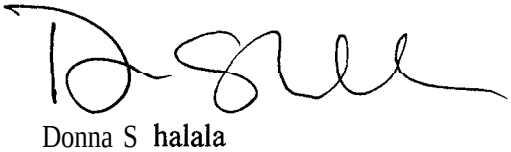


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Table of Contents

Acknowledgements iii

Overview v

1. Demographics and Geography: Estimating Needs 1-1
By: Martha R. Burt, Ph.D

2. Special Populations of Homeless Americans 2-1
By: Robert Rosenheck, M.D., Ellen Bassuk, M.D., and Amy Salomon, Ph.D.

3. Homeless Youth: Research, Intervention, and Policy 3-1
By: Marjorie J. Robertson, Ph.D., and Paul A. Toro, Ph.D.

4. Making Homeless Programs Accountable to Consumers, Funders and the Public 4-1
By: Dennis Culhane, Ph.D., David Eldridge, M.S.W., Robert Rosenheck, M.D., and Carol Wilkins, M.P.P.

5. Giving Voice to Homeless People in Policy, Practice and Research 5-1
By: Nicole Glasser

6. To Dance With Grace: Outreach and Engagement to Persons on the Street 6-1
By: Sally Erickson, M.S.W. and Jaimie Page, M.S.W., L.S.W.

7. A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy and Research 7-1
By: Gary Morse, Ph.D.

8. Balancing Act: Clinical Practices that Respond to the Needs of Homeless People 8-1
By: Marsha McMurray-Avila, M.C.R.P., Lillian Gelberg, M.D., M.S .P.H., and William R. Breakey, M.D.

9. Emergency Shelter and Services: Opening a Front Door to the Continuum of Care 9-1
By: Judith D. Feins, Ph.D. and Linda B. Fosburg, Ph.D.

10. Transitional Housing and Services: A Synthesis 10-1
By: Sue Barrow, Ph.D. and Rita Zimmer, M.P.H.

11. Reconnecting Homeless Individuals and Families to the Community 11-1
By: Debra J. Rog, Ph.D. and C. Scott Holupka, Ph.D.

12. What Do We Know About the Systems Integration and Homelessness? 12-1
By: Deborah L. Dennis, M.A., Joseph J. Cocozza, Ph.D., and Henry J. Steadman, Ph.D.

13. Rethinking the Prevention of Homelessness 13-1
By: Marybeth Shinn, Ph.D. and Jim Baumohl, D.S.W.

Appendix A – Agenda A-1

Appendix B – Biographies B-1

Appendix C – Participant List C-1

Acknowledgements

The editors of this report on the National Symposium on Homelessness Research: What **Works-Linda B. Fosburg and Deborah L. Dennis—**thank many others for their valuable assistance in planning, implementing, and reporting on the outcomes of the symposium. From the beginning in December 1997, this project has been a team effort that has benefited from the collaboration of many other persons.

First, we recognize the invaluable contributions of two other core members of the planning team-James **E. Hoben and Mary Ellen** O'Connell-the representatives of the cosponsors of the symposium, the Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS). We, as the core planning team, also thank the other planning team members-George **Ferguson, Jean Hochron, Walter Leginski and Marge Martin.**

Second, we thank the members of the expert panel who reviewed the initial plans and provided important input into the content and format of the symposium. Among those who participated in this activity were: **Martha Burt** (The Urban Institute), **Mary Ann Gleason** (National Coalition for the Homeless), **Steven Hornburg** (Fannie Mae Foundation), **Paul Koegel** (RAND Corporation), **Betsey Lieberman** (AIDS Housing of Washington), **Ann O'Hara** (Technical Assistance Collaborative), **Marjorie Robertson** (California Pacific Medical Center Research Institute), **Debra Rog** (Vanderbuilt University Institute for Public Policy Studies), **Nan Roman** (National Alliance to End Homelessness), **Robert Rosenheck** (West Haven Veterans Administration Medical Center), **Amy Soloman** (The Better Homes Fund), **Julie Sandorf** (Corporation for Supportive Housing), **Laurel Weir** (National Law Center for Homelessness and Poverty), and **Beth Weitzman** (New York University).

Third, we are grateful for the contributions of the Federal representatives who opened and closed the symposium, including: **Xavier de Souza Briggs** (Deputy Assistant Secretary for Research, Evaluation, and Monitoring at HUD), **Margaret Hamburg** (Assistant Secretary for Planning and Evaluation at HHS), **Fred Karnas, Jr.** (Deputy Assistant Secretary for Economic Development, Office of Community Planning and Development at HUD), and **Marsha Martin** (Special Assistant to the Secretary of HHS). We also thank all the facilitators at the symposium: **Ann O'Hara** did a wonderful job as the overall symposium facilitator; **Linda Boone, James Hoben**, **Jean Hochron, Mark Johnston, Walter Leginski, Gretchen Noll**, **James O'Connell, Mary Ellen O'Connell, Fred Osher, Fran Randolph, Amy Soloman**, and **Jean Whaley** provided the leadership for the facilitated discussions. We also acknowledge and thank **Donald Bradley** of the Freddie Mac Foundation for providing scholarships to allow formerly homeless persons to attend and for the reception at the end of the first day of the symposium.

We give a special thanks to all of the authors of the research synthesis papers who provided the substance for symposium. We also thank respondents to each of the research papers. The names of the authors and respondents are shown in the agenda in Appendix A. We thank the staffs of Abt Associates Inc. and Policy Research Associates who assisted us in all aspects of this project. Finally, we recognize the contributions of all of the authors who have conducted the research on homelessness over the past two decades. Their efforts are listed in the bibliographies of each of the research synthesis papers.

Overview

by
Linda B. Fosburg, Ph.D.
Deborah L. Dennis, M.A.

When passed in 1987, the Stewart B. McKinney Homeless Assistance Act (P. L. 100-77) was landmark legislation providing the first federal funds targeted specifically to address the needs of homeless persons. The McKinney Act originally consisted of fifteen programs providing a range of services to homeless people, including emergency shelter, transitional housing, primary health care, education, and some social service needs. By 1998, approximately one decade after the McKinney funds became available and research results on the impacts of funding were becoming available, it was appropriate to address the question-What works?

The National Symposium on Homelessness Research was convened in Arlington, Virginia on October 29th and 30th, 1998 under the auspices of the U. S. Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS) for this purpose. [1] Approximately 175 persons (including researchers, practitioners, policymakers, and formerly homeless persons) attended. During the two-day meeting, all in attendance had an opportunity to participate. Authors of eleven research papers presented their findings. Facilitated discussion groups followed the research presentations. Designated respondents provided prepared comments and other attendees gave additional feedback to the authors. Plenary discussions were another source of feedback to the authors and symposium planners. Consequently, the original papers were revised and the symposium planners commissioned two additional papers for inclusion in this compendium of research papers on homelessness.

Planning for the symposium began in January 1998 by a HUD/HHS joint planning committee consisting of representative from the two Departments and a team of two contractors (Abt Associates Inc. and Policy Research Associates, Inc.). An expert panel, convened in March 1998, provided input on the structure, agenda, topics, and participants for the symposium. Two complementary initiatives supported the researchers efforts to synthesize the lessons and implications of research done on exemplary practices for homeless people. One initiative, ***Workshop on Exemplary Practices: Addressing Homelessness and Health Care Issues,*** sponsored by the U. S. Department of Health and Human Services, focused on what is known about effective service delivery strategies and current policy questions. The second initiative, the ***National Symposium on Homelessness Research*** sponsored jointly by HUD and HHS, incorporated papers from the workshop, commissioned additional researchers to investigate what is known about the effectiveness of various components of the continuum of care and what should be the emphases for future research, and convened a national forum to discuss the resulting papers.

Common Themes Derived from the Research Papers

The Symposium was an historic opportunity to assess what we, as a nation, have learned about how to address homelessness since the McKinney Act was enacted: While there is much that remains to be understood about the effectiveness of programs for specific subpopulations of homeless persons, the

[1] Three appendices accompany this report. Appendix A is the agenda for the symposium. Appendix B contains brief biographies of the authors of the research papers. Appendix C is a list of all symposium attendees.

sentiment echoed by all in attendance was that we have learned a great deal about how to end homelessness.

We know that outreach works. We know that subsidized housing works. We know that involving homeless and formerly homeless people in the design and implementation of services is important to creating successful programs. We know that homeless people sometimes have complex needs. We know that case management and systems integration can help cement and support fragile interpersonal and interorganizational relationships, creating greater opportunity for positive client outcomes. We know that programs can be held accountable, that management information systems exist that can provide valid information for planning and policy, and that the communities can reliably and feasibly assess the local need for homeless services.

Some of the key themes that emerged from the papers commissioned for the Symposium as well as from the ensuing discussion were the following.

Homeless People: Diversity and Local Need

- Homeless people reflect the nation's diversity and their special and sometimes complex characteristics and needs must be identified, respected, and addressed.

- Despite their diversity, almost all homeless people are extremely poor. Regardless of their other difficulties, practitioners must address their basic tangible needs for material resources.

- In addition to responding to basic needs for shelter, food, clothing, and medical care, programs should begin with a systematic assessment of the unique needs of each homeless person.

- Homeless persons include families with children, single people, Veterans, runaway and homeless youth, persons with mental health and substance abuse problems, and persons who are homeless for purely economic reasons. Each group has distinct characteristics, needs, and preferences that should be considered when designing programs.

- **Some** homeless persons will require limited assistance; others will require extensive and long-term support. Over time, each person's needs will change and so should the necessary assistance.

- Homeless programs can help homeless persons to restore self-esteem, recover from illness, address disabilities, develop life and economic skills, and attain maximum self-sufficiency. Achievement of these objectives requires a partnership of individual effort and tailored assistance by the homeless service provider.

- Each community must collect its own data on homeless needs. The numbers and characteristics of homeless persons will vary by community and will change over time, based on regional economic conditions and public policies.

Services:

- Health care programs, which make special adaptations to the structure and delivery of health, mental health, and substance abuse services, will be more effective at serving homeless people.

- Some delivery adaptations should include extensive outreach, mobile sites, procedural flexibility, and follow up.

- Integration of primary care, mental health, and substance abuse services is the preferred approach for providing services to homeless persons.

- Research has demonstrated that outreach services are effective in engaging those who are unserved or underserved by existing agencies and those who unable or unwilling to seek services on their own.

- The employment of formerly homeless persons as outreach workers is an effective engagement strategy.

- The most effective case management strategies for homeless persons include: conducting assertive, community-based outreach; giving priority to client's self-determined needs; providing clients with active assistance to obtain needed resources; maintaining small case loads; and using an assertive community treatment (ACT) approach.

Housing:

- Receipt of affordable housing is the single greatest predictor of formerly homeless persons' ability to remain in housing. Homeless persons, who receive subsidized housing, will for the most part, remain in that housing. To afford private-market-unsubsidized housing, they will require increased income and employment assistance.

- There is a large unmet need for affordable housing for homeless and very low-income Americans. Intensive supportive services, especially for homeless persons with significant disabilities are also greatly needed.

- Consumer choice in housing is associated with residential stability for formerly homeless people. Thus, communities may need to offer a range of living options, with different degrees of social control and expectations for behavior.

- In many places, emergency shelter has been expanded from "three hots and a cot" to include client assessment, case management, and supportive services. The focus has shifted from shelter only to a reintegration into the community.

- Descriptive data from national surveys of transitional housing find that about 70 percent of those who completed transitional housing programs obtained housing. Despite the strong commitment of many to transitional housing, well-designed studies of its long-term effectiveness are almost non-existent.

- Providers are encouraged to experiment with new models of transitional housing that are "co-located" with or "convert" to permanent housing. This may provide a way to help individuals and families transition out of homelessness without the stigma and the repeated disruption of support networks that some transitional housing approaches entail.

Systems Integration:

- Services integration (client-level strategies) and systems integration (administrative-level strategies) must be undertaken at the same time in order for either to be effective.
- Systems integration must be pursued at the federal, state, and local levels.
- Three strategies are necessary for systems integration to occur: having a designated leader responsible for systems integration; getting the key players and decision-makers to the table (and keeping them there), and using a formal strategic planning process.

Program Effectiveness and Accountability:

- Programs for homeless persons are only effective if implemented in the context of a system that includes adequate affordable permanent housing and supportive community-based services.
- Providers of homeless services need client-based, longitudinal, networked data systems to administer effective continuums of care and to influence decisions about mainstream systems. The client information system should contain information on client needs, services, and outcomes. Individual client data must be kept confidential to protect privacy.
- Homeless programs must improve their ability to demonstrate accountability by documenting all outcomes.

Research on Homelessness:

- A great deal can be learned about program effectiveness by asking homeless persons, formerly homeless persons, and practitioners about what works, what doesn't work, and why.
- Evaluations of promising practices need to include longitudinal data collection and comparative analyses of experimental and control groups with adequate sample sizes to support findings.
- There must be an increased effort to document practices in the field and to translate the practical implications of research to the field in ways that speak to a non-research audience.

Consumer Involvement:

- Homeless and formerly homeless people can contribute in many ways to the planning and implementation of programs and policies designed to help them.
- Consumer input in research studies and program evaluations also greatly enhances the design, conduct and interpretation of results.
- There are many examples and models of how to involve consumers in policy, practice, and research.

Synopsis of Research Synthesis Papers

The symposium planning committee, with input from an expert panel, selected the topics for the research papers because of their relevance to various aspects of homelessness and potential contribution to the field. Hence, the research basis of the papers contained in this report varies from extensive to modest. Eleven of the research papers were presented at the National Symposium on Homelessness Research. After the symposium, the planners commissioned two additional papers (the third and fifth summarized below) for inclusion in this compendium. Each paper contains a wealth of information from the synthesized research that can inform future initiatives for homeless people by practitioners, policy makers, and researchers.

Demographics and Geography: Estimating Needs

Martha Burt's paper synthesizes the findings of nine studies of homeless populations over the past two decades. It describes the most comprehensive and latest data on important characteristics of homeless persons. It also summarizes the methodologies used by various jurisdictions to locate and describe homeless people and the factors that make them vulnerable to homelessness. The author documents that homelessness will vary among communities regarding the numbers, types of persons, and needs. She also states that different data sources may lead to different population appraisals and determinations of services needs. Based on this premise, the author provides local jurisdictions with recommendations for feasible and cost-effective methods to collect data on the local homeless population. The author underscores the importance of local data for local decision making as follows: "Having your own data eliminates local arguments about the existence of the problem and focuses attention on what to do about it" (p. 1).

Special Populations of Homeless Americans

Robert Rosenheck, Ellen Bassuk, and Amy Solomon review the research on the subpopulations of homeless Americans and conclude that they represent of all segments of society. They are men and women, old and young, families and single people, whites and minorities, rural. and city residents, persons with serious health problems and the able bodied. Some appear more vulnerable and in greater numbers than might be expected by their numbers in the population alone: e.g., single males and minorities. Despite their diversity, the subgroups share common needs. All are poor; they lack decent and affordable 'housing, and do not have an adequate income. The similarities and differences found by the studies of the past 15 years are illuminating. They point out that despite the evidence of common needs, some subgroups are seen as "deserving" while others are not. They conclude that the evidence shows that services should be targeted by the needs of the specific individual, not by the subgroup characteristics.

Homeless Youth: Research, Intervention, and Policy

Marjorie J. Robertson and Paul A. Toro review the research on homeless youth. According to some estimates, at least 5% of youth aged 12 to 17 are homeless and most evident in metropolitan areas. While the research conducted to date is limited, the authors have synthesized the extant literature and described what additional information is needed to provide a more accurate and complete description of this subgroup of homeless people. The authors describe characteristics of homeless youth using standard demographics and include precursors such as family and residential instability and prior school experiences. They also describe homeless youths' mental health, substance abuse, and health issues as well as their survival strategies while homeless. The authors discuss the intervention strategies that have

been attempted after the youth have been homeless for some period. Although there is less literature on prevention, the authors present two basic approaches to homelessness prevention through primary prevention interventions and through prevention of repeated spells of homelessness. Finally, the authors provide recommendations for future studies using large representative samples of homeless youth, valid and reliable measurement tools, and assessment of both the youths' strengths and problems.

Making Homelessness Programs Accountable to Consumers, Funders and the Public

Dennis Culhane, David Eldridge, Robert Rosenheck, and Carol Wilkins address the question: Are programs for homeless people delivering on their promises? This paper explores how performance measurement can provide program effectiveness indicators to consumers, funders, and the public, to improve programs. For example, consumer outcomes can inform whether consumer services are being delivered and consumer needs are being met. Program outcomes can provide funders with the information needed about future funding decisions. System outcomes can likewise provide the public with the information needed to ensure that community goals are being reached. The authors review the measurement strategies that can be used, ranging from simple and inexpensive to more complex and resource-intensive. They describe standard assessment tools that have been used at the three levels of accountability. Finally, they discuss the benefits of a cost benefit analysis, especially for homeless programs where cost comparisons with those of other institutions (e.g., hospitals, jails, mental institutions, etc.) can help to ensure continuing public support. They conclude that standardized information is a necessary basis for discussing the merits of existing and proposed policies and programs.

Giving Voice to Homeless People in Policy, Practice, and Research

The author of this paper, Nicole Glasser, brings her personal experience to this research assignment. She states: "Having personally walked many high roads and low roads as a consumer of mental health and homeless services, nothing makes more sense to me than allowing clients, or consumers of services to have a greater say in their services-from the direct provision of services, to policy, administration, and evaluation." Consumer involvement in programs that serve homeless people has been growing. There is an increasing body of literature that supports the benefits of consumer involvement, on the programmatic, policy, and administrative levels. Consumer empowerment ranges from participation in a community meeting or on an advisory board, to hiring consumer staff, to completely consumer-run programs and organizations. While there is resistance within any system to hand over power to a stigmatized group, once done, the system may find that it has higher quality and more responsive services. Research finds that consumers can perform as well as non-consumer staff and are especially skilled at engaging potential clients. Within consumer-run organizations, the focus of service delivery is on choice, dignity, and respect. There are a number of things that federal; state and local governments can do to encourage consumer involvement in decision-making, staff hiring, and the creation and survival of consumer-run organizations.

To Dance with Grace: Outreach and Engagement to Persons on the Street

Sally Erickson and Jaimie Page review the literature on outreach. By definition, outreach is the process of connecting or reconnecting a homeless individual to needed services. Much of the extant literature comes from mental health outreach programs. Because homeless populations vary by community, each community must tailor its outreach program to those in need. The authors cite several principles of successful outreach programs. These include: focus on individuals as people, recognition of the uniqueness of each individual, emphasis on empowerment and self-determination for homeless persons, delivery of outreach services with an attitude of respect, hope, kindness, advocacy, as well as flexibility

and creativity. One of the developments in outreach, cited by the authors, is employment of consumers/peers/formerly homeless persons as outreach workers. Success stories in outreach abound, yet funding remains an outstanding issue. The authors encourage communities to include outreach explicitly in their Continuum of Care proposals.

A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research

Over the past two decades, case management has become one of the most common practices in the delivery of services to homeless people, according the author, Gary Morse. Confusion over what constitutes case management abounds. To clarify, the author discusses several functional definitions of case management. He also presents case management approaches and models for various client subgroups and specialty areas. He concludes from his synthesis of studies on case management that there is strong support for the effectiveness of case management to help homeless people with severe mental illness into needed services, including stable housing. Frequent service contacts are critical to treatment retention and housing outcomes. Case management services are less effective with some clients than others. He also cites knowledge gaps about the effectiveness of case management for those with dual diagnosis, children, youths, women, or families; other mental disorders that are not classified as severe mental illness. Finally, he examines exemplary case management practices in terms of: staff skills and abilities, service principles, and organizational practices; and make recommendations for promoting exemplary practices

Balancing Act: Clinical Practices that Respond to the Needs of Homeless People

The occurrence of physical and/or mental illnesses is approximately two to six times higher for homeless people than for those who are housed (Wright, 1990). According to the authors, Marsha McMurray-Avila, Lillian Gelberg, and William R. Breakey, both types of illnesses have been implicated as "causes and consequences of homelessness for many individuals" (p.2). This is because the incidence of these illnesses creates vulnerabilities that can lead to the primary causal factors of homelessness: loss of income and home. After over a decade of practice with homeless populations, there is a growing agreement on what constitutes state-of-the art delivery of clinical services with homeless persons. The authors cite nine general principles that have emerged and discuss outcomes in terms of system-level and client-level outcomes. They conclude: health care programs need to be expanded into other areas (e.g., dental health); more extensive data on health care utilization, costs, and outcomes need to be collected; and retention programs for skilled practitioners to work with homeless people are needed.

Emergency Shelter and Services: Opening the Front Door to the Continuum of Care

Judith Feins and Linda Fosburg review the provision of emergency shelter and services to homeless persons in the U. S. They focus primarily on the Emergency Shelter Grant (ESG) program, which helps localities and states provide facilities and services to meet the needs of homeless people and, at the same time, aid in their transition from temporary shelter to permanent homes. In large part, this paper grows out of an evaluation of the ESG program conducted in 1993. Today's emergency shelters provide many more services than "three hots and a cot" (or three meals and a bed). Nearly all ESG-supported shelters provide one or more supportive services to clientele. The authors describe the populations served and the effective practices used in delivering emergency shelter and services. The authors conclude that the problem of homelessness is not likely to disappear soon. More research emphasis needs to be placed on both ends of the continuum of care, especially on effective strategies for homelessness prevention and programs to ensure a transition to stable economic self-sufficiency.

Transitional Housing and Services: A Synthesis

According to Susan Barrow and Rita Zimmer, in 1994, when the U. S. Department of Housing and Urban Development first required applicants for federal funding of homeless programs to create a continuum of care, transitional housing became a "required" element of a comprehensive response. The authors discuss the boundaries among transitional housing, emergency shelter, residential treatment programs, and permanent supportive housing. They also examine the ways that typical programs vary, especially in terms of program outcomes in five categories: service engagement and utilization, behavioral measures, self-sufficiency measures, housing variables, and cost effectiveness. The authors conclude that transitional housing can be effectively implemented' only in the context of adequately subsidized permanent housing and readily available supportive services. They also conclude that comparative research is needed between transitional housing models and other alternatives. Furthermore, more emphasis should be placed on consumers' perspectives, especially their attitudes toward acceptance of services as a condition for remaining in housing.

Reconnecting Homeless Individuals and Families to the Community

Debra Rog and Scott Holupka characterize the circumstance of homelessness as personal isolation and a lack of connections with family, jobs, and community. This paper explores what 'is known about reversing the process and reconnecting homeless people with their personal self-sufficiency, with residential stability and employability, as well as with family and friends. The authors explore what has been learned about various aspects of the process. First they discuss the reconnection process to residential stability and describe several program strategies (e.g., Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation Assistance Single Room Occupancy) and evidence of effectiveness. Next, they explore the process of reconnecting homeless people with the job market through a variety of program strategies (e.g., Job Training for the Homeless Demonstration Program, and Next Steps: Jobs). The authors also discuss the research on reconnecting with family and friends. They conclude that the best prospects for success may be a "three-legged stool" approach that encompasses housing, services, and employment.

What Do We Know About Systems Integration and Homelessness?

Deborah Dennis, Joseph Cocozza, and Henry Steadman maintain that despite calls for comprehensive systems of care for homeless people over the past decade, little has been done in this regard. The authors define and differentiate between systems integration strategies (e.g., involvement of interagency coordinating bodies, strategic planning, and pooled or joint funding) and services integration strategies (e.g., involvement of case management, individualized service planning, and assertive community treatment). They demonstrate with numerous examples how communities have addressed systems and services integration and made it work for them. They conclude that successful systems integration requires the commitment of key decision-makers to an on-going process and the resources required to implement an effective system. Both systems and services integration strategies must ultimately be implemented simultaneously.

Rethinking the Prevention of Homelessness

Marybeth Shinn and Jim Baumohl review the current state-of-the-art in homelessness prevention and draw the same conclusion as the U. S. General Accounting Office (1990) did; it remains "too early to tell" what works in preventing homelessness. The authors discuss the logic of prevention and the basic definition of what is included in homelessness prevention. Next, they critique the conceptual and

methodological problems. For example, while eviction prevention programs appear effective in some instances, they may be excluding people who are at higher risk of homelessness-those who do not have a lease, but who are precariously housed. Similarly, programs that target discharge planning or amelioration of domestic conflicts—even if 100% successful-may only reach a small proportion of those who are likely to become homeless in a given year. The authors conclude that while social services may be valuable for other reasons, services may not be the essential factor in preventing homelessness once access to subsidized housing is taken into account. Instead, the authors propose testing other models of homelessness prevention and point to the need for long-term followup. Otherwise, the ultimate results of a homelessness prevention program will remain inconclusive.

Summary

In summary, the thirteen research papers contained in this report offer many insights into what has been learned in the past two decades. Indeed, we have learned a great deal about how to end homelessness. Each of the papers offers its views on the emerging best practices and provides appropriate cautions where improved practices need to be developed and integrated into the current strategies for addressing the needs of homeless people.

Demographics and Geography: Estimating Needs

by
Martha R. Burt, Ph.D.

Abstract

This paper summarizes the latest and/or most comprehensive data on important characteristics of homeless people. It looks at the demographics and distribution of homeless people among communities of different types, as documented by a range of research methodologies in various jurisdictions and nationwide. It also examines how characteristics may differ depending on the locations in which a study looked for people to include, and factors that seem to make people vulnerable to homelessness.

The paper then turns to the need of local jurisdictions for information to help with service planning. It discusses the variety of people and agencies that might need information for planning, the types of decisions they must make, and what types of information would help them the most. It continues with a review of several strategies that work at the local level for collecting the most useful data, and the advantages and disadvantages of each method. Finally it draws the conclusion that every jurisdiction will be best served by gathering its own information about service needs for planning purposes.

Lessons for Practitioners, Policy Makers, and Researchers

- The best national and local studies of homeless populations show highly variable results for most demographic characteristics, including gender, age, race, ethnicity, household structure, and length of homelessness.
- No national data source will ever exist that can provide adequate information for local planning.
- Each jurisdiction should gather its own data on population characteristics and service needs. Local data are the only data that are truly useful for local planning.
- Feasible and reasonably-priced ways exist for local jurisdictions to collect their own data. More and more jurisdictions are doing so.
- Having your own data eliminates local arguments about the existence of the problem and focuses attention on what to do about it.
- What you learn about the characteristics and need of your jurisdiction's homeless population will depend on where you go for information. If you go only to shelters you will miss a lot, even if you have a shelter tracking database that provides unduplicated data over time.

Introduction

This paper starts with a summary of the latest and/or most comprehensive data on important characteristics of homeless people. It looks at the demographics and the distribution of homeless people (at a single point in time) among communities of different types. It also examines how characteristics may differ depending on the locality where people are found, and factors that seem to make people vulnerable to homelessness.

It then turns to the issue of what might be meant by "need". It discusses the variety of people who use information on needs among homeless people to make planning decisions, the types of decisions they must make, and what types of information might help them the most. The paper concludes by reviewing several strategies for obtaining data at the state and local levels, and the advantages and disadvantages of each for the various decision makers.

What Recent Studies Say

Who Are Homeless People?: I
Demographics and Patterns of Homelessness

Many studies have collected descriptive information about homeless populations over the past two decades. Most are studies of particular cities or parts of cities, and some analyze only the information from people staying in a single shelter. Some have specialized purposes such as examining the nature and extent of mental illness or substance abuse or the situations of homeless families, while others are quite general. No attempt has been made to summarize all of these studies. Rather, several of the most recent studies that have methodological interest, cover sizeable geographical areas, and provide overviews of homeless populations are reviewed.

Table 1 summarizes these studies, which include one that covers the entire United States (1990 Census S-Night), three of specific cities (New York, Philadelphia) or parts of cities (Los Angeles), one that is representative of all cities over 100,000 in the United States, one that covers an entire major Metropolitan Statistical Area (Washington, DC), two that provide important new information on homelessness in rural areas (Ohio and Kentucky), and one that summarizes studies on family homelessness. To help in interpreting the basic demographic information shown in Table 1, the table also includes the year(s) in which the studies were done, the types of venues where the studies located their respondents, and the methodological approach used. Gender (percent male), race/ethnicity, education (percent high school graduate or more education), whom respondents are with, and length or patterns of homelessness are the demographic and descriptive data examined in Table 1.

TABLE 1
SIMPLE DEMOGRAPHIC CHARACTERISTICS OF ADULT RESPONDENTS FROM VARIOUS STUDIES

Study	Census	Urban Institute	Los Angeles COH study	New York, Culhane**	Philadelphia, Culhane**	DC*MADS	Ohio	Kentucky	Rossi, Family Homelessness
Geographic Coverage	United States	US cities of 100,000+ (178 cities)	Los Angeles, downtown and west side	New York City	Philadelphia	Washington, DC metropolitan area (DC, 10 counties, 5 VA cities)	rural Ohio counties	Kentucky (heavily rural)	various
Date	1990	1987	1991	1990-92	1990-92	1991	1990	1993	1985-91
Data Collection Venues	SH	SH, SK	SH, SK, ST	SH	SH	SH, SK, ST	SH, SK, 0	SH, ST, 0	various
Methodological Approach	census	randomly selected cities, programs within cities, people within programs	sample allocated proportionally to locations, then random; longitudinal	shelter tracking database	shelter tracking database	combination of block probability and service-based, plus encampments	snowball	service-based plus outdoor search	various
Gender of AdultsC % male	70	81	83	52/59	45/59	76	49	68-urban 39-rural	0-27

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Study	Census	Urban Institute	Los Angeles COH study	New York, Culhane**	Philadelphia, Culhane**	DC*MADS	Ohio	Kentucky	Rossi, Family Homelessness
Race/Ethnicity									
% African-American	41	41	58	65/65	91/88	76	10	12	10-91
% White	49	46	21	5/8	6/8	17	85	85	4-85
% Hispanic	16*	10	14	29/24	3/3	6	3	1	2-33
% Other	10	3	8	1/3	0/1	--	2	2	--

SH=Shelters, SK = soup kitchens/meal programs, ST = Astreets,@ 0 = Other. * Census asks Hispanic status and racial status separately, so the categories are not mutually exclusive. ** First number is average daily (point-in-time); second number is cumulative and unduplicated for the period June 1990 through May 1992.

Sources: Urban InstituteCBurt & Cohen, 1989; CensusCBarrett, Anolik & Abramson, 1992; OhioCFirst, Rife & Toomey, 1994 and personal communication; DC*MADSCBray, Dennis & Lambert, 1993 and personal communication; LA COHCKoegel, Meiamid & Burnam, 1995 and personal communication; KentuckyCKentucky Housing Corporation, 1993; Rossi, *Troubling Families,* 1994; New York & PhiladelphiaCCulhane et al., 1994; Kuhn & Cuihane, 1998.

Basic Demographics

Looking first at gender, males as a proportion of the homeless population range from a high of 83 percent (in Los Angeles) to a low of 39 percent (rural Kentucky), excluding for the moment a consideration of the family homelessness studies reviewed by Rossi. The statistics on gender from the Table 1 studies lead to the generalization that the more urban/central city a place is, the higher the proportion male among the homeless population. Conversely, the more suburban/rural a place is, the higher the proportion female, largely due to the higher ratio of families to singles in the suburban/rural jurisdictions. New York and Philadelphia appear to be the exceptions to this generalization, probably because New York unlike most cities really does have a high ratio of families among its homeless population even at single points in time, and the Philadelphia database probably misses many of the single men who use the biggest shelter. The studies reviewed by Rossi, concerned as they are exclusively with family homelessness, report much lower proportions of adults who are male.

Race/ethnicity varies considerably among the Table 1 studies, owing largely to the variation in the racial and ethnic composition of the communities where the studies were conducted. Regardless of location, however, African-Americans are significantly overrepresented among homeless people compared to the general population. Compared to 12 percent of the U.S. population who are African-American, the Urban Institute's 1987 study found that 41 percent of homeless people in large U.S. cities were African-American (and not Hispanic) while the 1990 S-Night counts in shelters found that 41 percent of the people enumerated were African-American (including those who were also Hispanic).

People of Hispanic origin do not appear to be consistently overrepresented among homeless populations. For instance, DC*MADS found 5.9 percent of the homeless population to be Hispanic compared to 5.2 percent of the total 1990 population of the Washington, D.C. MSA, and Culhane and colleagues (Culhane, et al., 1994) report that 3.4 and 27.2 percent, respectively, of Philadelphia and New York shelter users over a three-year period were Hispanic, compared to 1990 Hispanic populations of 5.6 percent in Philadelphia and 24.4 percent in New York City.

There is substantial agreement among the studies as to the educational achievement of respondents, with 52-62 percent having completed high school or a higher level of schooling. With respect to whether people were homeless by themselves, with children, or in some other arrangement, studies differ but there is some systematic variation we can account for. Urban studies that went beyond shelters to include substantial parts of the street population found that single men comprised three-quarters or more of the "households." The more rural the location of the study, the larger the share of households that are families with children. Also, when one relies on shelter data only, as in the case of the New York and Philadelphia tracking data bases, the proportion male declines and the proportion of families with children (most headed by females) goes up. When a data source leaves out the relatively large proportion of single homeless men who do not use shelters or, as in the case of Philadelphia, does not count the shelter use of the most erratically shelter-using single men, the omission distorts the picture of household structure among homeless people.

Homeless youth are one part of the homeless population often missing from policy consideration. Most studies of homeless populations do not include a significant number of youth homeless on their own, both because most of the venues where studies go to find homeless people serve only adults, because many homeless youths are reluctant to use services at all, and because it is difficult to identify homeless youth with other study techniques. Estimates of youth homelessness are often given not as point-in-time estimates but as "homeless within the past 12 months" estimates, and range from about half a million to a million and a half (Ringwalt et al., 1998). Ringwalt et al. (1998) used recent data from youth interviewed from *households living in conventional dwellings* for the Youth Risk Behavior Survey to estimate that 1.6 million youth ages 12 to 17 (7.6 percent [± 0.7 percent] of the population in this age range) had a

homeless episode of at least one night's duration within the 12 months before being interviewed. Only about 2 in 5 of these youth said they used shelter services during their homeless episode.

This review makes clear the great extent to which basic information about homeless people varies by geography and also depends on the venues from which people are interviewed or data are assembled. It is very important for decision makers to be fully aware of the inclusions and omissions in the data they use for planning, because different data sources (e.g., shelter only, shelter and other services, or services plus "street" sources) may lead to quite different assessments of population characteristics and hence of need.

Length and Patterns of Homelessness

The studies in Table 1 report their sample members' length of homelessness or patterns of homelessness quite differently. Some report the length of time that people have been homeless during their current spell, some divide their sample into groups such as chronic, episodic, and transitional/crisis/first time. Findings vary considerably, but some generalization may be possible. However, to interpret the length/patterns data correctly, it is necessary to leave out the New York/Philadelphia tracking database information for the moment. Looking first only at the point-in-time data, it ***appears*** that we can say four things: (1) long spells (more than 1 year) and or chronic homelessness characterize urban samples much more than they characterize rural areas; (2) in urban areas about 40 percent or more report long current spells; (3) more people in the rural than in the urban samples are in their first spell of homelessness, and these are quite short; and; (4) the higher the proportion of families in the study, the shorter the spell length or the more short spells are reported.

Looking next at the New York and Philadelphia data, it is clear that these multi-year unduplicated data show quite the reverse of these generalizations. Indeed, the vast majority of the homeless population (using shelters) in these cities are transitional (first-time or short-term). With the advantage of unduplicated data covering several years, the New York and Philadelphia results make very clear the dangers of relying on point-in-time data to describe what proportions of the homeless population have spells of different lengths or different patterns of homelessness. Point-in-time data will always be biased toward showing higher proportions of longer spells. When planners use point-in-time data, which they most often will because that is all they can get, it is very important to try to compensate for its biases toward long spells and away from short ones. If this is not done, the whole system of homeless services may be structured in ways that are not in tune with the needs of the people coming for assistance.

Who Are Homeless People?: II
Predisposing Conditions and Experiences

Quite a number of studies, both longitudinal and cross-sectional with comparison data, have documented strong associations of negative childhood experiences with homelessness (Bassuk, et al., 1997; Caton et al., 1994; Herman et al., 1997; Koegel, Melamid and Burnam, 1995; Mangine, Royse and Wiehe, 1990; Susser, Struening and Conover, 1987; Susser et al., 1991; Weitzman, Knickman and Shinn, 1992; Wood et al., 1990). The most common childhood experiences associated with a higher risk of experiencing homelessness are: histories of foster care and other out-of-home placement, physical and sexual abuse (which often precede out-of-home placement), parental substance abuse, and residential instability and homelessness with one's family as a child. These experiences are much more common among people who have been homeless as adults than among people who have not.

In addition to evidence that risk factors from an individual's childhood predispose to homelessness, an important new type of research documents the contribution of certain environments to homelessness even

after taking into account the characteristics and histories of those who become homeless while living in these environments. Culhane, Lee and Wachter (1996) analyze the addresses of families applying for emergency shelter in New York City and Philadelphia, and find them much more concentrated geographically than poverty in general. (Culhane has recently obtained similar results for the neighborhoods of origin of homeless families in Washington, DC.) Neighborhoods producing high levels of family homelessness have high concentrations of poor African-American and Hispanic female-headed households that include children under six years of age. The housing is the poorest in the city, and despite the fact that rents are the lowest available, residents still cannot afford them, with the consequence that housing is overcrowded and many families double up, even though apartment vacancy rates are high. These conditions create a large pool of families at risk of homelessness, from which it only takes a small percentage every week to fill the available homeless shelters.

Where Are Homeless People?

The matter of "where" homeless people may be found can have several interpretations. The first examined here is: how are homeless people distributed geographically among central cities, the suburbs and urban fringe areas that make up the balance of the territory within Metropolitan Statistical Areas (MSAs), and rural areas (outside of MSAs)? The second is how homeless people are distributed among types of services and street locations within communities.

Geographic Distribution

Only a few studies exist that can shed light on the issue of geographical distribution because only a few studies include any geographical diversity in their sampling. The 1990 Census counts of people in emergency, domestic violence, and youth shelters on the night of March 20-21, 1990, which was done on a single night and treats everyone, including children, as individuals, found 75 percent in central cities, 18 percent in suburbs and urban fringe areas (the parts of MSAs that are not central cities), and 7 percent in rural areas (Burt et al., 1993—these figures do not include anyone counted in the "visible in the streets" part of the 1990 Census). This compares to the overall 1990 U.S. population distribution of 32 percent in central cities, 43 percent in suburbs and urban fringe areas, and 25 percent in rural areas.

In Kentucky's 1993 study, one of the few that covers a whole state and goes well beyond shelters), 21 percent of homeless individuals were found in the three major urban areas of Louisville, Lexington, and Covington which have 25 percent of the state's 1990 population, while 79 percent were found in the remaining 117 counties of the state where 75 percent of the population reside.[1]

In DC*MADS, Washington, D.C. accounted for 77 percent of homeless and transient individuals, with the remainder found in the suburbs and urban fringe (no areas were included in the study from outside the MSA). In the Washington, DC MSA as a whole, only 15 percent of the population is located in Washington, DC.

Everyone expects to find more homeless people in highly urbanized areas than in suburban and rural areas, but it is also true that the *rate* of homelessness per 10,000 people has been shown to vary considerably even when one considers only homelessness in large cities. DC*MADS estimates produce a homelessness rate of about 150/10,000 population for Washington, DC and a rate of about 33/10,000 for the whole DC metropolitan area. Using Shelter Partnership's estimate of 80,000 to 90,000 homeless people in Los Angeles County produces a homelessness rate of 88/10,000 to 99/10,000 for the county as

[1] The number of homeless people in Louisville is probably underrepresented by these data, because Louisville reported only its *sheltered* population at *a point in time,* it did not use the overall study method of a two-month data collection period and a variety of agencies, nor were there searches of outdoor locations in Louisville.

a whole in the late 1990s. Burt (1992a) obtained rates for U.S. cities with 100,000 or more population in 1986 ranging from under 10/10,000 up to 65/10,000 (average = 1 8/10,000) based on the number of shelter beds available in the city rather than on actual estimates of homeless people. This magnitude of variation strongly suggests the wisdom of having one's own local data rather than relying on national averages.

What Services Do Homeless People Use?

A second way to think about "where" homeless people are is to think about the services they might use, and therefore where they might be found within a community. Important locations where people might be found include streets, outdoor locations, and other locations "not meant for human habitation" (for short, "the streets"). Although the streets are not a service, one important issue for planning is how many homeless people are being missed if one focuses one's data collection efforts only on those who use services, and what types of services they might need. This was a very serious problem when studies went only to shelters, or attempted to augment shelter-based data collection with a street component, because street searches are almost always unsatisfactory. Often they do not locate many people, and they become more dangerous to do the more thoroughly one tries to get to the most hidden places. So the problem is, what is a safe and comprehensive way to include homeless people who do not use shelter services in data collection?

A breakthrough, not less helpful because it was serendipitous, occurred in our ability to include a large part of the non-shelter-using homeless population in data collection when studies began including soup kitchens and other feeding programs in their service samples (1987 Urban Institute study, DC*MADS). As we learned when this happened, many currently and formerly homeless people who do not use shelters do come to soup kitchens. The 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC-Tourkin and Hubble, 1997) extended this concept even further to include a wide variety of homeless assistance programs, and the Kentucky Housing Corporation went well beyond homeless assistance programs in its efforts to locate homeless people.

Results from several of these studies are telling. In the 1987 Urban Institute study, 36 percent of homeless adults and 22 percent of children in homeless families used both sheltersand soup kitchens in the week before being interviewed. Thirty-two percent of homeless adults and 73 percent of children in homeless families only used shelters, and 29 percent of homeless adults (but only 5 percent of children in homeless families) used only soup kitchens in the past week (Burt and Cohen, 1989, p. 37). Thus inclusion of soup kitchens in the study design increased the coverage of non-shelter users considerably.

DC*MADS added a soup kitchen component to its design after finding very few people in the street part of its original shelter/street design. The resulting ability of DC*MADS to map the overlapping movements of its respondents produced very interesting patterns. Fifty-six percent of respondents had used a shelter within the previous 24 hours, 65 percent had used a soup kitchen, and 21 percent had spent time on the streets. The overlap of these populations was considerable, with 27 percent using both shelters and soup kitchens. Of all the respondents to DC*MADS, only 7 percent would not have been found if the study had left the street component out entirely and gone only to shelters and soup kitchens (Bray, Dennis and Lambert, 1993, p. 3-3). This was true for the entire literally homeless population in DC*MADS, as well as for the population including transients.

The degree of population coverage achieved by DC*MADS through its shelter and soup kitchen components is very encouraging, but must be qualified in several ways. Even within DC*MADS, subgroup analysis revealed that coverage was somewhat worse without the street component for some groups. The people least likely to be captured were heavy alcohol users, about 15 percent of' whom would have been missed without the street component. On the other hand, coverage for those with drug

use during the month of the survey was actually better than for the sample as a whole (over 95 percent). Other evidence for differential coverage by population subgroup comes from the Course of Homelessness study in Los Angeles, where only 16 percent of young, single men on the west side of Los Angeles would have been captured with a design that relied only on shelters and soup kitchens, without a street component (Koegel, personal communication, 1996).

A final caveat is that DC*MADS achieved its level of coverage using a homeless-specific service-based approach in an environment where many homeless-specific services are available. In environments such as many suburbs and rural areas where homeless-specific services are scarce or nonexistent, such an approach would clearly miss almost everyone. In these environments more and different types of service agencies would have to be incorporated into the design to achieve adequate coverage, as was done in NSHAPC and in the Kentucky statewide study. Even then, the Kentucky Housing Corporation augmented its service-based approach with a targeted search of outdoor locations.

Limitations of the Data

Many of the studies reviewed in Table 1 used quite sophisticated methodologies, and produced elegant and reliable results. However, they were very expensive to conduct and, while they may be helpful at the national level and to answer particular research questions, are of limited utility to local planners. The most important lesson to be learned from these studies is that even expensive, methodologically sophisticated studies cannot produce consistent findings because the reality of homelessness varies a good deal with the geographic location of interest. Therefore, local decision makers should make every effort to collect their own data using less perfect but "good-enough" methods, collect it with sufficient regularity and thoroughness that it becomes a useful tool for decision making..

What Planners Need To Know About "Need"

Information for Planning: Who Needs What?

Many people may be involved in planning homeless service systems or in estimating how much service is needed at a given time. Table 2 shows the variety of people who plan, from administrators in direct service programs up though the staff of federal government agencies. It also shows the things they may plan for (column 2) and the information that might help them accomplish this planning, together with the sources that might provide the information (column 3).

Simple Planning

Planning may be very simple, such as predicting how many meals to prepare, how many cots or mats will be needed for overflow conditions, or how many nurses will be needed for a health clinic at Shelter X on the next Tuesday. These types of decisions are very local and very practical. Usually they are made at the program level on the basis of past experience, without a great deal of data-based analysis except perhaps to look at agency records of services delivered, if they exist. Temporal variations over the week, month, or season are also important for planners at this level, and will most likely be based on historic agency data or personal experience.

A similar type of planning may occur at the city or county level as officials try to anticipate how many shelter or transitional housing beds might be required to accommodate average and maximum demand, and how many services of other types might be appropriate for shelter users. The simplest approach to this is to ask what was used last year. Need for growth or change in the system's capacity could be approached by examining local economic factors (e.g., plant closings, economic downturns), and

possibly also by looking at service requests that could not be met anywhere in the system as an indicator of unmet need. Care must be taken, however, to be sure that one does not count persons turned away from one facility on one day who receive the requested services either from another provider on the same day or any provider within a few days of the request.

More Complicated Planning issues

Once planning advances to questions of the types of service that ought to be available, to planning a comprehensive and accessible continuum of care, or to client length of stay and its relation to needs for different types of services at different points during a stay, more detailed data are needed if planning decisions are to be driven by facts. It will probably be important to be able to anticipate client characteristics that call for different program structures and services.

For instance, knowing the proportion of households with children who will ask for homeless assistance, in comparison to women or men by themselves, may help agencies or whole communities structure their emergency and transitional shelter resources to accommodate these different types of households. Likewise knowing that, historically, half the people asking for help have some type of immediate health problem may let agencies or community planners prepare to treat those problems. Knowing how many people using homeless assistance programs suffer from mental illness, chemical dependency, and other debilitating conditions can indicate what the level of need for those services are in the population. Finally, knowing how many people are released from psychiatric hospitalizations, detoxification programs, jails or prisons without any reliable plans for housing can provide clues about the demands these people will make on the emergency services system, and possibly also provide documentation to support enhancing the capacities of mainstream systems to take responsibility for aftercare so as to prevent homelessness among these vulnerable groups.

An important issue for planning is knowing how *clients* see their needs, and how their perceptions might differ from the ways that *agency staff see* needs. Clients tend to focus on the end point (a job, an apartment), while staff tend to focus on the steps that need to be taken before that endpoint can be achieved (gaining skills, conquering addictions). Both are important. It may not always be easy for staff and clients to reach a meeting of minds about what needs to be done today and tomorrow if the clients' ultimate goals are to be reached. On the other hand, planners must not lose sight of the need for more jobs, more housing, and more services that help people keep their jobs and housing. More case management will not help people get jobs and housing if there are no jobs or housing available.

Another significant issue for planning is knowing whether the clients coming into homeless assistance programs will be short-term or long-term users. This is especially important in shelter/ housing and health programs, where the intake and other procedures that occur on the first day are often the most costly and absorbing of staff time. Client flow is also important in planning caseworker load and types of services to offer. If a program's clients or a whole city's homeless population are mostly short-term, a greater proportion of resources will need to be dedicated to intake than if most of the clients are long-term.

TABLE 2
INFORMATION NEEDS FOR PLANNING

Who Plans?	What Do They Plan For?	What Information Might They Need?	Where Might They Get the Information?
• Direct service program administrators • Local governments • Other local funders/planning groups • State governments • Other state funders/planning groups • Federal agencies	• Developing a continuum of care appropriate to the needs of homeless people in a community • Capacity-number of beds, meals, health care visits, job training slots • Appropriate types of service, either within a single program or within an entire service system • Intake vs. ongoing cases/length of stay/caseworker load • Achieving various goals-prevention, emergency assistance, leaving homelessness	• Numbers and characteristics of service users on an "average day" • Actual past use of various services • Characteristics of clients that imply need for particular services (e.g., mental illness, presence of children, no job skills) • Client flow-numbers per year or other extended period • Major service needs, as seen by client and by provider • Patterns of homelessness among clients--crisis, episodic, chronic • Temporal variations-weekly, monthly, seasonal • Trends in population size • Location variations-central cities, suburbs, rural	• Agency records • Client interviews • Staff interviews • Tracking data bases

In addition, some services will not be appropriate or needed for short-term clients. One should not plan to put every client through an assessment process that takes three weeks if the average length of stay is two weeks, nor can one expect to produce major life changes in two weeks. What is being asked for is, quite literally, emergency assistance. With respect to transitional programs, if the maximum length of stay is two years and a program has a sequence of services that requires two years for its full effect, the program will be less effective when the average length of stay is six months. Also, any program with many short-term clients that has any plans for follow-up work or data collection with former clients will quickly be overwhelmed by the growing number who need tracking; this issue is less severe if the program has mostly long-term clients.

Finally, client flow data are important when planning solutions to homelessness. If the homeless population of a community is small and stable (mostly long-term), investing in permanent supported housing will probably be a more humane and cheaper solution than maintaining people in emergency shelter. But if the same small population is largely short-term and turnover is great, finding solutions to homelessness will entail helping a group of people that in one year may be three (New York City, average length of stay=4 months), six (Philadelphia, average length of stay=2 months), or even more times the number of people who are homeless at any given time (Burt, 1994; Culhane et al., 1994).

As an evaluator by trade, the author would feel remiss if she did not point out in this paper that one critical piece of information important to planners is almost always missing, namely, information about which programs and services are effective. People always ask this question, but very few agencies are willing to spend the time and money to find out. So planners use all the information available to assess needs, and then support programs that for the most part have not been proven to have a track record of success (which does not mean they are failures, merely that we do not know which are the most effective, and cost-effective, ways to spend homeless assistance dollars). This point will ve revisited at greater length at the conclusion to this paper.

Methods for Collecting Information for Planning

Many methods exist to obtain information about the client characteristics and geographical location that planners may use to estimate need for services (for extensive descriptions of these and other methods, see Burt, 1992b). None of these is always right, or always better. Certain data needs may require specialized techniques of data collection, but it is also true that many different techniques are capable of gathering the basic types of information listed earlier in Table 2. Every data collection effort is a compromise among data needs, the expense of getting relevant information, respondents' tolerance for talking to data collectors, and the planner/researcher's abilities and resources for analysis and interpretation. This being said, Table 3 details some commonly used methods of data collection, dividing the options into those designed to obtain full counts through methods that do not rely on probability sampling, methods based on probability sampling, tracking databases, and other approaches.

TABLE 3
COMMON METHODS FOR COLLECTING PLANNING INFORMATION

Method	Usual Places to Find People for Study	Usual Period of Data Collection and of Estimate	Probable Complexity of Data Collected
Full Counts and Other Non-Probability Methods			
Analysis of agency records	Specific agency	Varies; usually not done to develop a population estimate	Whatever the agency routinely records in its case documents
Simple count, involving significant amounts of data by observation or from minimal agency records (e.g., Boston, Nashville, Minnesota quarterly shelter survey)	Shelters, Astreets@	1 night; point-in-time estimate	Enumeration, ± very simple population characteristics (gender, adult/child, race)
Simple count with brief interview (e.g., Pasadena, Colorado)	Shelters, meal programs, Astreets@	1 night; point-in-time estimate	Enumeration + basic information as reported by respondent
Screener, counts and brief interviews for anyone screened in, plus unduplication using unique identifiers (Kentucky)	Service agencies of all types	Several weeks or months; point-in-time and period prevalence estimate	Enumeration + basic information as reported by respondent
Complete enumeration through multiple agency search and referral (Ohio, First et al.), followed by extensive interview (also unduplication)	Service agencies and key informants	Several weeks or months; point-in-time and period prevalence estimate	Usually extensive
Probability-Based Methods			
Block probability with substantial interview (e.g., Rossi, Vernez et al., DC*MADS)	AStreets@	Several weeks or months; point-in-time estimate	Usually extensive
Other probability approaches	Abandoned buildings, conventional housing in poor neighborhoods	Several days or weeks; point-in-time estimate	Enumeration + basic information as reported by respondent
Service-based random sampling (e.g., Rossi; UI 1987; DC*MADS; NSHAPC)	Usually homeless assistance programs	Several weeks, months, or years; point-in-time estimate	Usually extensive

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Shelter and other service tracking systems that allow unduplication across all services in a jurisdiction over time	Service agencies	Ongoing; point-in-time or period prevalence for periods of any length	Whatever the system collects, but usually simple data for administrative purposes
Other Interesting Methods			
Surveys of the housed population (e.g., Link)	At home	Multi-year; produces period prevalence for periods asked about	Basic information as reported by respondent
Longitudinal studies (e.g., in Los Angeles, Oakland, Minneapolis, New York City)	Shelters, soup kitchens, Astreets@	Multi-year; does not produce a population estimate	Extensive information, collected from the same person at several points in time

Boston-Emergency Shelter Commission, 1990; Nashville-Lee, 1989; Minnesota-Department of Children, Families and Learning, Office of Economic Opportunity; Pasadena-Colletti, 1993; Colorado-State of Colorado, 1988; Kentucky-Kentucky Housing Corporation, 1993; Ohio-First, Rife & Toomey, 1994; Rossi, Fisher & Willis, 1986; Vernez et al., 1988; DC*MADS-Bray, Dennis & Lambert, 1993; Burt & Cohen, 1989; NSHAP--Tourkin & Hubble, 1997; tracking databases-Culhane et al., 1994; Burt 1994; for ANCHOR, see www.prwt.com/anchor1; Link et al., 1994, 1995; longitudinal studies-Wong, 1997.

Full-Count and Other Non-Probability Methods

Included in Table 3 as its first row is a method that is probably the most widespread of all-analysis by each agency of its own records of service delivery, to understand past experience as a guide to the future. Some communities, as well as some whole states, have developed ways to aggregate these single-agency experiences by having each agency report common data elements to a central office that compiles the information for planning purposes. Even with such data, however, duplicate counting of individuals is often a problem at every level, and for even the shortest time periods. Soup kitchens may be able to tell you how many meals they served yesterday, but not how many people. Large shelters may be able to say how many bed-nights were used during the past week or month, but not how many people were sheltered. Even if individual agencies can produce unduplicated counts of people, once two or more agencies pool their data into community-wide or statewide reporting, there usually is no way to tell what the duplication might be across agencies either on the same day (e.g., Person A uses both a soup kitchen and a shelter on Thursday) or on different days (e.g., Person B uses Shelter 1 during week 1 and shelter 2 during week 2).

Efforts to obtain simple counts of the homeless population usually occur on a single night and within a relatively well-defined and not too large geographical area, and include searches of outdoor locations and enumerations within shelters. Early and ongoing efforts to perform such counts occurred in Boston and in Nashville (Emergency Shelter Commission, 1990; Lee, 1989). They obtained only the total number of homeless people encountered, plus some minimal descriptive data such as gender and whether the person was an adult or a child. The Office of Economic Opportunity in the Minnesota Department of Children, Families and Learning has conducted a statewide variation of this type of count four times a year since 1985, learning for a specific night each quarter how many people in each reporting area are sheltered on that night, along with whether they are men, women, or children, and whether the children are dependent or alone. The fact that these surveys occur regularly (although Nashville has stopped doing theirs) gives these jurisdictions a documented history and the ability to track trends, which can help with planning.

One variation on the simple count is to conduct a brief interview (usually about 10 minutes) with the people enumerated, taking either a random sample or everyone. This approach has been used in many places, including Pasadena, California (Colletti, 1993) and Colorado (State of Colorado, 1988). The data collection is still largely limited to one night or to one 24-hour period, and produces a point-in-time snapshot of the population. Because the interview is brief, relatively few issues related to service need can be explored in depth, but more information can be obtained with this approach than is usual with the simple count that relies heavily on observation.

The Kentucky Housing Corporation (1993) conducted another variation on the simple count. It used a brief interview as did Pasadena and Colorado, but made several methodological changes that might be of great interest to planners in other areas with relatively sparse populations and few homeless-specific services. This study greatly expanded the types of agencies through which contact was made with homeless people, including many mainstream agencies that homeless people might approach for assistance. These included health and mental health centers, jails, libraries, community action agencies, food pantries, agencies handling FEMA/EFSP funds, welfare offices, and generic social service agencies, among others. Contact with each individual approaching an agency began with a two-question screener that quickly identified the people who would need to complete the remaining 16 questions on the interview. In addition, the time frame for data collection was extended from the usual one night to two months. These changes were made to accommodate the scarcity of homeless-specific services and the different patterns of service use found in the rural areas that make up most of Kentucky. Agency contacts were supplemented by searches of outdoor locations, using homeless or formerly homeless individuals as guides. This study also had to devise a method for unduplicating the various reports of homeless people coming in from the different agencies over the two-month period, which it did by means

of a unique identifier based on the last four digits of a social security number and the first four letters of the person's last name. Kentucky will repeat this survey in 1999. A more elaborate version of this methodology was pursued in rural Ohio (First, Rife & Toomey, 1994), using the same broad array of contact agencies to identify homeless people, a six-month data collection period, and a much more extensive interview.

Probability-Based Methods

The next set of methods described in Table 3 are those based on taking random samples and developing estimates rather than full enumerations of homeless populations. Various things can be sampled at the first stage, including city blocks or other geographic areas, abandoned buildings or conventional housing units in very low-income neighborhoods, or homeless assistance and other service programs. Once at the sampled location, individuals found there are sampled and interviewed. Block probability methods have proved to be very expensive, and are mostly not used any more since it has become clear that different versions of service-based methods will achieve as much or more coverage of the homeless population in many instances. There are exceptions, of course, for specific subpopulations among the homeless who rarely or never use services. But the way to assure coverage for these subpopulations will most likely involve visits to locations they are known to frequent rather than on random selection of blocks. The data collection sites may be randomly selected (for instance, by selecting abandoned buildings from a city's list of tax-foreclosed properties), or they may be purposively selected as in DC*MADS' use of street "encampments" and the Course of Homelessness study's use of known outdoor locations in downtown Los Angeles and the parking and camping areas in Los Angeles' west side beach communities where many homeless people who did not use services could be found.

Probability-based methods take more sophistication to use than simple one-night sweeps of shelters and city streets, but their advantage is that they usually can provide more accurate estimates of the non-sheltered parts of the homeless population. And, because sampling cuts down the number of individuals one must speak with, more extensive data may be collected through interviews for the same resource commitment as would be used to try to find and/or speak with everyone. Much has been written about the advantages of these methods, so no more will be said here, except to point out that service-based random sampling could be done by local researchers for reasonable cost and could provide much useful information.

Tracking Data Bases

Tracking databases (usually of shelters) have received a lot of attention recently, due in part to the many articles that have appeared using the Philadelphia and New York City databases (see, e.g., Culhane et al., 1994) and to the growing interest in ANCHOR and other tracking database software. A growing number of other cities have similar types of tracking systems, including Boston, Detroit, Anchorage, Baltimore, St. Paul/Ramsey County, Minnesota, Columbus/Franklin County, Ohio, Santa Monica and San Diego, California, Ft. Worth, Texas, Denver, Colorado, the State of Rhode Island, and Maricopa County, Arizona (including Phoenix). Burt (1994) summarizes data from some of these. Interest has been growing among municipalities in developing systems that can unduplicate across programs and over time, and there has been an effort to develop "canned" systems that still contain the flexibility to be adapted to the needs of different communities. Systems developed in Denver and San Diego have been adapted by some other localities, and the U.S. Department of Housing and Urban Development has supported the development of the ANCHOR system by a group at the University of Pennsylvania and PRWT, Inc. (For information about ANCHOR, visit its website at www.prwt.com/anchor1). Approaches to actually getting the data into the community-wide system have varied, with some communities placing linked computers in every service agency, others having service agencies send hard copy to a central location for data entry, and some communities do both.

Culhane and Kuhn (1998) make a strong case for the value of this type of data for administrative purposes. They discuss the value to planners of obtaining knowledge of client flow, the distribution of short and long stays, and analysis of client characteristics among people with significantly different patterns of stay. These data would contribute to planners' ability to estimate the potential demand for prevention and crisis services, and to informed decision making about where the system wants to put its resources.

These systems have not been without their glitches and downsides, however. They are hard to get up and running to the satisfaction of all users of the system. Some systems may be set up with an emphasis on community-wide analysis of data but individual agencies do not get much feedback that is of immediate help to them in serving clients. Other systems emphasize the control of individual agencies over their own data, which makes it valuable to each agency, but are weaker on the shared use of data and the production of systemwide statistics. Issues of privacy and data confidentiality are always present, but can be solved with concerted effort. This is important because once they start using a tracking data base system, service agencies quickly recognize the value to their clients of being able to share information about the client with other agencies. But if the system has been set up with maximum privacy protections, this sharing may be difficult to achieve in retrospect. Another disadvantage of current systems is that few include any services other than shelters. Maricopa County, Arizona is an exception, as it includes a large health care for the homeless site that serves many street homeless people and also asks about the homed or homeless status of people using other agencies in the system such as Head Start and community action agency programs.

A final issue that is beginning to arise in some communities with several years of experience with working data bases has to do with getting paid. Agencies have come to realize that some of their budget comes in the form of reimbursement for services given to clients, and that these services are being registered in the data system. There are anecdotes that agencies have become possessive of their clients, possibly up to the point of not referring them to other agencies for services because they want all the "credit" for that client. Communities installing tracking data bases and intending to use them as one element in funding decisions would do well to address these issues of ownership and sharing directly, so that clients get the appropriate services from the appropriate providers.

Other Methods

The last two data collection methods included in Table 4 are unlikely to be conducted by local or state planners, but the information from the original studies should be of great interest. These include national (or more limited) telephone surveys of households using random digit dialing, and longitudinal studies of homeless populations. The first method can be used to get estimates of lifetime and recent homeless experiences of currently housed people, while the second shows us the patterns of entering and leaving homelessness over extended periods of time.

The estimates produced by shelter tracking databases of the proportion of whole city populations that have experienced homelessness, hovering around 3 percent of the population over a three-year period, are supported by results from a completely different source-household telephone surveys using random digit dialing conducted by Link and his team. Their results are that about 3 percent of American adults (7 to 8 million people) experienced literal homelessness within the past five years (Link, Susser et al., 1994; Link, Phelan et al., 1994).

Obviously, most of the homeless episodes tallied by the shelter tracking and the household survey data did not last a very long time, or the one-day homeless population would be much higher than the 500,000 to 600,000 commonly thought to be a reasonable estimate for a 24-hour period. The new results have

made both researchers and policy makers think again about what might be the best approach to serving homeless people, and to consider what services might be relevant for someone who just needs a little help to leave homelessness or for whom appropriate interventions might prevent homelessness, as well as for someone who needs a lot of help.

Longitudinal studies of homeless cohorts became available in the 1990s for the first time. Several research projects (in Minneapolis, Minnesota, Los Angeles and Oakland, California, and New York City) followed a sample of homeless people over extended periods of time. These efforts (see Koegel & Burnam, 1991; Koegel, Burnam & Morton, 1996; Piliavin, Sosin & Westerfelt, 1993; Robertson, Zlotnick & Westerfelt, 1997, Schinn, 1997) reveal in great detail the complexity of homeless careers. While some people may have only one homeless episode, during which they are "on the streets" for the entire time, many people who are homeless at the time a sample is taken have moved in and out of housing frequently, depending on their available funds and other supports.

The results of longitudinal research studies help us understand many things about homeless careers. On one hand, they help us to see how many people experience single short spells of homelessness and are able to leave on their own and never return. These people may never draw much attention from service providers and planners because they do not draw heavily on service resources. Nevertheless, their experiences can help us understand the circumstances that allow people to leave homelessness and stay housed, and may also be important when planning prevention efforts.

On the other hand, these longitudinal studies help us to see the difficulties encountered by another set of people who find it very hard to leave homelessness for good, and what it will take to truly *end* this type of homeless career. Longitudinal studies have documented some of the near-term causes of homeless episodes, and shown just how fragile is the hold some people have on stable housing. Planners should be aware of these results as they think through what continuum of services they want to create in their communities.

What Works?

Without knowing what works, planners with the best information in the world about the service needs of homeless people will not be able to make the best decisions about which programs are the best investment of local resources. Information about program performance and impact is relatively scarce in the homeless services arena (which does not make homeless assistance services any different from most other service arenas). Further, the information that we do have is skewed to particular types of programs for particular segments of the homeless population. For the most part, we have the best information about programs for people with mental illness and substance abuse problems and minimal information about the effectiveness of services for anyone else, including families. Other papers in this symposium go into much greater depth on issues of service effectiveness than there is space for here, but some information about "what works" is essential here because it is so critical for decision makers to know, and so rarely available, that it would be inappropriate for anyone to think they had all necessary information just because they were able to describe their homeless population.

We know a good deal about how to serve homeless people with mental illness, drug abuse, or alcoholism because several provisions of the Stewart B. McKinney Homeless Assistance Act of 1987 directed federal government agencies to sponsor relevant service research projects. Portions of the Act authorized funding to identify effective models of care that could maintain these most difficult-to-help long-term homeless people in stable housing situations. The evaluation research was funded through the National Institute of Mental Health and the National Institute on Alcohol Abuse and Alcoholism (Fosburg et al., 1996; Mdrrissey et al., 1996; National Resource Center on Homelessness and Mental Illness, 1992; Randolph et al., 1996; Shem et al., 1997; Sosin et al., 1994; Tessler and Dennis, 1989).

The first, most remarkable thing we know is that *the programs do work.* Many of them have been able to retain around 80 percent of the previously homeless people they serve in decent, stable housing arrangements. We also know that *without services attached, they do not work.* The critical services needed are: negotiating with landlords and neighbors, handling situations of decompensation or slipping off the wagon, assuring that the rent is paid and the housing is kept clean, and supplying tangible goods when necessary such as furniture, transportation, and food. *These critical services are not readily available from other agencies in the community, nor are they the responsibility of any other agency. Therefore, they tend to be absent if federal funds do not cover them.* Local decision makers would do well to consider supporting these services with local funds if they want to create maximally effective residential programs for their hardest-to-serve chronically homeless population.

Further, we know that without services, not only do the previously homeless people with serious disabilities lose their own current housing, but they lose it in a way-by antagonizing landlords and neighbors-that the housing unit itself is likely to stay lost and unavailable for other homeless persons. Thus the program wastes the energy and resources already invested in finding and arranging the housing, and has to start over with a bad track record. This is wasteful for all concerned, and does little to build community good will toward homeless people with severe disabilities. Local planners may want to assess the wisdom of spending funds for housing but not including the supportive services that make housing investments successful.

The limited amount of research available on service outcomes for homeless families (Rog and Gutman, 1997; Shinn, 1997; Wong, Culhane and Kuhn, 1997) indicates the efficacy of providing housing subsidies as a means of stabilizing residential patterns among homeless families and suggests that without such subsidies, these families' personal resources, skills and human capital are not adequate to maintain themselves in housing and otherwise take care of family responsibilities. These are also the families likely to be the least capable of finding employment at the level of self-sufficiency, and therefore to be the hardest hit by welfare reform provisions limiting the time of welfare receipt. Loss of welfare income may precipitate episodes of homelessness.

Implications

We have learned a great deal about homeless populations in the past decade and a half, and have learned even more about how to learn about them. Many of the methods described in this paper can be adapted for use at the local and state levels, where they could produce extremely valuable information for planning purposes. Most of the methods, once beyond simple counts, can supply decision makers with a great deal of data about the characteristics of homeless people using services in a community. These characteristics extend far beyond the simple demographics described above, and include the presence of various disabling conditions that can be used to design the specialized services most appropriate to the local population.

More and more communities are coming to recognize the value of good data for rationalizing their service programs for homeless people. When you go to a community that has installed a tracking data base, for example, they are most likely to tell you that the data don't resolve all of their priorities or make all of their decisions. But since they have had the data, they say, they no longer spend any time arguing about the scope of the problem (which they used to do all the time), and can focus their efforts on deciding what to do about it.

The newest types of data, in particular the tracking data bases, have raised many important policy issues that were semi-invisible before. We now know, or could know, the proportion of homeless spells that are very short term and the characteristics of the people who have them. This information could help us design appropriate emergency services, including some that would not require a person to become literally homeless (i.e., to enter a shelter) just to access them. By the same token, we now know, or could know, the proportion of homeless spells that are very long-term, the characteristics of the people who have them, and the amount of system resources they absorb. This information could help us to decide that there are better, and even cheaper, ways to help these people through stable, supported permanent housing arrangements.

The episodic group among the homeless is the most interesting, because its picture is least developed. Culhane, because his data source is shelter stays, calls people episodic when they go in and out of shelter regularly. But perhaps they are not episodic in the sense that they go in and out of homelessness; they could merely move to the streets and back again to shelter. Other types of data would be more capable of exploring different patterns of episodic homelessness.

In addition, we should ask what we mean by "episodic," as the word could have a number of different meanings. Longitudinal studies help us to understand what some of these meanings might be. People whose incomes last them only three weeks out of every month could be in hotels or motels for those three weeks, and in shelters or on the streets for the rest of the month. This is a pattern that combines both an episodic element and a long-term element (they have been doing this for years). In shelter tracking data bases using a 30-day exit criterion, all of these people would be counted a continuous stayers (they would never be out of shelter for a period greater than 30 days), but this pattern may not be what we intuitively mean when we speak of "long-term chronic". Knowledge of patterns of service use may stimulate a community to ask itself what it is really trying to accomplish with its services, and perhaps to design better ways to intervene in pursuit of those goals.

Finally, it bears mentioning that we are living in a time when major streams of income support for very poor individuals and families are being eliminated outright (General Assistance at the state and local levels) or limited and restricted to certain people, for certain time periods, and contingent upon certain prescribed behaviors (Temporary Assistance to Needy Families, formerly Aid to Families with Dependent Children; Food Stamps). Anecdotes about how well welfare reform is "working" are balanced by anecdotes about individuals and families who have lost benefits and become homeless. It will be important in the coming years to document the effects of the fraying safety net on the abilities of people to remain housed or to leave homelessness once in that condition.

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Special Populations of Homeless Americans

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Abstract

Surveys conducted over the past two decades have demonstrated that homeless Americans are exceptionally diverse and include representatives from all segments of society-the old and the young; men and women; single people and families; city dwellers and rural residents; whites and people of color; and able-bodied workers and people with serious health problems. Veterans, who are among the most honored citizens in our society, appear in substantial numbers among the homeless, as do former criminal offenders and illegal immigrants. Each of these groups experiences distinctive forms of adversity resulting from both societal structures and personal vulnerabilities, and has unique service delivery needs. All, however, experience extreme poverty, lack of housing, and a mixture of internally impaired or externally inhibited functional capabilities. Attention to the distinctive characteristics of subgroups of the homeless is important in facilitating service delivery and program planning, but may also diffuse attention away from shared fundamental needs, and generate unproductive policy debate about deserving vs. undeserving homeless people.

Lessons for Practitioners, Policy Makers, and Researchers

- People who are homeless reflect the nation's diversity, and their special characteristics and needs must be identified, respected, and addressed.
- In addition to responding to basic needs for shelter, food, clothing and medical care, the unique needs of each subgroup of homeless person should be sensitively addressed.
- Systematic assessment is frequently required to identify the specific needs of each subgroup among the homeless population.
- Despite their diversity, almost all homeless people are extremely poor and lack decent affordable housing and an adequate income. Regardless of their other difficulties, practitioners must address their basic tangible needs for material resources.
- Although it is essential that providers help facilitate homeless people's access to basic resources, they also should advocate for increasing the overall pool of resources. Providers are often in a position to be powerful advocates.

Introduction

Surveys conducted over the past two decades have demonstrated that homeless Americans are exceptionally diverse and include representatives from all segments of society-the old and young; men and women; single people and families; city dwellers and rural residents; whites and people of color; and able-bodied workers and people with serious health problems (Rossi, 1989; Burt, 1992; Robertson & Greenblatt, 1992). This diversity illustrates how difficult it is to generalize about the needs of homeless people, and how challenging it is to assist them.

Homeless People Reflect the Diversity of Society

- Age: Children, Adolescents, Elderly
- Gender: Men and Women
- Living Units: Single Individuals and Families
- Location: Urban vs. Rural
- Racial or Ethnocultural Minorities
- Health Status: Medial, Psychiatric, Addictive Disorders, AIDS, Good Health
- Social Status: Veterans, Criminal Offenders, Illegal Immigrants

In contrast to the diversity, two characteristics are remarkably consistent across subgroups of homeless people: a lack of decent affordable housing and a lack of adequate income. In view of the homogeneity of homeless people with respect to these characteristics, and the obvious relationship of poverty to homelessness, their diversity is striking and deserving of review. Because policy priorities are largely determined by the relative emphasis placed on the diverse rather than the common characteristics of homeless people, it is important to consider the validity of each approach before reviewing the literature on variations in subgroups.

Advantages of Evaluating Differences

Examining differences among subgroups of homeless people has some clear advantages. First, each subgroup has unique service needs and identifying these needs is critical for program planning and design. Detoxification programs, for example, are of little relevance for programs assisting homeless children, and job counseling has limited value for people with severe addictions. Even psychosocial characteristics, such as demoralization, lack of self-confidence or self-esteem, may have distinct roots for people with different backgrounds.

Subgroup Focus: *Advantages*

- Identify specific service needs
- Guide staff selection
  - Specific skills
  - Common background facilitates empathy and understanding
- Guide interagency network development

Second, identifying subgroup needs can guide agencies in hiring staff with skills that are matched to their client's needs. Programs serving people with mental illness need access to clinicians with expertise in treating these disorders, while programs serving latinos and other minorities must hire linguistically and culturally competent staff.

Finally, identifying group-specific service needs can provide crucial information to guide development of responsive interorganizational service networks. Homeless people typically need assistance in multiple areas, often involving distinct agencies. Building alliances among agencies with different missions, goals and values can be complex and time consuming, and it is important that these efforts are appropriately targeted.

Drawbacks to Evaluating Differences

Focusing attention on subgroup differences also has potential risks. While differenting subgroup needs may assist some types of service planning and delivery, attention may also be distracted from the basic needs homeless people have for safe, decent housing and income resources. Attending to differences may numb awareness of the inevitability that in a market-oriented industrial nation with a limited commitment of resources to safety net services, some people inevitably fall into extreme poverty and homelessness. Scholars and researchers consider declining employment and public support of the poor, and reduced availability of low-cost housing to be the primary reasons for the increase in homelessness since the late 1970s (Jencks, 1994; Rossi, 1989; Burt 1992; Koegel, Burnam & Baumohl, 1996; O'Flaherty, 1995). Programs that target special needs may blur awareness of the structural causes of homelessness and may lead policy makers to erroneously explain homelessness as a result of personal or subgroup failings. Who is vulnerable in a particular housing market should not be confused with why homelessness occurs at all. "Social poverty", although it may appear differently in different subgroups, is often derived from long exposure to demoralizing relationships and unequal opportunity (Tilley, 1998).

Subgroup Focus: *Disadvantages*

- Distracts attention from common needs for housing, income, employment
- Results in focus on personal failing
- Reinforces concept of different levels of deservingness

Populations that are prominently represented among the homeless are poor and lack access to low cost housing. These subgroups may be better characterized as being systematically under-served by our society's social safety net programs and opportunity structures rather than being uniquely burdened by individual incapacities. Personal characteristics often found among homeless people may represent markers of societal neglect and bias. Historical surveys of the changing faces of homelessness indicate that the subgroups most vulnerable to losing their homes change with societal attitudes, safety net programs, and medical technologies. The profile of homeless people reflects, in part, our social history. For example, at the turn of the century the homeless population included amputees from the Civil War and railroad accidents, the blind, and many people with syphilis (Bassuk & Franklin, 1992).

Commonalities: The Need For Adequate Housing And Income Support

Before we consider research on subgroup-specific needs of homeless people it is important to briefly review the critical impact of policies and interventions that directly address housing and income needs of all types of homeless people.

- During the Great Depression of the 1930s, large numbers of able bodied men were forced into homelessness due to unemployment rates that approached 25 percent. With the outbreak of World War II, however, the federal government provided employment for almost 18 million men and many millions of women, and virtually eliminated homelessness from the American landscape.
- During the early 1950s, homelessness in urban skid rows was largely a problem of older alcoholic men. With the advent of social security retirement and disability benefits poverty among the elderly declined from 50 percent in 1955 to 11 percent in 1975 (Weir et al., 1988) and the risk of homelessness for older Americans was vastly reduced (Rossi, 1989).
- A study comparing homeless and non-homeless people who used the same soup kitchens in Chicago documented that the major difference between these two groups was that those who were not

homeless were receiving income through supplemental security income (SSI) (Sosin & Grossman, 1991).

- A prospective study of homeless mentally ill applicants for social security disability benefits found that among those who received benefits, 50 percent exited from homelessness within three months of the initial disability determination as compared to only 20 percent among those who were turned down for benefits (Rosenheck, unpublished data).
- A study of housing vouchers and intensive case management for homeless people with chronic mental illness found that vouchers, but not intensive case management, improved housing outcomes and that neither intervention affected clinical outcomes (Hurlburt, Hough & Wood, 1996).
- A recent epidemiologic study of risk and protective factors for family homelessness indicated that factors compromising a family's economic and social resources were associated with increased vulnerability to homelessness. Specifically, being a primary tenant, receiving a housing subsidy or cash assistance, and graduating from high school were protective against family homelessness (Bassuk et al., 1997a).

An evaluation of a nine-city services-enriched housing program for homeless families (N=781) with multiple problems, many of whom had been recurrently homeless, found that the vast majority of these families were still in Section 8 housing at an 18-month follow-up. The authors concluded "that it may be an investment in helping families to regain their stability and ultimately perhaps, their footing in the workforce." (Rog et al., 1995b, p.5 13)

In each of these cases, in spite of the heterogeneity of the populations, income or employment support substantially contributed to resolving the problem of homelessness. In the sections that follow we consider empirical evidence on the background and needs of specific subgroups of homeless people. We conclude by reconsidering the relative importance of homogeneity vs. heterogeneity in policy development and service planning for homeless people.

Subgroups Of Homeless People

People who are homeless can be differentiated along six dimensions: (1) developmental phase of life (age); (2) gender; (3) social unit (families vs. single individuals), (4) racial or ethnocultural groups; (5) health status (psychiatric illness, substance abuse, HIV/AIDS, and the multiply diagnosed); and (6) social status (veteran vs. citizen vs. criminal vs. illegal immigrant). In the sections that follow, we review empirical research on the specific experiences and circumstances of each subgroup.

Developmentally Differentiated Groups: Children, Youth, and the Elderly

The loss of "home"-a place that nurtures development and provides safety across the lifespan-is especially troubling to homeless children, youth, and elderly persons. Being without a home challenges the unique developmental tasks of each age group. In addition, all these subgroups are particularly vulnerable to the exigencies of shelter or street life because of their age, frailty, and dependence on others.

Children

Prompted by increasing numbers of children living in poverty in the United States (Danzinger & Danzinger, 1993), research in this areas has grown since the mid-l 980s (McLoyd, 1998; Duncan & Brooks-Gunn, 1997). In general, studies indicate that persistent rather than transient poverty is more detrimental to children, and that children experiencing either type of poverty do less well on school achievement, cognitive functioning, and socioemotional measures than children who have never been poor (McLoyd, 1998).

Homeless children are among the poorest children nationally (Rossi, 1989; Wright, 1991). Researchers have noted the similarities between homeless and poor housed children; homeless children look worse on only some parameters (Ziesemer et al., 1994; Buckner & Bassuk, 1997; Bassuk et al., 1997; Masten et al., 1993; Rubin et al., 1996). These findings suggest that homelessness may be only one stressor among many in the lives of poor children and that cumulative effects of multiple stressors may be more detrimental. In addition, one recent study of sheltered homeless and poor housed (never homeless) children and families conducted in Worcester, Massachusetts [henceforth called the Worcester Family Research Project (WFRP) (Bassuk et al., 1996)] found that the most powerful independent predictor of emotional and behavioral problems in both homeless and housed poor children was their mother's level of emotional distress (Buckner & Bassuk, 1997). Clearly, interventions that support the healthy development of poor children must address the well-being of their mothers as well.

Homeless children are generally young children. According to a study of homeless families in nine major American cities, the typical homeless family is comprised of a single mother, 30 years of age, with two children under the age of five years (Rog et al., 1995). Research indicates that homeless children have high rates of both acute and chronic health problems. They are more likely than their poor housed counterparts to be hospitalized, to have delayed immunizations, and to have elevated blood lead levels (Alperstein, Rappaport, & Flanigan, 1988; Parker et al., 1991; Rafferty & Shinn, 1991; Weinreb et al., 1998). They also have high rates of developmental delays (Molnar & Rath, 1990; Bassuk & Rosenberg, 1990), and emotional and behavioral difficulties (Bassuk & Rosenberg; Molnar & Rath, 1990; Zima, Wells & Freeman, 1994; Buckner & Bassuk, 1997). In the WFRP, the cognitive functioning of homeless infants was comparable to their non-homeless peers. However, as children became more aware of their environments, and the stresses of poverty and homelessness accumulated, mental health and behavioral problems began to develop. Twenty-one percent of homeless preschoolers and almost 32 percent of older homeless children (ages 9-17) had serious emotional problems. In addition, violence was endemic in the lives of both homeless and housed poor families, with the majority of children either witnessing violence or being directly victimized.

Homeless, more than poor housed children, face the formidable challenges associated with residential instability and related family and school disruptions. Children who have moved three or more times are more likely to have emotional and behavioral problems, be expelled from school, or be retained in the same grade for more than one year (Simpson & Fowler, 1994 ; Wood et al., 1993; Baumohl, 1998). A typical trajectory into homelessness is marked by multiple moves, with almost 90 percent of families frequently doubling up with relatives and friends in overcrowded situations prior to becoming homeless. The WFRP, found that homeless preschoolers had moved 3.1 times in the previous year, while the average homeless school age child had moved 3.6 times (Bassuk et al., 1997b, Buckner & Bassuk, 1997).

In addition, many homeless children experienced other significant disruptions in their family and school lives. In the WFRP, 9 percent of homeless infants and toddlers, 19 percent of preschoolers and 34 percent of school age children had been placed outside their homes. Not only is this rate significantly higher than among their housed counterparts, but predictive modeling has shown that foster care is an

independent predictor of a myriad of adverse outcomes, including later homelessness (Bassuk et al., 1997a). The WFRP also found that nearly three-quarters of homeless school-age children changed schools at least once in a given year and nearly one-third repeated a grade. Consistency in schools or daycare arrangements is associated with academic competence and later achievement (Baumohl, 1998).

Several researchers have looked at the adverse effects of shelter on children's development. While often qualitative in nature, these studies generally underscore the importance of quiet, private space, the potential negative impact of congregate living on parenting and the mother/child relationship, and the negative impact of homelessness and shelter life on self esteem (Boxill & Beaty, 1990, also see section on families); Hausman & Hammen, 1993).

Children spending time during their developmental years without the safety and stability of a permanent home are at risk for various negative outcomes. Whether they are victims or witnesses to violence, have learning difficulties or struggle with asthma or other health conditions, these children need to gain access to developmentally appropriate services. In addition, permanent housing and adequate incomes for their families are critical. An integrated approach toward designing a comprehensive system of care that serves the well-being of the whole family is crucial.

Youth

Consolidation of one's identity, separation from one's parents and preparation for independence are key developmental tasks of adolescence and critical for becoming a well-functioning adult in our society. Most adolescents prepare for this transition to adulthood in their homes and schools. However, a growing segment of young people leave their families prematurely, joining the ranks of homeless and runaway youth (Powers & Jaklitsch, 1993). Whether by choice or forced to leave, these adolescents are generally ill-equipped for independent living and many become easy prey for predators on the streets.

Despite increasing numbers of homeless youth and their growing proportion among the overall homeless population (US Conference of Mayors, 1987), this subgroup was considered among the most understudied and undeserved until relatively recently (Institute of Medicine, 1988; Farrow et al., 1991). Although empirical studies have been methodologically limited, the growing literature suggests that homeless youth are a special population that require innovative programmatic and policy solutions (Robertson, 1991).

Pathways onto the streets are multiple and complex and include: 1) strained family relationships, including family conflict, communication problems, abuse and neglect, and parental substance abuse and mental health problems; 2) economic crisis and family dissolution; and 3) instability of residential placements like foster care, psychiatric hospitalization, juvenile detention, and residential schools. (Robertson, 1991; Camino & Epley, 1998). While terms and definitions vary, the essential distinction between homeless and runaway youth appears to rest on assumptions about choice in leaving home, access to the home of origin or an alternative home, and time away from home. Distinctions such as these can be problematic because of presumptions about motives and options. Most definitions of homeless youth refer to unaccompanied young people under age 18; the legal status of minor distinguishes them in terms of access to services, employment, housing, and many other resources (Robertson, 1991).

To survive, many homeless youth resort to drug trafficking, prostitution, and other forms of criminal activity (Janus, McCormack, Burgess & Harman, 1987). Homeless youth are at risk for health and mental health problems, including substance abuse (Robertson, 1989; Windle, 1989; Yates, MacKenzie,

Pennbridge & Cohen, 1988), HIV/AIDS (Pennbridge, Yates, David & Mackenzie, 1990; Robertson, 1991; Rotheram-Borus, Koopman, & Ehrhardt, 1991), pregnancy (AMA, 1989; Edelman & Mihaly, 1989), and suicidal behaviors (Shaffer & Caton, 1984; Yates et al., 1988). Their high rates of exposure to various forms of violence, both as witnesses and victims, increases the likelihood of developing post-traumatic stress disorder and depression (Kipke et al., 1997). Many homeless youth have high rates of mental health, alcohol and drug problems often in combination (Miller et al., 1980; National Network, 1985). Special needs groups within the population include: pregnant teens and young mothers, physically and developmentally disabled youth, sexually exploited youth, gays and lesbians, and youth with serious mental health, alcohol and drug problems (Robertson, Koegel, & Ferguson, 1990).

Limited shelter placements, fear of providers and shelters, and distrust of highly structured, rule-bound programs, present unique challenges to service delivery. Streetlife makes it particularly difficult for youth to access health and mental health services as well as educational programs (Powers & Jaklitsch, 1993). In addition, the multiple problems of homeless youth often bring them into contact with unintegrated health, education, mental health, and law enforcement services. Rarely do these agencies respond to the psychosocial and developmental needs of the whole person (Lindsey, Jarvis, Kurtz & Nackerud, 1998). Homeless youth would benefit from programs that meet their immediate and basic needs first, and then help them to address other aspects of their lives; both approaches should minimize institutional demands and offer a broad range of services (Hughes, 1998). Also specially designed programs that include street outreach, job training and employment, education, transitional housing, youth staffing and mentors, and health care services have been described as especially important (Camino & Epley, 1998).

Elderly Homeless

Although the proportion of older persons in the total homeless population has declined in recent years, the numbers of homeless elders, age fifty and older, have grown (Susser, Moore & Link, 1993; Cohen et al., 1997). While still a relatively small subpopulation, their numbers are likely to escalate as homelessness continues unabated, increasing numbers of babyboomers reach older adulthood, and the demand for affordable housing continues to outstrip supply (Cohen et al., 1997; Gilderbloom & Mullins, 1995).

Elderly homeless persons are of special concern because of their vulnerability to victimization both in shelters and on the streets, their frailty due to poor mental and physical health, and the reluctance of traditional senior service systems to incorporate them into ongoing programs (Ladner, 1992). Homelessness uniquely challenges elderly persons. Not only does their vulnerability make meeting basic human needs for food, shelter, and safety more problematic, but it interferes with resolving the later developmental tasks of the lifecycle: the opportunity to reflect on one's life, consolidate personal integrity, and experience completeness rather than despair (Erickson, 1963, 1986; Martin, 1990).

The research on homeless elders remains limited (Crane, 1994). With the declining age of the homeless population, studies have primarily addressed the needs of younger individuals and families. Earlier research that contained samples of older men among the single adult population focused on alcoholism or "skid row" lifestyles rather than their age or life-cycle challenges. In addition, declining rates of poverty among the elderly and a federally mandated system of targeted benefits and programs for older Americans, coupled with the stigmatization of this subgroup, has made the elderly of limited concern to policy makers.

Where studies exist, the age limit used for definition of elderly homeless people varies, from 50 to 65 years (Hudson et al., 1990; Kutza & Keigher, 1991; Cohen et al., 1988). Regardless of chronological

age, due to the harsh living conditions and the resulting magnification of acute and chronic physical ailments, the elderly homeless appear older than individuals of the same age living in housing (Tully & Jacobson, 1994). Depending on study samples, the proportion of men and women in the elderly homeless population differ widely. Women are estimated to comprise 20 percent of the older homeless population nationally, with numbers ranging from 8-33 percent, but make up a larger proportion of older homeless individuals who use services (Cohen et al., 1997; Burt, 1992; Douglass, 1988; Ladner, 1992; Roth Toomy & First, 1992; Kutza & Kreigher, 1991). Older homeless women's levels of alcoholism, drug abuse and criminality are low compared to homeless men and younger women, while levels of serious mental illness appear higher than among men and younger women (Cohen et al., 1997; Fisher, 1991; Wright & Weber, 1987; Crystal, 1984).

Factors that have been identified as contributing to the presence of elderly persons among the homeless include deinstitutionalization (Boondas, 1985), poverty, especially among elderly women (Kutza & Keigher, 1991), and the lack of affordable housing (Boondas, 1985; Kutza & Keigher, 1991; Tully, 1994). Limited access to affordable housing and supportive services is especially problematic for minority elders (Bell et al., 1976; Bowling, 1991; Heuman, 1984; Tully, 1994). While elderly homeless are generally thought to have more consistent income from pensions or social security than younger homeless individuals, poor older women who have never worked, individuals with very limited benefits, and elders whose meager incomes have been exploited by others, are still too poor to support themselves in stable housing. In addition, based on information from service providers, many elderly become homeless for the first time after the death of a spouse, child, or friend who had served as their caretaker or provided financial support (Rafferty, 1986).

Older homeless adults experience various health and mental health problems, are more likely targets for victimization and consequent injury, and lack networks of relatives or friends that could provide emotional or material support (Hudson et al., 1990). One early report indicated that more than 50 percent of homeless individuals over age 50 suffered from chronic mental illness (U.S. House of Representatives, 1984); other studies indicate that these individuals suffer from cognitive impairments, degenerative mental diseases, and other psychiatric problems (Doolin, 1986; Kutza & Keigher, 1991). Complications of aging may increase the stress of homelessness; for example, the decline in hearing and vision that accompanies old age may create a general lack of trust and heightened anxiety since older homeless people need to maintain vigilance to survive (Hudson et al., 1990). In addition, since older shelter users are more likely to be crime victims than non-users (Keigher et al., 1987), some elders choose to remain on the streets rather than use shelters. (Cohen & Sullivan, 1990)

Elder homeless need a complex and coordinated system of care that includes: specialized outreach, help in meeting basic needs and sometimes routine activities of daily living, 24-hour crisis assistance, health and mental health care, transportation services, assistance with the development of social relationships and social ties, and a range of housing options with easy access to services. Studies indicate that some elders do not trust service providers and fear limitations to their independence and the possibility of institutionalization (O'Connell, 1990; Kutza & Keigher, 1991, Tully & Jacobson, 1994). For homeless elders in hospitals, drug treatment programs or nursing homes, policies must ensure that they are discharged only when adequate residential services are secured and that they are never discharged to shelters or the street. In addition, cost reimbursement policies should not encourage premature discharge or discharge without housing in place (Ladner, 1992).

Gender Issues

Since the mid-1980's, many more women have become homeless with the ratio of men to women approaching 3:2. Women now comprise more than one-fifth of the overall homeless population (Burt & Cohen, 1989, Rossi, 1990; US Conference of Mayors, 1991). The rapidly growing numbers of homeless mothers (i.e., families with children in tow) and homeless women alone ("singles") account for these numbers. Although the majority of "single" women have children, they reside in shelters without them. In contrast only an estimated 40 percent of single men are fathers who are less likely to have been married and are not active caretakers (Burt & Cohen, 1989; Calsyn & Morse, 1990). Burt & Cohen concluded that "women bring their gender responsibilities into the homeless situation" (p. 521). As a result, many authors have called for programming to meet their unique needs (Stoner, 1983; Bachrach, 1987; Merves, 1992).

In part, the transformation of homelessness by women reflects the feminization of poverty. Many extremely poor women have limited earning power, job skills, and education and are overwhelmed by childcare responsibilities. If they are raising children alone, these burdens are compounded. Female-headed families are generally poorer than two-parent families because of the presence of a single income and the cost of child care. Despite these facts, poor women do not have a realistic place in the current labor market, which is designed to support nuclear families with male breadwinners. For example, the gap between women's and men's income remains wide, and occupational and gender-related discrimination is rampant. Women earn less over their lifetime than men, and the economic burden of divorce often falls on their shoulders. Service sector jobs do not pay a livable wage or provide essential benefits and TANF benefits, which will be cut as a result of the passage of the 1996 welfare reform legislation, do not help women climb out of poverty (Merves, 1992; Bassuk, 1995; Buckner & Bassuk, in press).

For women with limited education and job skills the picture is even bleaker. Improved technology coupled with job competition from third world countries have led to reduced wages and higher unemployment for these women. The availability of fewer jobs paying decent wages has particularly affected the standard of living of young adults and minority group members (Buckner & Bassuk, in press). Many homeless mothers have worked sporadically at low-paying service jobs such as sales clerks, waitresses, cashiers, and babysitters, but generally not in the year before becoming homeless. Even if a woman were working full-time and was able to arrange free child-care, her housing expenses are likely to comprise an inordinate proportion of her income-far more than the 30 percent allotment that is considered feasible; women comprise a disproportionate percentage of households who are "cost-burdened" (Merves, 1992).

Various researchers have demonstrated that motherhood (in particular, pregnancy and the recent birth of a baby), especially when parenting alone, may jeopardize a woman's ability to maintain her home (Knickman & Weitzman, 1989; Hausman & Hammen, 1993). Women must juggle many roles-worker, homemaker, and mother-often without adequate resources and social support. Raising children is a financial burden and without government-sponsored childcare and enforceable child support laws, it further constrains a mother's already limited job possibilities and earning power. Poor women who manage to work are often on the edge of a precipice: a missed paycheck, medical emergency, unreliable childcare, or other complication, may lead to job loss, eviction, and homelessness.

Although eviction and housing-related problems are a common precipitant of homelessness, domestic violence is also a major factor. The risk of victimization is heightened in neighborhoods plagued by extreme poverty, in situations where women are alone and lack protection, and in relationships with men

who suffer addictions (Bassuk & Rosenberg, 1988). Once on the streets, homeless women, especially the "singles," are constantly vulnerable "to crime, street hazards and the elements" (Merves, 1992, p. 230). A vast majority of single women who have been on the streets for longer than 6 months are likely to have been assaulted and/or raped. As described in the section on homeless families, interpersonal violence is also rampant in the lives of poor women and must be addressed in program planning.

Not surprisingly, many homeless people have various personal difficulties as well. Both single women and men are far more likely to have histories of mental disorders, hospitalization, and suicide attempts than women with children in tow (Hagen & Ivanoff, 1988; Burt & Cohen, 1989). As a result, many single women have had their children placed in foster care or other out-of-home placements. With regard to substance use disorders, single men have double the rate of single women who have double the rate of mothers with children. It is also more likely that men are on the streets because of substance use problems and involvement with the criminal justice system. Calsyen & Morse (1990) described that men as compared to women tend to be on the streets longer, suffer a poorer quality of life, and receive less housing and income assistance. They also found a "service gender gap" and speculated that "homeless men are at the bottom of the hierarchy (of deservingness), in part, because of their greater abuse of alcohol and drugs, and their criminal difficulties (Calsyn & Morse, 1990, p. 607). Culhane & Kuhn (1998) also reported that an estimated one half of homeless men in comparison to one third of women will be readmitted to the shelter system within two years.

In sum, although pathways into homelessness may be different for homeless men and women, each has unique service needs that require innovative programming. "Homeless women suffer disproportionately from every catastrophe specific to their gender and race. The problems they experience mirror those of low-income women and are further compounded for women of color. These problems obstruct all women, but not with the same intensity and frequency. Homelessness specifically demonstrates how gender-related inequalities in large measure shape women's experiences." (Bassuk, p. 238). Although pathways into homelessness are somewhat different for homeless men, they too suffer inordinately and require comprehensive programming to address their complex service needs.

Social Units: Homeless Families

Family homelessness is a relatively new American social problem. Not since the Great Depression have significant numbers of families and children been on the streets. Beginning in the early 1980's, families with young children in tow have become one of the fastest growing segments of the homeless population and now comprise approximately 36 percent of the overall numbers (U.S. Conference of Mayors, 1997).

The rapidly increasing gap between the incomes of rich and poor in America has jeopardized the stability of large numbers of families. With limited education, job skills, child support and child care, their only options for survival are low wage jobs or public assistance, neither of which provide sufficient resources to keep a family stably housed. Often employed at minimum wage jobs, these families tend to pay an inordinate percentage of their income on housing, thus increasing the pool of families at risk for losing their homes (Buckner & Bassuk, in press).

Homelessness is a devastating experience. Losing one's home is a metaphor for disconnection from family, friends, and community. Not only have homeless people lost their dwelling, but they have also lost safety, privacy, control, and domestic comfort (Somerville, 1992). Homelessness disrupts every aspect of family life, damaging the physical and emotional health of parents and children and sometimes threatening the intactness of the family unit. For example, many family shelters exclude men and adolescent boys. To avoid the stress of homelessness, some parents voluntarily place their children with

family, friends or even in foster care. Others lose their children to the foster care system just because they are homeless (Shinn & Weitzman, 1996).

Goodman et al. (1991) have argued that homelessness is psychologically traumatic; it is a life event that is "extraordinary, overwhelming and personally uncontrollable" (p. 1219). The stresses of living in shelters are devastating for most people, but especially for women with young children. Although some shelters involve residents in governance, overcrowding, curfews and other rules, as well as "public parenting" tend to diminish any real sense of autonomy or personal control. Families have little privacy and generally live in cramped quarters, sometimes with the entire family sleeping in one bed. In accord with some shelters' policies, parents must relinquish responsibility for setting rules for their own children. Severely stressed by the loss of a home, these mothers are often less able to protect and support their children under these circumstances. Boxill and Beatty (1990) have described how the mother-child relationship tends to unravel, in part because of the necessity of mothering publicly, and sets up a cycle that is harmful to both. In an attempt to cope, it is not unusual for older children to assume the role of parent-trying to nuture and protect their younger siblings and even their mothers from a dangerous, uncertain and unreliable world (Bassuk & Gallagher, 1990).

Most research describing the needs of homeless families has been conducted in single cities, such as Boston, New York, St. Louis, Minneapolis, Los Angeles, and Philadelphia. All have defined a family as a pregnant mother or a parent with a child in tow. The samples include families residing in family shelters. An important exception is the nine city assessment of the Robert Wood Johnson/HUD Homeless Families Program; these families were residing in services enriched housing for longer than 4 months (Rog et al., 1995a, 1995b). Despite the difference in sampling frames, the findings are remarkably similar to those previously reported.

When evaluating research on homeless families, it is important to be aware of certain limitations; the samples generally exclude women residing in shelters for adult individuals, "singles"; the vast majority of these women have children who are currently not residing with them. Smith & North (1994) documented that homeless women have more personal vulnerabilities than homeless mothers such as higher rates of psychiatric and substance use disorders (i.e., alcoholism), and some may have lost their children as a result. In contrast, they describe homeless mothers as more socially vulnerable because of their lack of employment and the stress of caring for dependent children. As Johnson and Krueger (1989) concluded, homeless "singles" need more intensive psychosocial services, including mental health and alcohol treatment, than homeless mothers with children in tow. (See section below on Gender.)

Who are homeless families and what are their needs? Most are headed by women in their late 20's with approximately 2 children, the majority of whom are less than 6 years old. Their race/ethnicity reflect the composition of the city in which they reside, with minority groups disproportionately represented. The majority of mothers did not graduate from high school and were not currently working. However, most had some work experience. Not surprisingly, homeless families were extremely poor, with incomes significantly below the federal poverty level (Bassuk et al., 1996, Rog et al., 1995b, Shinn & Weitzman, 1996)

In the year before seeking shelter, many had become increasingly residentially unstable and had moved 3-5 times. Just before seeking shelter, most were doubled up in overcrowded apartments. When asked why they lost their homes, Rog's sample most frequently mentioned eviction, inability to pay rent, and domestic violence. Researchers agree that all families require decent affordable safe housing, adequate income, education and job training, jobs that pay livable wages, and reliable high quality childcare.

In addition to these basic needs, other aspects of these family's lives must be addressed. Interpersonal violence may well be the subtext of family homelessness. Abuse and assault seem to be the salient feature of homeless mother's childhood and adult experiences. Women suffer its devastating medical and emotional consequences for the rest of their lives. The Worcester Family Research Project (WFRP) (Bassuk et al., 1996) documented that a staggering 92 percent of the homeless (N=220) experienced severe physical and/or sexual abuse as measured by the Conflict Tactics Scale. More than 40 percent had been sexually molested by the age of 12. As adults, almost 2/3 of the overall sample had been severely physically assaulted by an intimate partner and 1/3 had a current or recent partner who was abusive. More than one-fourth of homeless mothers reported having needed or received medical treatment because of these attacks (Bassuk et al., 1996). Supporting these findings, Rog et al. (1995b) reported that almost two-thirds of her sample of 743 women described one or more severe acts of violence by a current or former intimate partner. Many women are fleeing violent relationships when they enter shelter. Others are unable to leave these relationships without extensive support and as a result are unable to maintain jobs. To be effective, policy makers must account for the pervasiveness of interpersonal violence in program planning.

In addition to violence, homeless mothers suffer from other extreme stresses associated with poverty. Similar to low-income women generally, they "experience more frequent, more threatening, and more uncontrollable life events than does the general population (Belle 1990, p. 386). Unfortunately, they often do not have adequate support to buffer these stresses. Compared to housed mothers, homeless mothers had fewer non-professional network members, extremely small networks, more conflicted relationships, and were less willing to seek support. In addition, the network members of the homeless had fewer basic resources such as adequate housing and jobs, two meals a day and money to pay bills (Goodman et al., 1991, Bassuk et al., 1996).

Given the high levels of stress and the pervasiveness of violence, it is not surprising that homeless mother's have high lifetime rates of major depressive disorder (twice the rate of the general female population), post traumatic stress disorder (PTSD) (three times compared to the general female population), and substance use disorders compared to the general female population. Currently (within the past 30 days), more than one-third had an Axis I diagnosis. In contrast to single adult homeless individuals, homeless mothers do not suffer disproportionately from psychoses, such as schizophrenia. Given the oppressive systemic and personal circumstances that engulf many homeless women, it is also not surprising that they have astonishingly high rates of attempted suicide. In the WFRP, nearly one-third of homeless mothers reported that they had made at least one suicide attempt before age 18 (Bassuk et al., 1996). In Rog's (1995b) sample, more than one-quarter had attempted suicide, with 57 percent reporting multiple attempts particularly by overdose.

Why do some very low-income families become homeless while others do not? Using univariate statistics, researchers in New York City (Shinn, Knickman & Weitzman, 1991; Weitzman, Knickman, Shinn, 1992), Los Angeles (Wood et al., 1990) and Boston (Bassuk & Rosenberg; Goodman 1991a, 1991b) have examined variables, such as social support, violence, and mental health, which may account for a family's increased risk of becoming homeless. The results have been inconsistent across these domains. Discrepancies may be due to differences in the timing of assessments, the type of comparison group, and macro-level factors within the city (Buckner & Bassuk, in press).

A recent epidemiologic study (WFRP) investigated factors that might be protective against family homelessness. Using multivariate modeling, protective factors included housing subsidies, TANF, graduating from high school, having more people in one's social network and having fewer conflicted relationships. Factors that reduced a family's economic and/or social

capital were also associated with homelessness. For example, mental hospitalization within the last two years and frequent use of alcohol or heroin were risk factors although they were uncommon among the sample (Bassuk et al., 1997).

In response to the growing crisis of family homelessness a safety net of family shelters and transitional housing facilities have sprung up in the United States. Based on the latest HUD shelter survey (1989) conducted in areas with populations greater than 25,000, the number of family shelters had doubled between 1984 and 1988—from 1900 to 5000 and are now the most common shelter type. More recent estimates are unavailable, but with the continuing growth of homeless families, it is likely that the number of family shelters has continued to climb, "although probably at a lower rate of annual increase" (Weinreb & Rossi; p.88, 1995). In addition to housing assistance, most programs provide a broad array of programs including social services (e.g., case management, counseling) and life skills training. Almost half of the shelters provide follow-up to their residents (Weinreb & Rossi, 1995). In addition to shelters, most communities also provide transitional or bridge housing for families who need more services and support. Lengths of stay tend to be longer (6 months to 2 years) and services address both basic and complex service needs. Rarely, permanent service enriched housing is also available, but these programs tend to target families already living in subsidized housing who need additional services to become self-supporting (Bassuk, 1990; Shlay, 1993). Although this continuum of care is a good beginning, the data indicate that the emphasis in program planning should be on permanent housing with services and supports available to families who chose them. (See section on gender). Until more comprehensive programming is accomplished the well-being of these families will continue to be compromised.

Racial and Ethnocultural Subgroups

Racial and ethnocultural minorities have long been at a serious disadvantage in the United States. In a trenchant analysis of the ways in which intergroup patterns of social interaction become institutionalized, Charles Tilley has described the process through which "durable inequality" emerges from exploitation of categorically defined subgroups. Through this process persistent disadvantage becomes institutionalized, appearing inevitable, intrinsic, and deserved-a basic fact of the way things are (Tilley, 1998). Perhaps the perniciousness of this processes and its ability to shape social perception has contributed to our inattention of homelessness among minority groups-as if it were expectable and therefore, in some sense, acceptable. Thus although minorities are at dramatically greater risk for homelessness than other Americans, there has been virtually no specific study if minority pathways into homelessness. Studies that address minority issues, have been, almost exclusively, sub-analyses of other, more general surveys. For this reason alone, it is important that a report on subgroups of homeless people not overlook the importance of race and ethnocultural group identity.

Blacks and latinos in America are far more likely than other Americans to be poor and therefore, more likely to be homeless. In 1980, as the numbers of homeless began to grow, 30 percent of African Americans lived in poverty and 23 percent of Hispanics, as compared to only 9 percent of non-Hispanic whites (Baker, 1996). A government study released in 1998, based on a careful analysis that included government and job-related benefits, found the gap between rich and poor, black and white, to be increasing, even as the stock market soared (Passell, 1988).

Consistent with these income statistics, surveys conducted in the 1980s all showed that about half of all homeless people were black, almost five times their representation in the general population (Hopper & Milburn, 1996). Hispanics, paradoxically, were not over-represented among the homeless in most localities and were under-represented in some (Baker, 1996). Therefore, we must consider the specific circumstances of minority groups separately.

Homelessness Among African Americans

It is important to note, at the outset, that poverty alone does not account for the high risk of homelessness among blacks. A systematic comparison of the proportion of blacks among the homeless and among domiciled people living in poverty in US cities with populations of 100,000 or more, showed that poor blacks living in urban settings were twice as likely to be homeless as poor whites in the same cities (Rosenheck et al., 1996). Several factors may explain this additional difference: (1) wealth is likely to be more important than income in the etiology of homelessness, (2) white flight and the departure of middle class blacks to the suburbs have left pockets of concentrated poverty and reduced job opportunities in urban areas, and (3) extreme segregation of housing by race and class seriously augments the adverse effects of other types of economic disadvantage.

First, the gap in wealth between white and blacks is considerable. Oliver and Shapiro (1995) point out that typical poverty statistics focus exclusively on income (e.g., average annual earnings, dividends and government benefits) and exclude data on wealth - the totality of accumulated assets. While the income gap between blacks and whites has narrowed considerably in recent years (black married couples earn 80 percent of white married couples, an annual difference of $6,500), the gap in wealth has not (black married couples own only 27 percent as much as white married couples, a difference of $47,600). Differences in wealth reflect differences in the long-term accumulation by assets in families. The major asset of non-hispanic whites is their personal home, an asset whose value has increased markedly since the end of World War II. Blacks however had little chance of owning a home in the immediate post-war period; this partially explains why the wealth gap has yet to be narrowed.

Racial differences in wealth are important because, while income reflects resource availability in an average week or month, wealth (savings) is what allows people to survive periods &adversity such as job loss or recession. Thus, the much larger gap between blacks and whites in wealth can be expected to result in far greater vulnerability among blacks to residential displacement during economic downturns and lower levels of resource buffering capacity in their social networks.

Second, as documented by William Julius Wilson (Wilson, 1987, 1996), the loss of jobs in inner cities has dramatically reduced employment opportunities for black men. This loss has been compounded as upwardly mobile blacks have followed whites to more prosperous communities in the suburbs. Thus, many inner city communities have lost their internal cultural strength.

Third, housing segregation has contributed substantially to the exceptionally high risk of homelessness among blacks. As chronicled by Massey and Denton (1993) "redlining", the official government policy during the 1930s that kept blacks from moving into white neighborhoods, and continuing patterns of de facto discrimination in housing markets (Turner & Reed, 1990) have kept blacks and whites separate. The separation is increasing and it seriously compounds problems associated with poverty and limited employment opportunity (Massey & Denton, 1993). In a racially and socio-economically integrated community, even though the disadvantaged suffer disproportionately especially during economic downturns, neighborhood institutions and functioning are little affected because of the contributions of better off residents. In contrast, in segregated communities, when poor people experience an economic

downturn or a reduction in public support, their communities suffer devastating losses of material resources, infrastructure, and institutional capital. Although briefly sketched, factors operating at the community level are likely to account substantially for the increased risk for homelessness among blacks beyond income differences.

Several studies have noted systematic differences between homeless blacks and homeless whites—differences that underline the relevance of these broad structural factors. Studies of two separate national samples of homeless veterans (Leda & Rosenheck, 1995; Rosenheck et al., 1997) and a sample of several thousand homeless people from 18 cities who are participating in the ACCESS demonstration program (unpublished data from R Rosenheck & J Lam) have shown that homeless blacks are less likely to have severe mental illnesses than whites, and have more social supports and stronger employment histories. These strikingly consistent findings suggest that while disabling mental illness and social isolation are major factors in the genesis of homelessness among whites, blacks are also affected by the historical legacy of discrimination (e.g., in their lack of accumulated assets) and current urban dynamics which push them over the edge into homelessness. In addition, an outcome study that compared black and white veterans found that while admission to residential treatment in addition to case management had little impact on outcomes among whites, black veterans had substantially better outcomes when they were admitted to residential treatment programs (Rosenheck et al., 1997). Although not conclusive, these data suggest that depletion of community social and economic resources may require additional interventions at both the community and individual levels.

We have presented these issues at length for two reasons. First, they suggest that interventions seeking to address homelessness among African Americans may require special consideration of institutional and structural contexts. Second, they demonstrate that examination of the specific needs of subgroups of homeless people must not stop at descriptions of individual susceptibilities, but must also examine group-specific social issues.

Homelessness Among Latinos

The under-representation of latinos among homeless people in spite of their high poverty levels has been deftly explored by Susan Gonzalez Baker (1996) who coined the phrase "The Latino Paradox". She suggested four possible explanations for the low numbers of latinos among the homeless: (1) survey methods may systematically undercount latinos in homeless samples, (2) latinos may have lower levels of personal risk factors such as psychiatric or substance abuse disorders that reduce their risk of homelessness, (3) latinos may face fewer social disadvantages than other groups, particularly compared to blacks and (4) exceptionally strong traditions of mutual familial support may be protective against homelessness. Baker suggests that the evidence does not support survey bias or differences in personal risk factors, although a recent epidemiologic study conducted in California suggested that mental illness was far less common among new immigrants than among those who had been in this country for many years or had been born here (Vega et al., 1998). Although not definitive, available data most strongly suggest that latinos may be subject to less housing and job discrimination than blacks, and that they are more likely to incorporate additional family members in a single household (Greene & Monahan, 1984; Mindel, 1980).

In the brief period since Baker's study, considerable attention has been focused on the large and growing number of hispanic immigrants in this country, both legal and illegal, especially in California and the Southwest. Originally "invited" to provide a new source of low-wage labor, the rapidly growing numbers of immigrants from Latin America has generated a formidable backlash (Suro, 1997). Studies of the new immigrants have documented several characteristics that may affect their risk for homelessness. (1) Immigrants from the same towns in Latin America are tightly bound to one another and are deeply

committed to mutual protection (Suro, 1998). (2) They are often apprehensive about using conventional governmental services for fear of being identified as illegal residents (either correctly or incorrectly). Finally, epidemiologic studies suggest that recent migrants, especially those in the Southwest, have fewer health problems (including mental health problems) than latinos who were born in this country (Vega et al., 1998).

A recent study from the Northeast, however, also found that Puerto Rican single mothers who were poor had experienced less violence and had fewer mental health problems (with the exception of major depression) than whites (Bassuk, Perloff & Coll, 1998). Each of these factors could result in a reduced risk of homelessness among recent immigrants and among less acculturated latinos. Little is known about the specific risk of homelessness among recent immigrants. The possibility that the Latino paradox may reflect specific conditions faced by more recent immigrants will hopefully generate additional discussion and research. The findings of Vega et al., (1998) may suggest that as acculturation proceeds, the risk of homelessness among latinos may become similar to that of the impoverished populations.

Native Americans Among the Homeless

Although blacks and latinos are the most numerous minority groups in this country, they are not the only ones that face adverse circumstances. The presence of other subgroups among the homeless and the documentation of their needs have received minimal attention. We note, however, a large national study of homelessness among Native American veterans because it further illustrates many of the themes we have been exploring (Kasprow & Rosenheck, 1998). This study of almost 50,000 homeless veterans showed that Native Americans are substantially overrepresented among homeless veterans (even without considering the prevalence of homelessness on reservations) and that, unlike other groups, they suffer overwhelmingly from alcohol abuse, with far lower rates of diagnosed psychiatric disorders. Alcohol abuse has been widely identified as a substantial problem in Native American populations, and is viewed by many as one consequence of the genocidal treatment of Native Americans by European conquerors (White, 1992).

Homelessness and Health: Psychiatric, Substance Abuse and Medical Disorders

As in our review of literature on generational, gender and familial circumstances and needs of homeless persons, we have found that examination of racial and ethnocultural subgroup experiences also reveal both distinctive vulnerabilities and service needs specific to each subgroup, as well as more common experiences of social disadvantage and personal deprivation. As we turn to an examination of illness, and specifically mental illness among homeless people, we move from issues which reflect major features of societal organization that have received only limited attention, to issues that have been at the center of public understanding of the problems of homeless people and have been thoroughly and carefully researched.

The prevalence of psychiatric and addictive disorders among homeless people has probably been studied more intensively and more rigorously than any other problem. Early accounts suggested that as many as 90 percent of homeless people might be suffering from mental illnesses-including many with severe illnesses such as schizophrenia and other psychoses (Bassuk, Rubin & Lauriat, 1984). Many critics quickly identified the deinstitutionalization of people with mental illness from state hospitals as a major "cause" of homelessness in the 1980s (Koegel, Burnam & Baumohl, 1996). Others pointed out that both sampling and diagnostic tools used in early studies of mental illness among homeless people were seriously inadequate, and that the timing of deinstitutionalization could not directly implicate it as a direct cause of homelessness.

In the mid-1980s the National Institutes of Mental Health funded a series of rigorous epidemiological studies based on systematic sampling strategies and state-of-the-art assessment methods. These studies demonstrated that 20-25 percent of homeless single adults had lifetime histories of serious mental illness; about half had histories of alcohol abuse or dependence; and about one-third had histories of drug abuse or dependence (Susser, Struening, & Conover, 1989; Breakey et al., 1989; Koegel, Burnam & Farr, 1989). While these rates of lifetime mental illness were 3-5 times greater than rates in the general population, these studies demonstrated that most homeless people did not have serious mental illnesses, and that less than 15 percent had suffered from schizophrenia (Koegel, Burnam & Baumohl, 1996; Tessler & Dennis, 1989). Although far more modest than rates reported in previous studies, these data clearly showed that severely mentally ill people were at much higher risk for homelessness than others and that they endured homelessness for greater periods of time. Because the public believed that the needs of people with serious mental illness had not been adequately addressed by the community mental health movement, and because it was more widely accepted that people with serious mental illness "can't help themselves," the public has been willing to support outreach programs to facilitate the entry of distrustful homeless people with mental illness into programs.

Alcoholism has long been identified as a central feature of the lives of homeless people and an explanation for their homelessness (Bahr & Caplow, 1973; Wiseman, 1973). However, among the homeless people who became visible during the 1980s, alcohol addiction was often found in younger members of minority groups (Koegel & Burnam, 1987) and among people with concomitant mental illness. About half of those with serious mental illness also had substance abuse disorders-the so-called dually diagnosed (Drake, Osher & Wallach, 1991). Alcohol abuse and dependence were often combined with the use of illicit drugs, especially crack cocaine (Jencks, 1994). Because crack cocaine was much cheaper than other drugs and other forms of cocaine, it was widely used by low income people during the years after1984.

The high level of addictiveness of crack cocaine resulted in sustained, widespread use; one survey found 66 percent of anonymous urines collected in a New York City homeless shelter were positive for crack cocaine (Jencks, 1994). While the path from alcoholism to homelessness was not a new one, the path from crack cocaine to homelessness was new, and was markedly facilitated by the low cost of the drug. Here, too, it affected the poor, infirm, and disadvantaged with special harshness,

In addition to the high rates of alcohol, drug, and mental disorders, homeless people also suffer from serious medical infirmities and experience mortality rates as much as twice a great as those of poor, domiciled people with mental illness (Kasprow and Rosenheck, 1998). The rate of HIV infection is especially. high among homeless people. One study conducted in a New York City men's shelter found that 19 percent of homeless mentally ill men were HIV positive (Susser, Valencia & Conover, 1993) while another found 62 percent of homeless men were HIV positive and 18 percent had active tuberculosis (Torres et al., 1990). Another large study of New York City shelter users found that use of drugs, alcohol, and the presence of psychiatric disorder are all associated with poorer physical health, even distinct from specific illnesses such as HIV, and that the physical health status of homeless men is well below that of community samples (Streuning & Padgett, 1990).

Homelessness is thus both an effect and a cause of serious mental and physical health care problems. On the one hand, survey data strongly suggest that people with physical and mental infirmities are far more likely to become homeless than others. On the other hand, the exposure to the elements, poor nutrition, and lack of basic comforts experienced by homeless people worsens their already compromised health status. There is little question that homeless people need health services well beyond those they receive through conventional channels. The mentally ill among homeless people are often the most demoralized

and hopeless, and least convinced that they can improve their situation. Supportive case management within a sustained healing relationship is an especially important component of services for this segment of the population.

Homeless People with Special Status in Society

Homeless Veterans

For as long as there have been armed forces, veterans have been honored and received considerable public attention and concern. Since the development of citizen armies in the 19th century, in recognition of their service and sacrifice, their power as a political force, and the potential threat they pose to social order, veterans have had a unique status in society (Severo & Milford, 1989). Surveys conducted during the 1980s indicated that as many as half of homeless veterans served during the Vietnam era compared to only one-third of veterans in the general population. These estimates led many to suggest that homelessness among veterans might be yet another consequence of military service during the Vietnam War and, more specifically, of combat-related posttraumatic stress disorder (PTSD) (Robertson, M, 1987). Although studies have clearly shown that some Vietnam veterans have suffered prolonged psychological problems related to their military service, the assumption that homelessness among veterans is primarily related to Vietnam service is not supported by available evidence.

A systematic synthesis of survey data indicated that 40 percent of homeless men report past military service, as compared to 34 percent in the general adult male population (Rosenheck et al., 1994), a modest increase in risk. Further studies using numerous, diverse data sets show that homeless veterans are not more likely to have served during wartime or in combat than age-matched peers who were not homeless, and were no more likely to have war-related posttraumatic stress disorder than non-homeless low income veterans (Rosenheck et al., 1996). A causal model of the genesis of homelessness among veterans also found that while mental illnesses other than PTSD, substance abuse, and social isolation were significantly related to homelessness, combat exposure and PTSD were not major predictors (Rosenheck & Fontana, 1984). In fact, the subgroup of veterans at greatest risk of homelessness as compared to their non-veteran peers are those who served after the Vietnam war, during the initial period of the All Volunteer Army, when the military was unpopular, paid low salaries, and was forced to admit many poorly adjusted recruits (Rosenheck, Frisman & Chung, 1984).

Studies conducted during the 1980s consistently reported that homeless veterans were older and are more likely to be white than other homeless men (Roth et al., 1992; Schutt et al., 1986; Streuning & Rosenblatt, 1987; Robertson, 1987). Some of these studies also reported that homeless veterans had more often been in jail than homeless non-veterans, were more likely to have problems related to alcohol use, or are more likely to have been hospitalized for a psychiatric or a substance abuse problem. A re-analysis of data from three surveys conducted during the late 1980s found that homeless veterans were older than non-veterans; more likely to be white; better educated; and more often previously or currently married, but were not different on indicators of residential instability, current social functioning, physical health, mental illness or substance abuse (Rosenheck & Koegel, 1993). Thus, it appears that the personal risk of homelessness among veterans was due primarily to the same factors as homelessness among other Americans-poverty, joblessness, mental illness and substance abuse.

However, homeless veterans have received considerable special attention and some degree of incremental service funding because of their past service to society. A headline in *USA Today*, for example, hailed "a shattered army: 500,000 homeless veterans most of whom served in Vietnam," a degree of sympathetic attention not granted to other subgroups of the homeless. Secretary of Veterans Affairs Jesse Brown told

the Congress that homelessness among veterans "is an American tragedy. . . .The way a society treats its veterans is an indication of who we are as a nation." It is unlikely that any other cabinet officer has spoken as feelingly or as convincingly about a particular subgroup of the homeless.

Criminal Justice System Users

In dramatic contrast to the public's view of veterans are the feelings about the large numbers of homeless persons who have past histories of involvement in the criminal justice system (Fisher, 1992; Gelberg, Linn & Leake, 1988). An estimated 20 percent to 66 percent of homeless people have been arrested or incarcerated in the past as compared to only 22 percent of men and 6 percent of women in the general population (Fisher, 1992). These high rates may reflect one of four distinct personal configurations: (i) long-term deviant life styles (people who are deeply involved in crime and antisocial behavior as a way of life, including drug abuse); (ii) subsistence (the need to commit crimes for material sustenance); (iii) adaptation (criminal behavior as a necessary part of adjusting to life on the street), or (iv) diminished capacity (crime resulting from the inability to tell right from wrong due to mental illness). Reliable estimates of the relative importance of these four patterns among homeless people are not available, although they have different implications for social policy. Long term deviant life styles, for example, might suggest the need for increased incarceration while the diminished capacity explanation suggests targeting additional treatment resources to the homeless.

One author points out that the rise in homelessness during the 1980s corresponds closely to the increase in numbers of prison inmates (0' Flaherty, 1996). Between 1974 and 1984, for example, the prison population of New York State increased 2.3 times-from 12,532 to 28,992. In this view, personal characteristics are less central that social policy in explaining the large numbers of criminal justice system users among the homeless. By incarcerating a growing proportion of poor, often drug abusing, largely minority, citizens, criminal justice policy cut these vulnerable citizens off from the communities from which they came, unintentionally reducing the likelihood that they would ever be able to reestablish themselves after their release from jail or prison. Homelessness among former inmates may reflect an unanticipated negative consequence of a failed solution to a misunderstood social problem.

From another perspective, however, it has been observed that the criminal histories of many homeless people primarily reflect arrests that occurred after they became homeless-arrests for stealing or disturbing the peace that are an intrinsic part of life in public spaces (Fisher, 1992; Snow et al., 1989). Here, too, we have little information on the relative importance of each of these processes, but it is important to note the dramatic contrast between interpretations that view homeless people with past histories of involvement in the criminal justice system as victims of societal mistreatment, as contrasted with interpretations that emphasize behavioral deviance as determined at the individual level (Benda, 1987; Martell & Elliott, 1992; Martell, Rosner & Harmon, 1995).

Considerable emphasis has been placed in the literature on the possibility that people with serious mental illness are being referred with increasing frequency to the criminal justice system because of the inadequacies of the mental health system (Torrey et al., 1992). Advocates have suggested expanding jail diversion programs to appropriately channel people with mental illness to the mental health, rather than criminal justice system (Steadman, Barbera & Dennis, 1994).There is a considerable need for further research on the interrelationship of homelessness, mental illness, minority status and involvement in the criminal justice system.

, Illegal Immigrants

We conclude this section by describing a subgroup of homeless people whom virtually nothing has been written: illegal immigrants. While this population has been growing rapidly and has provoked a harsh backlash reflected in the passage of Proposition 187 in California in 1994 (Suro, 1998), we know of only clinical anecdotes revealing the presence of such people among the homeless. Little is known about this population for the following reasons: (i) they may not be very numerous, (ii) they may be unwilling to identify themselves for fear of being deported, and (iii) they receive little attention because they have the least claim on our sympathies (a point deeply underscored by the passage of Proposition 187). To better serve this group, additional information about their needs is necessary.

Summary: Heroes, Deviants, and the Invisible

In this brief survey of homelessness among veterans, users of the criminal justice system, and illegal immigrants we have described three subgroups that cross social status levels: from some of the most idealized members of society, to some of the most despised, to the largely ignored. And yet survey data suggest that the boundaries among these groups may be much clearer in the public imagination than in reality. In a sample of over 10,000 homeless mentally ill veterans seen in a national Congressionally funded VA program, one-third of whom had served the nation in combat, over 50 percent of the sample had significant criminal justice histories (Rosenheck et al., 1989); in fact, they differed little from other homeless men in this or any other respect. The parable of the good Samaritan urges us to care for strangers just as we would care for our closest relatives. In our reflection on homelessness among these three subgroups we confront most dramatically the tension between attending to each subgroup in order to better understand and respond to their needs—or to differentiate among them to best decide who are deserving of public provision and who are not.

Discussion

In this presentation we have reviewed research on the diverse needs of various subgroups of homeless people. While we have discussed the distinct needs of each subgroup, we have also provided evidence indicating that the most effective way of preventing homelessness is to directly provide residential services and adequate income support. Although many homeless subgroups, especially the young and the mentally ill need personal support and remoralization to take full advantage of expanded opportunities, the late 1970s and early 1980s was not a time of epidemic demoralization, but of structural change in our society.

Why then have we focused on subgroup characteristics? To answer this question, we must briefly review American attitudes and public policy towards social support for the disadvantaged. Between the 1880s and 1920s the major industrial nations outside of the United States guaranteed protection for all citizens against insufficient income due to old age, disability, illness, or unemployment (Weir, Orloff & Skocpol, 1988a; Skocpol,1992; Wilensky & Lebeaux, 1965; Rimlinger, 1971). Programs for workman's compensation, old age pensions and insurance, health insurance, unemployment insurance, and mother's insurance were instituted not just to attack poverty, but to generate a form of social citizenship that guaranteed basic rights and expressed the solidarity of national community (Heclo, 1995). For various cultural (Rimlinger, 1971) and political reasons (Weir, Orloff & Skocpol, 1988a; Skocpol, 1992) a broad commitment to social welfare never developed in the United States.

For example, in the mid-1980s in five European nations, Australia, and Canada, 23 percent of the population would have lived in poverty without welfare benefits. However, only 5 percent were poor as a result of government benefits, a reduction of 18 percent which was attributable to public provision. In contrast, in the United States, 20 percent of the population would have lived in poverty without welfare benefits; 13 percent remained in poverty even after consideration of benefits, a drop of only 7 percent (Mischel & Bernstein, 1993). While European nations spent an aggregate of 20 percent of GDP on social welfare programs in the mid-1980s, the US spent only 16 percent (Weir, Orloff & Skocpol, 1988a).

These statistics reflect deeply held American attitudes. While other industrial nations have maintained a broad commitment to social provision for their citizens-even as they have reduced the generosity of benefits in recent years-the United States has long questioned the motives and deservingness of its poor (Katz, 1989). In fact, Americans have reduced their national commitment through various welfare reform measures and retrenchments (Mishel & Bernstein, 1993). The American approach to public assistance has traditionally been based on a critical evaluation of deservingness, rather than on a broad commitment to assisting the economically disadvantaged. The current withdrawal of public support has occurred in the face of compelling evidence that the distribution of income has become increasingly inequitable since the mid 1970s, and that earning opportunities for unskilled workers continue to diminish even in a booming economy (Passell, 1998).

It is not surprising that within this context the differential composition of the homeless population in America receives so much attention. While in other wealthy industrial countries, the mere fact of homelessness justifies a public response, the traditions of social provision in this country demand further justification of the claim for public sympathy and support for each specific subgroup of homeless people. In a broad empirical review of the performance of the U.S. Government, former President of Harvard University, Derek Bok, concluded that while our country excels above all others in its productivity and high standard of living, and that our government is both effective and efficient, it does less well than other countries at protecting its citizens and assuring their personal security (Bok, 1997, p. 63-64).

Convincing others that people are deserving of assistance requires that researchers specializing in the problems of each subgroup advocate for the legitimacy of their needs. This also may explain why so much scholarly attention is directed at subgroups of the homeless who are regarded as "deserving": families, children, the severely mentally ill, and veterans. Little emphasis is placed on other subgroup characteristics such as extreme poverty, minority status, or being an illegal immigrant.

We do not mean to underplay the importance of addressing the pressing needs of subgroups of the homeless. Children must be educated, single mothers must have child care and job training, the mentally ill need treatment for their illnesses, and veterans deserve honor and recognition for their past sacrifices. All the disadvantaged need encouragement and support (Bardach, 1997). But the studies we have reviewed suggest that as important as these specialized services are, they are not the most effective way out of homelessness. That data strongly indicate that all services must be targeted to the specific needs of individual clients, and that emphasizing subgroup characteristics and needs should in no way imply a *de facto* acceptance of homelessness itself as irremediable and therefore, as acceptable. Since we as a people are not committing the funds to provide subsistence resources for the poor, we understand that there will continue to be hundreds of thousands of homeless persons on any given night, and we are resigned to providing for their educational, health care and job training needs within that context. To do so is certainly preferable to neglecting those needs. However, it is imperative that policy makers understand that such a response may reflect capitulation to an outcome that is not inevitable. If the political will were present, homelessness could be eradicated or at the very least, very markedly reduced.

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Homeless Youth: Research, Intervention, and Policy

by
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Abstract

Homelessness among youth in the U.S. is disturbingly common, with an estimated annual prevalence of at least 5 percent for those ages 12 to 17. Although homeless youth appear throughout the nation, they are most visible in major cities. Rigorous research on this special population is sparse, making it difficult to capture an accurate and complete picture. Despite its limitations, recent research describes homeless youth as a large and diverse group. Many homeless youth have multiple overlapping problems including medical, substance abuse, and emotional and mental problems. Literature suggests that comprehensive and tailored services are needed that address both the immediate and long-term needs of homeless youth. Where appropriate, services should include assistance with meeting basic needs as perceived by youth as a gateway to other needed services. In addition to serving those already homeless, interventions are needed to prevent homelessness among at-risk youth.

Lessons for Practitioners, Policy Makers, and Researchers

- As used here, the term "homeless youth" focuses on minors who have experienced literal homelessness on their own-i.e., who have spent at least one night either in a shelter or "on the streets" without adult supervision. On occasion, where warranted by the research being discussed, the term is also used to describe homeless young adults up to age 24.
- Homelessness among youth in the U.S. is disturbingly common. With an "estimated annual prevalence of at least 5 percent for those ages 12 to 17, adolescents appear to be at greater risk for literal homelessness than adults. Although homeless youth appear throughout the nation, they are most visible in major cities.
- Research on homeless youth has major limitations. Rigorous research on this special population is sparse, making it difficult to capture an accurate and complete picture of homeless youth. Research would. benefit from studies that include large representative samples, reliable and valid measures, comparison groups, and assessment of strengths as well as problems of homeless youth. Research with this special population would likely benefit from more input by service providers, policy makers, and the youth themselves.
- Despite limitations of the literature, it seems clear that homeless youth constitute a large and diverse group
- Many youth have multiple overlapping problems. Many youth come from homes where family conflict and child maltreatment are common. A wide range of health and behavior problems have been documented among homeless youth, including substance abuse, emotional and mental problems, and medical problems. While some of these problems appear to be long-standing, others are probably exacerbated by the stressful experiences of homelessness. Homeless youth, especially

those on the streets, sometimes resort to illegal activities such as prostitution or drug dealing in order to survive. Many youth' are victimized while homeless.

- Few interventions with homeless youth have been formally evaluated. Careful program evaluation of services is sorely needed, especially based on rigorous experimental designs.
- The limited literature suggests that comprehensive and tailored services are needed that address the immediate and long-term needs of homeless youth. Where appropriate, services should include assistance with meeting basic needs as perceived by youth as a gateway to other needed services. Other needed services include screening and treatment for health, mental health, and substance use problems, reconciling family conflict, and educational or vocational training. In addition to serving those already homeless, interventions designed to prevent homelessness among at-risk youth are needed.

Estimating Needs Based on Existing Research

Homelessness among young people in the United States and other nations is a serious and complex problem.[1] The population of homeless youth seems to have disproportionately high rates of health problems, emotional and behavioral problems, and substance use. Homelessness itself potentially poses health risks to youth and can interrupt normal socialization and education, which likely affects a young person's future ability to live independently. This paper provides a profile of homeless youth in the US, documenting their diversity and their service needs. The paper then describes various intervention approaches for homeless youth and discusses relevant social policy. It ends with recommendations for future research.

Limitations of Existing Literature

The available literature on homeless adolescents has major limitations. Rigorous research on this special population is sparse. Much research and other information about homeless youth is fugitive and often dated. As a body of research, it is much less rigorous than contemporary research on homeless adults or families. Information on homeless youth in large urban areas is most prevalent but may not generalize to other areas, and different definitions and methods often prohibit meaningful comparisons. Cross-sectional samples over represent longer-term homeless youth, which results in an over-reporting of factors related to chronic homelessness. In addition, many studies lack rigorous sampling strategies, which limits their generalizability.

Capturing a complete picture of homeless youth is difficult. In some cases, what is known about a particular characteristic of homeless youth may be based on a single study. Where multiple studies are available, findings may be contradictory.

Often contradictory findings occur because the results from a study depend very much on the source of its sample. Recent literature has relied on four basic approaches to sampling. One surveys large groups of teens in the general population and identifies youth from this pool who have a history of homelessness (e.g., Ringwalt et al., 1998; Windle, 1989). These approaches under-represent youth who have longer histories of homelessness or institutional histories. The second approach draws youth from shelters (e.g., McCaskill et al., 1998) who are often younger and less likely to have previous histories of homelessness. The third draws a sample from clinical settings such as medical clinics (Yates et al., 1988). Such studies describe youth seeking treatment and who are often very different from youth who do not seek treatment. The fourth involves sampling from street locations where homeless youth are known to congregate (e.g., Cauce et al., 1994a; Kipke et al., 1995; Robertson, 1989). This street-sampling method, especially if it includes youth who are 18 or older, generally yields a much more "deviant" profile of homeless youth.

Despite its limitations, recent literature suggests that homeless youth constitute a large and very diverse population.

[1] Though most of the research literature on homeless youth has been generated in the United States, there has been some research conducted in other areas including Canada, Great Britain, and Australia, and Latin America. However, work reviewed here draws exclusively on studies on homeless youth in the United States.

Definitions

Defining what constitutes a "homeless youth" may seem fairly straightforward but, in fact, the issues involved in the task are rather complicated. Most researchers studying homeless persons tend to focus on persons who are "literally homeless" (Rossi, 1989). In this paper, we take a similar approach, using the term "homeless youth" to refer primarily to minors on their own who have spent at least one night either in emergency shelter or "on the streets"-that is, in places outdoors or in improvised shelter without parental supervision.[2]

An important decision to be made in defining "homeless youth" involves age. Across the existing literature on homeless youth, the age range has varied widely. In this paper, we will generally use the term "homeless youth" to refer to those between the ages of 12 and 17. However, many studies of homeless youth have also included young adults up to age 24. We will still review studies of youth that also include young adults, but we will note the extended age range involved.3

The target population for this review is heterogeneous and includes youth described with a variety of terms in research and popular literature (Kennedy et al., 1990; Robertson, 1996). These terms include "runaways," who have left home without parental permission, "throwaways," who have been forced to leave home by their parents, and "street youth," who have spent at least some time living on the streets. All studies reviewed here include youth who have spent at least one night literally homeless, regardless of the conditions of separation from their last home. It is important to note that some homeless youth have experienced long or repeated episodes of. homelessness, while others are having their first experience with homelessness or have been homeless only for a few days.

To avoid the sort of terminological confusion common in the existing literature, throughout this paper we will refer to this overall group as "homeless youth." However, when referring to specific reports or studies, we may use the language of their authors specifically to identify the subgroup of homeless youth they studied.

How Many Homeless Youth Are There?

The methodological problems in estimating the prevalence of homelessness have been widely discussed and debated (Appelbaum, 1990; Blau, 1992; Burt, 1994, 1998; Culhane, Dejowski, Ibanez, Needham, & Macchia, 1994; Foscarinis, 1991; Kondratas, 1991, 1994; Link, Susser, Strueve, Phelan, Moore & Struening, 1994; Robertson, 1991; Rossi, 1989, 1994; Solarz, 1988; Toro & Warren, 1999; Wright, Rubin, & Devine, 1998). Though most of this debate has involved homeless adults, many of the controversies and methodological problems identified in the literature apply to homeless youth.

2 In our review, we exclude adolescents who are homeless with their parents.

3 To the extent that studies of homeless youth include persons who are 18 and over, the profile of homeless youth becomes more similar to the profile for homeless adults. For recent overviews on the general characteristics of homeless adults, see Burt (1998); Jahiel(l992); Robertson and Greenblatt, 1992; Shlay and Rossi (1992); Toro (1998); and Wright, Rubin, and Devine (1998).

Notwithstanding the debates, evidence suggests that the size of the homeless youth population is substantial and widespread.[4] A recent large-scale survey of U.S. adolescents provides the most comprehensive data to date on the extent of homelessness among youth (Ringwalt, Greene, Robertson, and McPheeters, 1998). In 1992 and 1993, researchers interviewed a nationally representative household survey of 6,496 youth, ages 12 to 17, as part of the National Health Interview Study (NHIS) sponsored by the Centers for Disease Control and Prevention. To assess literal homelessness in the previous 12 months, youth were asked whether they had spent one or more nights in specific types of places. These included: a youth or adult shelter; any of several locations not intended to be dwelling places (i.e., in a public place such as a train or bus station or restaurant; in an abandoned building; outside in a park, on the street, under a bridge, or on a rooftop; in a subway or other public place underground); or where their safety would be compromised (i.e., with someone they did not know because they needed a place to stay). Based on these estimates, researchers estimated the annual prevalence of literal homelessness among this age group to be 7.6 percent (or 1.6 million youth in a given year), Even after revising their estimate down, removing youth whose only experience with homelessness was in a "shelter" (a potentially ambiguous term used in the interview), they still estimated that 5 percent had experienced literal homelessness in the previous year (or more than 1 million youth in a given year). The prevalence of homelessness did not vary significantly by family poverty status (determined by parent's reported income), geographic area, or sociodemographic factors other than by gender (i.e., with significantly higher rates of homelessness for males than females).

These estimates suggest that adolescents under age 18 may be at higher risk for homelessness than adults. In 1990, researchers surveyed a nationally representative sample of 1507 adults in households with telephones (Link, Susser, Stueve, Phelan, Moore, & Struening, 1994). To assess literal homelessness, adults were asked if they had ever considered themselves to be homeless. Next they were asked if, while homeless, they had ever slept in a shelter for homeless people or another temporary residence because they did not have a place to stay, or in a park in an abandoned building, in the street, or in a train or bus station. Among those who reported literal homelessness, those who had been homeless within the previous five years were identified. Among US adults, five-year prevalence of self-reported homelessness among those ever literally homeless was estimated at 3.1 percent (or 5.7 million adults in a five-year period) and *lifetime* prevalence was estimated at 7.4 percent (or 13.5 million adults). Other studies report similar lifetime rates (8%; Manrique & Toro, 1994).

Geographic Distribution and Patterns of Homelessness

Based on the national survey of housed youth described above, those with a history of recent homelessness were found throughout the nation and across urban, suburban, and rural areas (Ringwalt et al., 1998). Nevertheless, homeless youth appear to be most concentrated and visible in major cities (as is the case for homeless adults and families). It is hard to determine whether this apparent concentration in urban areas is a function of where researchers are located or a "true" over-representation of homeless youth in urban areas.

[4] For historical perspective, a 1983 report from the US Department of Health and Human Services estimated the prevalence of runaway and homeless youth to be between 733,000 and 1.3 million per year, based on service-provider reports (Russell, 1998). A study by the Justice Department (using telephone surveys of 10,367 households and 127 institutions in 1988 and early 1989) estimated that 500,000 youth under age 18 become runaways or throwaways each year. State and local studies based on data collected in the mid-1980s also suggested that the phenomenon was sizable and geographically widespread (for detail on such estimates, see Chelimsky, 1982; Hemmens & Luecke, 1988; McClure & Dickman, 1988; Russell, 1998; Ryan, Goldstein, & Bartelt, 1989; and Solarz, 1988).

Street Youth. The research literature documents significant numbers of youth actually living "on the streets" (i.e., not in shelters), primarily in certain large metropolitan areas on the east and west coasts. While street youth have been studied in areas such as Los Angeles, San Francisco, Seattle, and New York City, such, youth have rarely been documented in Midwestern and southern communities. While street youth represent an unknown proportion of all homeless youth, this subgroup is of obvious concern and much research has focused on it. As we will document in this review, street youth generally show the most disturbing histories of life disruptions and personal problems. This subgroup also often has longer histories of homelessness and is less likely to use traditional services.

Local Residents. Contrary to popular stereotypes, several older studies show that most homeless youth are in fact "local kids." For example, the majority (72%) of youths served in 17 runaway and homeless youth programs nationally were from the immediate geographical area in which the program was located (van Houten & Golembiewski, 1978). Most New York City shelter clients were born in the city (Citizens' Committee for Children of New York, 1983; New York State Council on Children and Families, 1984). In Albany, New York, the majority were from Albany or other parts of the Capital District (58%); only about one-quarter were from out of state (Council of Community Services, 1984). Service providers in Los Angeles County reported that the majority of their clients are from within the cotmty (67%) or within the state (18%; Rothman & David, 1985). Even in Hollywood, California, where one might expect a more transient population, three-quarters of a sample of street youth had been residents of the surrounding county for more than a year (Robertson, 1989). Although most homeless youth seem to be local residents, many homeless youth (2542%) are not local.

History of Homelessness. History of homelessness seems to vary by whether youth are sampled from shelters or from the streets. Studies of homeless youth obtained from shelters generally find that most homeless youth have been homeless for relatively short periods of time and have not experienced prior homeless episodes. For example, in a probability sample of 118 adolescents (ages 12-17) from all six major youth shelters in the Detroit metropolitan area, two-thirds had never been homeless before, and most (86%) had been homeless for four weeks or less in their current episode (McCaskill, Toro, & Wolfe, 1998). In contrast, in one Hollywood street sample (ages 13 to 17), most youth demonstrated patterns of episodic (i.e., multiple episodes adding up to less than one year; 44%) or chronic homelessness (i.e., being homeless for one year or longer; 39%) (Greenblatt & Robertson, 1993).

Characteristics of Homeless Youth

There is no typical homeless youth, and there is no single cause for youth homelessness. The literature describes youth who experience homelessness and offers varied explanations for why youth become homeless in the first place or why they may remain so. Yet, it is difficult to determine the degree to which any particular characteristic or experience might be a primary cause or a contributing factor to youth homelessness. Below, we review these findings and highlight the diversity of the homeless youth population.

Background Characteristics

Gender and Age. In a national survey of youth (Ringwalt et al., 1998) males were significantly more likely than females to report recent homelessness. In local studies of homeless youth, gender representation seems to vary depending on the source and age of the sample (Robertson, 1996). Samples from shelters suggest either even numbers or more females. In contrast, samples of street youth or older youth tend to include more males.

Based on recent studies, the vast majority of homeless youth appear to be age 13 or older, although several studies have identified small numbers of youth homeless on their own who are as young as nine (Clark & Robertson, 1996; Robertson, 1991).

Race or Ethnicity. A national survey of youth found no differences in rates of recent homelessness by racial or ethnic group (Ringwalt, et al., 1998). While local studies tend to document that homeless youth generally reflect the racial and ethnic make-up of their local areas, three local studies also report over-representation of members of racial or ethnic minorities relative to the local community. For example, African Americans were over represented in a probability sample from shelters throughout metropolitan Detroit, where 46 percent of 118 homeless youth were African-American compared to 22 percent in the area's general population (McCaskill et al., 1998). Both African Americans and Native Americans were reported to be over-represented in a street sample from Seattle (N=229; ages 13-21; Cauce et al., 1994a) and a statewide sample from Minnesota (N=165, ages 11-17; Owen et al., 1998).

Sexual Orientation. The rate of gay or bisexual orientation among homeless youth varies across studies. In several studies with shelter and street samples, 3 to 10 percent of youth have reported their sexual orientation as gay, lesbian or bisexual (Greenblatt & Robertson, 1993; Johnson, Aschkenasy, Herbers, & Gillenwater, 1993; Rotheram-Borus et al., 1992b; Toro et al., 1998; Wolfe et al., 1994). Such rates suggest that homeless youth are no more likely than non-homeless youth to report gay or bisexual orientation when compared to the national rate of about 10 percent (Dempsey, 1994). However, higher rates of gay or bisexual identity (16 to 38%) are reported in another set of studies.[5] The higher rates in these studies (16 to 38%) can be accounted for by samples that came from street or clinical sites; tended to be older; included more men (who generally have higher rates than women for gay or bisexual orientation); or came from areas with significant concentrations of gay or bisexual persons in the larger community.

Family Poverty and Youth Homelessness. Youth who experience literal homelessness seem to come from less impoverished backgrounds than homeless adults. For example, sheltered youth came from significantly better socioeconomic circumstances than the sheltered adults in Detroit,, (Bukowski & Toro, 1996). In a representative national sample of youth (ages 12 to 17), those living with families in poverty *were not* more likely than other youth to have experienced homelessness in the previous year (Ringwalt et al., 1998b). In contrast, among adults in a representative national sample, those with lower socioeconomic status (SES) were *more* likely to experience homelessness in the previous five years (i.e., lower SES was defined by less than high school education; history of public assistance; or current annual income of $20,000 or less) (Link et al., 1994).

Some state and local studies suggest that disproportionate numbers of homeless youth may come from lower-income or working-class families and neighborhoods. For instance, for a broad four-state Midwestern sample of 602 homeless youth, two-thirds of the youths' parents (68%) reported family incomes under $35,000 (ages 12-22, obtained from shelters, street sites, and drop-in centers in urban, rural and suburban areas) (Whitbeck et al., 1997b). In a Detroit shelter, most youth (69%) came from

[5] Among patients of a medical clinic in Los Angeles (ages 10 to 24), 16 percent of runaways reported homosexual or bisexual identity, compared to 8 percent of non-runaways (Yates, et al., 1988). In a study of homeless young men (ages 15 to 20) in a Covenant House medical clinic in New York City, 25 percent reported being homosexual or bisexual (Stricof et al., 1991). Similarly, in inner city Houston, one-quarter of homeless youth (ages 1 l-23) reported their sexual preference as homosexual or bisexual (Busen & Beech, 1997). A rate of 38 percent (43% for young men and 27% for young women) was reported for a Hollywood street sample that included youth who had been on the streets for two or more consecutive months as well as non-homeless youth who were integrated into the "street economy" (72% of the sample was homeless; overall age ranged from 12 to 23; Kipke et al., 199.5). Using similar sampling methods in Hollywood, this same research team found a 20 percent rate (Albomoz, Montgomery, & Kipke, 1998; the age range was, again, 12 to 23).

families in which the parents held unskilled or blue-collar jobs (McCaskill et al., 1998). Most youth also (80%) came from neighborhoods where the median family income was under $40,000 (which was the approximate 1990 median family income for the total Detroit metropolitan area). A more recent study in Detroit, with a broader probability sample of 176 homeless youth (ages 13-17), obtained similar findings (Toro et al., 1998).[6]

The profile of homeless youth observed in the literature is highly dependent on the source of the sample (as observed for homeless adults by Link and colleagues, 1994). Findings suggest that while family poverty may not be related to homelessness among youth per se (given findings from the national household survey), family poverty may be related to more chronic or repeated homelessness (given recent local cross-sectional studies). Household surveys of *formerly* homeless youth may be more useful for setting lower-bound estimates of the extent of homelessness among youth within a given period of time. Such household surveys also likely present a more complete picture of the larger homeless youth population and of factors that put a youth at risk for homelessness. However, because of their method, they under-represent youth with longer histories of homelessness or institutional stays. On the other hand, the profile of ***currently*** homeless youth from studies with cross-sectional samples is a "snap-shot" of homeless youth on a given day, a population which likely over-represents youth with more chronic histories of homelessness. Since they represent the potential service population, such cross-sectional profiles may be more useful for assessing needs and service planning.

Family Conflict and Abuse. Youth consistently report family conflict as the primary reason for their homelessness. Sources of conflict vary but include conflicts with parents over a youth's relationship with a step-parent, sexual activity and sexual orientation, pregnancy, school problems, and alcohol and drug use (Owen et al., 1998; Robertson, 1996; Toro, Goldstein, & Rowland, 1998; Whitbeck, Hoyt, Tyler, Ackley, & Fields, 1997b).

Neglect and physical or sexual abuse in the home are also common experiences. Across studies of homeless youth, rates of sexual abuse range from 17 to 35 percent, and physical abuse ranges from 40 to 60 percent (Busen & Beech, 1997; Robertson, 1989; Rothman & David, 1985). For example, most (75%) of 122 sheltered homeless youth (ages 12-17) in Detroit reported some form of maltreatment (Boesky, Toro, & Wright, 1995). Neglect was most common (57%), though many also reported physical (40%) and sexual abuse (31%). Many experienced multiple forms of maltreatment as well (e.g., 16% reported all three). When compared to housed peers, these homeless youth reported more maltreatment and received higher scores on the standardized measures of family conflict (Wolfe, Toro, & McCaskill, 1999). Homeless youth reported that their parents were more physically and verbally aggressive toward them, and that they were more verbally aggressive toward their parents. While violence from these youth may very well have been in response to the parent's initial violence, violence in these families seemed to occur in a context where both the youth and their parents may be engaging in violent or provocative behavior and where escalation is a dangerous prospect.

There is evidence that neglect and abuse may actually precipitate separations of many youth from their homes. In a Hollywood street sample (ages 13-17), many youth specifically reported leaving their homes in the past because of physical abuse (37%) or sexual abuse (11%). One-fifth of the sample (20%) had at some earlier point been removed from their homes by the authorities because of neglect or abuse (Robertson, 1989). Similarly, a study of 356 street youth (ages 13-21) in Seattle found that 18 percent had been removed from their homes (MacLean et al., 1999).

[6] As demonstrated here, the profile of homeless youth depends very much on the source of the sample. The national household survey of formerly homeless youth reveals a different profile than studies of currently homeless youth (Ringwalt, et al., 1998), as has been observed for homeless adults (Link, et al., 1994).

Families of Origin. Many homeless youth report disrupted family histories, which may contribute to the risk for homelessness. In a Hollywood street sample (ages 13-17), many homeless youth never knew their father (16%) or their mother (9%). Among the parents who were known, almost three-quarters had been either divorced or never married (Greenblatt & Robertson, 1993). In a probability sample of 122 sheltered homeless youth from Detroit (ages 12-17), most grew up in single-parent (34%) or "blended" (32%) families, many (22%) had been formally placed outside the home by officials, and about half (48%) had lived with relatives (not parents) for a substantial amount of time (Reed, 1994).

Residential Instability. For many youth, homelessness appears to be part of a long pattern of residential instability (Robertson, 1996). Consistently, homeless youth report repeated moves during their lifetimes. For example, three quarters (73%) of a probability sample of 176 homeless youth in Detroit and surrounding counties had experienced at least one move during the prior 12 months, and 55 percent had move twice in this time period (ages 13-17; sampled from shelter, juvenile justice, and mental health agencies) (Toro, 1998).

Many studies report that many homeless youth have repeated contacts with public social service systems, many of which occurred at very early ages. Across several studies, rates of foster care placements have ranged from 21 percent to 53 percent (Cauce, Paradise, Embry, Morgan, Lohr, Theofelis et al., 1997; Owen et al., 1998; Robertson, 1989, 1991; Toro et al., 1998). Many homeless youth also report stays in psychiatric facilities and criminal justice facilities. For example, one-quarter of a Hollywood street sample (24%) reported previous psychiatric hospitalizations (Robertson, 1989). Majorities in two street youth samples in San Francisco and Hollywood reported stays in juvenile detention facilities, and most had multiple detentions (Clark & Robertson, 1996; Robertson, 1989).

Similarly, many adolescents in public systems have histories of homelessness or residential instability. Adolescent psychiatric inpatients in Los Angeles were found to have histories of high residential instability, with an average of 3 runaway episodes; most (70%) also had a history of placement into foster care or with an alternative caregiver (Mundy, Robertson, Robertson, & Greenblatt, 1989). In Albany County, New York, between 33 percent and 40 percent of jail inmates (ages 16 to 20), were homeless (Council of Community Services, 1984).

Evidence from two studies suggests that youth in residential placements or in institutional settings risk becoming homeless upon separation from those settings. In studies of street youth in Hollywood and San Francisco, more than one-quarter of those who had been in foster care, group homes, or juvenile detention became homeless upon their most recent separation. These youth reported that they had spent their first night after leaving the respective sites either in a shelter or on the streets (Clark & Robertson, 1996; Robertson, 1989). (However, it is unclear whether these moves into homelessness were the result of "running away" from the institutional placement or running away from the discharge site after leaving the placement.)

Some providers suggest that youth who are returned inappropriately to their prior homes due to lack of more appropriate alternative long-term placements may also be at risk. A 1985 Boston report suggested that the lack of available out-of-home resources (e.g., foster and group homes) is often more influential in service planning than the needs of the adolescents and their families. Half of the cases of first-time, out-of-home placements in one setting were returned home despite the assessment of the emergency shelter staff that this was an inappropriate placement decision (Greater Boston Emergency Network, 1985).

Additionally, some youth "age out" of the foster-care system with limited alternatives in place. One recent follow-up of such youth found that, in the 12 months after "aging out," a full 12 percent of the youth had spent at least some time homeless (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 1998).

According to an older survey of providers, less than half (47%) of youth in Los Angeles shelters were considered to have a realistic prospect of returning to their homes (Rothman & David, 1985). Only 19 percent were good candidates for immediate family reunification; and 25 percent were chronic runaways who were very unlikely to be returned home or to placement. In contrast to these findings, the majority of youth in federally funded shelters nationally (57%) were reunited with families or placed in a safe living environment (National Network of Runaway and Youth Services Inc., 1985).

School and Learning Difficulties. Consistently, studies suggest that many homeless youth have had interrupted or difficult school histories, and many are currently not attending school. In several studies, 25 to 35 percent of youth report being held back a year in school (Clark & Robertson, 1996; Robertson, 1989; Upshur, 1986; Young, Godfrey, Matthew, & Adams, 1983). In two studies of street youth, about one-quarter report participation in special or remedial classes (Clark & Robertson, 1996; Robertson, 1989). In a Detroit sample of 176 homeless youth, 85 percent had at some point been suspended from school, 26 percent had been expelled, and 15 percent had dropped out of school (Toro et al., 1998). One study found a high rate (28%) of attention deficit disorder (Cauce et al., 1997). While a history of school problems is prominent in the literature, its contribution to homelessness is unclear. School problems are often hypothesized to be a precipitant of family conflict that results in a runaway response. Others suggest that school difficulties are merely symptoms of more pervasive family problems.

Emotional and Mental Problems

Mental Disorders. As for homeless adults, the assessment of mental health status among homeless adolescents poses a number of problems (Robertson, 1992; Toro, 1998). It is difficult to determine whether a homeless youth's emotional disturbance at a given point in time is more causally associated with an underlying emotional or mental disorder, the exigencies of homelessness; chronic stresses such as family violence or parental substance abuse; the youth's own use of alcohol or other drugs; or combinations of these (Robertson, 1996).

In any event, several studies have documented high rates of emotional and mental health problems among homeless youth. Rates of serious disorders assessed with standardized instruments with diagnostic criteria range from 19 to 50 percent. For example, half of a sample of 150 youth from a New York City shelter (50%) had at least one major affective disorder as assessed by the DISC (Feitel et al., 1992). Among street youth in Hollywood (ages 13-17), 26 percent met DSM-III criteria for major depression compared to 4-9 percent of community and school samples of adolescents (Russell, 1996). In addition, many youth reported serious psychotic symptoms (Mundy, Robertson, Greenblatt, & Robertson, 1989). In another street sample (ages 13-21), 45 percent of the youth received at least one DSM-III-R diagnosis for a mental disorder (Cauce et al., 1997). These disorders included depression (19%), dysthymia (14%), mania (13%), hypomania (9%), and psychosis (9%). In two different probability samples from throughout metropolitan Detroit (one from shelters only, N=122; the other from a variety of sites, including shelters, juvenile justice facilities, and mental health centers, N=180), similar rates for these same mental disorders were obtained (McCaskill et al., 1998; Toro et al., 1998).

It should be noted that in a rare study that included a carefully-matched comparison group of housed youth, McCaskill and colleagues found that the rates for many mental disorders were not significantly different, although homeless youth did have significantly higher rates of disruptive behavior disorders

and alcohol abuse or dependence. Such findings highlight the need for appropriate comparison groups when attempting to identify distinctive characteristics of homeless youth.

As in the adult homeless population, the co-occurrence of substance abuse disorders and serious mental health problems has also been documented in several studies (Robertson, 1989; Rotheram-Borus, 1993; Russell, 1998; Shaffer & Caton, 1984; Upshur, 1986; Yates, MacKenzie, Pennbridge, & Cohen, 1988).

In San Francisco, two-thirds of a street sample met DSM-III-R diagnostic criteria for post-traumatic stress disorder (PTSD) (Clark & Robertson, 1996). Almost half of the sample (46%) had experienced PTSD symptoms related to their disorders within the previous two weeks. Most frequently reported traumatic events included seeing another person hurt or killed or being physically or sexually assaulted themselves.

Suicide Attempts. Studies of homeless youth consistently report suicide attempt rates that are higher than rates for normative groups. In a study of homeless youth in New York City shelters, more than one-third (37%) had ever attempted suicide, and one-third of these had made repeated attempts (Rotheram-Borus, 1993). Many in the sample (16%) reported suicide attempts in the previous month. Nearly one-quarter (24%) of runaways in New York City shelters (Shaffer and Caton, 1984) and 18 percent of runaways using an outpatient health clinic in Los Angeles (Yates et al., 1988) reported suicide attempts. About half (48%) of a Hollywood street sample (age 13-17) had attempted suicide, and more than half of these had repeated attempts. More than one-quarter of the sample (27%) had attempted suicide during the previous 12 months (Robertson, 1989). Other studies have reported equally high rates (Ackley & Hoyt, 1997; Feitel et al., 1992; Powers, Eckenrode, & Jaklitsch, 1990). All reported rates of suicide attempts for homeless youth are higher than the lifetime rate for adults reported in the LA ECA project which was 4 percent (Russell, 1998).

Conduct Problems. A wide range of conduct problems are reported for homeless youth. Though it appears that many such problems are of long duration, some may develop or become exacerbated by experiences while homeless. In three studies of homeless youth, rates of conduct disorder ranged from 48 percent to 93 percent (Cauce et al., 1997; Feitel, Margetson, Chama, & Lipman, 1992; Robertson, 1989) using the Diagnostic Interview Schedule for Children (DISC) (Fisher, Wicks, Shaffer, Piacentini, & Lapkin, 1992). It is important to note that current diagnostic criteria, in fact, consider the experience of running away or being homeless, itself, as a key sign of conduct disorder. However, even excluding such criteria, the rate of conduct disorder among homeless youth is high. For instance, in a study of sheltered youth (ages 12-17) that used the DISC but excluded such criteria, the rate of disruptive behavior disorders (primarily conduct disorder) was still high (39%) and significantly greater than that in a matched housed sample (20%) (McCaskill et al., 1998).

Research suggests that homeless youth may have associations with deviant peers, some of whom may themselves be homeless. Gang activity appears common among homeless youth. Across several studies on homeless youth, a history of gang participation has ranged from 14 percent to 53 percent (Kipke, O'Conner, Palmer, & MacKenzie, 1995; Robertson, 1989; Toro et al., 1998; Whitbeck et al., 1997a).

Substance Use and Abuse

Youth Substance Use. Though it is not possible to determine from existing research the extent to which alcohol or other drug use may contribute to youth homelessness, many youth report substance use themselves and by their parents. Based on DSM-III criteria, most youth in a Hollywood street sample (ages 13-17) met diagnostic criteria for substance use disorders [i.e., alcohol disorders (48%), other drug disorders (39%), or both (26%)] (Robertson, 1989; Robertson, Koegel, & Ferguson, 1989; Russell, 1998). About one-quarter (26%) reported a history of injection drug use (IDU). The majority used illicit drugs before they experienced homelessness the first time (74.7%), and several reported that their own drug use had contributed to their leaving home (17.7%).

In a study of clients of a Hollywood outpatient clinic (ages 12-24), recent alcohol and other drug use was significantly higher among homeless compared to non-homeless youth using the same clinic (48% vs. 19%, respectively). Many reported IDU (8% compared to 0.1% of non-homeless clients) (Kipke, Montgomery, & MacKenzie, 1993). About half of youth in New York City shelters (ages 11-19) reported physical symptoms of substance abuse, and 17 percent reported addiction symptoms (Koopman, Rosario, and Rotheram-Borus, 1994). In a probability sample of sheltered homeless youth, 21 percent met DSM-III-R criteria for alcohol abuse or dependence and 24 percent for drug abuse or dependence (McCaskill et al., 1998).

Rates of substance use seem to vary dramatically by history of homelessness. In three large national samples, street youth showed the highest rates of substance use followed by sheltered youth and runaways and finally housed youth (Greene, Ennett, & Ringwalt, 1997). Comparing youth who reported having run away once, two or more times, or never, Windle (1989) found a similar pattern, with those having multiple homeless episodes showing the highest rates of substance use or abuse.

As with the general population, rates of substance use and abuse increase with age. Among homeless clients of a community-based clinic in Hollywood, older youth were significantly more likely to report use of alcohol, stimulants, narcotics, and injection drug use (Kipke, 1995). Among a probability sample of 122 youth in shelters in metropolitan Detroit (ages 12-17), older youth had significantly higher rates of DSM-III-R diagnoses of drug abuse or dependence (Boesky et al., 1997). However, rates for the youth overall were significantly lower than homeless adults from shelters in the same city (Bukowski & Toro, 1996).

Parental Substance Use. One study suggests that parental alcohol use may contribute to youth homelessness. In a Hollywood street sample, 24 percent of the youth (ages 13-17) reported that they had "run away or left home" at least once because their parent or step-parent had an alcohol problem which caused frequent arguments or physical violence (Robertson, 1989). Other studies suggest high substance use by parent. For example, a study of intake records for over 44,000 youth in federally-supported shelters reported that drug abuse by the parent figure was the principal problem of 16 percent to 18 percent of youth (U.S. Government Accounting Office, 1989). For youth in 17 shelters across the nation, parental alcohol abuse was correlated significantly with runaway behavior (van Houten & Golembiewski, 1978). Miller, Hoffman, and Duggan (1980) found that 41 percent of runaways reported that one or both of their parents had a problem with alcohol and 17 percent reported that one or both parents had a serious drug problem. Toro et al. (1998) found that 44 percent of homeless youth reported that one or both of their parents had at some point received treatment for alcohol, drug, or psychological problems.

Health Status. Like homeless adults, homeless youth appear to be at greater risk than their domiciled counterparts for a variety of medical problems, and their health often deteriorates while homeless. Youth

on the streets in particular often sleep too little, and when they do, it is often in an unsafe, unclean, or overcrowded environment (Clark & Robertson, 1996). They may have little money and eat poorly. They may have little opportunity to maintain adequate personal hygiene and are hard put to find the time or place to recuperate adequately from illness or injury. They suffer disproportionately from traumatic injury, skin infestations, infectious diseases, nutritional disorders, and other conditions (Kennedy et al., 1990; Yates et al., 1988). Because of the patient mix and the concentration of health problems that are less common in conventional medical practices, a specialization of sorts in "street medicine" has developed among health professionals who treat homeless youth, (Kennedy et al., 1990).

Sexual Behavior. The literature reveals high rates of sexual activity among homeless youth, but variable rates of protection against pregnancy or sexually transmitted diseases. Studies consistently report that the majority of youth (i.e., from 62% to 93%) are sexually active (i.e., had sex at least once). For example, in New York City shelters, most males (93%; ages 12 to 17) were sexually active (Rotheram-Borus, Meyer-Bahlburg, Koopman, Rosario, Exner, Henderson et al., 1992a; 1992b). Similarly, 92 percent a Hollywood street sample (ages 13 to 17) were sexually active. While most of these (82%) reported using birth control the last time they had sex, only about half reported condom use (Robertson, 1989). In another study of Hollywood street youth (ages 12-23), most (70%) reported recent (30 day) sexual activity (Kipke et al., 1995). In a sample of 602 homeless youth from 4 Midwestern states, Whitbeck et al. (1997b) found that most youth had intercourse prior to age 16 (70% of the males and 85% of the females, ages 12 to 22). Among those reporting intercourse in the past year, only one-third (36%) reported always using condoms. In Detroit, Wolfe, Levit, and Toro (1994) found that 71 percent of homeless youth (age 12 to 17) in shelters had ever had intercourse and 43 percent reported being currently sexually active. In another Detroit study, Toro et al. (1998) found that 62 percent of 176 homeless youth (age 13 to 17) reported ever having had vaginal, anal, or oral sex. Both studies also found that, compared to matched housed youth, the homeless youth were significantly more sexually active.

Pregnancy. In four local studies, the lifetime rate of pregnancy for homeless girls has ranged from 27 to 44 percent, and 6 to 22 percent have reported having given birth (Cauce, Morgan, Wagner, Moore, Sy, Wurzbacher et al., 1994a; Owen et al., 1998; Robertson, 1989; Toro et al., 1998; Whitbeck et al., 1997b). Studies have identified as many as 10 to 20 percent of homeless young women who are currently pregnant (e.g., Toro et al., 1998; Robertson, 1996). Young women who are pregnant while homeless are at risk for low-birthweight babies and high infant-mortality because they are unlikely to get prenatal care and may not have adequate health and dietary habits (Kennedy et al., 1990; Sullivan & Damrosch, 1987).

Risk for HIV and AIDS. Homeless youth present a high-risk profile for human immunodeficiency virus (HIV) infection. Specific high-risk sexual and drug use behaviors including multiple sex partners, high-risk sexual partners, survival sex, minimal condom use, injection drug use, sharing needles, and having sex while high (Allen, Lehman, Green, Lindergren, Onorato, Forrester, Field Services Branch, 1994; Kipke et al., 1995; Greenblatt & Robertson, 1993; Rosenthal, Moore, & Buswell, 1994; Rotheram-Borus, 1991, 1992a, 1992b; Toro et al., 1998). Risk behaviors for HIV exposure are more common among youth who are older, homeless longer, and not staying in shelters. Despite knowledge about transmission modes, many homeless youth do not use protection against exposure.

Recent seroprevalence studies in clinical samples suggest that HIV is already a widespread health problem among homeless youth and young adults in some areas. In one study of HIV rates in clinical samples of homeless youth ages 15 to 24, the rate of HIV-positives across four cities was 2 percent. Rates were higher among youth over age 19, and they varied dramatically by site. These included Dallas (O%), Houston (1%), New York City (4%), and two sites in San Francisco (2% and 7%) (Allen et al.,

1994). Similarly, in a medical clinic in Covenant House in New York City, 6 percent of "street kids" overall tested HIV-positive (6% of young men and 5% of young women; Kennedy et al., 1990). Covenant House health clinics also produced elevated rates in New Orleans (3%), Fort Lauderdale (3%) and Houston (2%). Because these communities have higher rates of HIV infection generally, the high rates of HIV in New York or San Francisco may not generalize to other areas. Yet the risk of exposure poses a real threat to homeless youth across geographic areas who report high-risk behaviors.

Survival While Homeless

Shelter, Food, and Other Basics Needs

Many youth have difficulty meeting basic needs. For example, in a San Francisco street sample (ages 15 to 19), most youth reported that they had spent the previous 30 nights outside, in abandoned buildings (or "squats"), traveling, and in public places such as doorways, allies, parks, beaches, and under bridges. Very few had stayed even one night in a shelter (15%). Several reported institutional stays including one young woman who had been in a hospital for childbirth. One youth reported spending three nights in a dumpster (Clark & Robertson, 1996). In this same study, youth who slept in public spaces often formed groups in which individuals took turns staying awake to keep guard. A few reported committing offenses that resulted in arrest in order to secure "shelter" for the night (Clark & Robertson, 1996). Providers occasionally report that minors sometimes misrepresent their age to gain access to adult shelters.

In a study of Hollywood street youth (ages 13-17), most (79%) identified "improvised shelter" as their usual sleeping place. This included abandoned buildings, vehicles, parks and beaches, loading docks, rooftops, and crawl spaces under houses. Relatively few in the sample had used shelters recently (15%) due largely to the scarcity of shelter beds in the area (i.e., at the time, 50 youth shelter beds throughout Los Angeles County) (Robertson, 1989; Greenblatt & Robertson, 1993). Shelters or meal programs were the most usual sources of food. Yet about half of the youth (48%) reported difficulty getting adequate food, and the majority (57%) had spent at least one day in the past month with nothing to eat. Many also reported difficulty finding a place to clean up, to obtain medical care, or to find clothing (Greenblatt & Robertson, 1993; Robertson, 1989). Youth reported little if any income, most of which came from legal sources such as odd jobs or family gifts. However, income from illegal activities was also common including sex work and drug dealing (Robertson, 1989).

Anecdotal reports from staff and youth suggest that staff at shelters and other sites sometimes exclude youth with severe emotional problems, those dangerous to themselves or others, those with alcohol or drug problems, or those with HIV infection.

Resorting to Illegal Activities

Many homeless adolescents report illegal behavior. However, some of this behavior may be part of their strategies for survival. Some illegal behaviors may provide for basic needs directly (for example, breaking into an abandoned building for a place to stay or trading sex for food or shelter) while others may generate income to meet basic needs (for example, selling drugs or sex). In a 4-state Midwestern sample of 602 homeless youth, 23 percent reported stealing, 14 percent forced entry to a residence, 20 percent dealt drugs, and 2 percent engaged in prostitution (Whitbeck et al., 1997b). In an unusual sample of 409 Los Angeles street youth (ages 12-23), which included many who were not literally homeless but who were "integrated" into the street economy, 43 percent of the sample (46% of young men and 32% of young women) reported ever engaging in survival sex, which included trading sex for food, a place to

stay, drugs, or money (Kipke et al., 1995). Of these, 82 percent traded sex for money, 48 percent for food or a place to stay, and 22 percent for drugs. Almost one-quarter of the sample (22%) reported survival sex in the previous 30 days. Similarly, among clients of a Hollywood health clinic, 26 percent of runaway clients reported involvement in "survival sex" compared to only 0.2 percent among non-runaway clients (Yates et al., 1988). Similarly, about one-third of a Hollywood street sample (ages 13-17) reported ever trading sex for money, food, or shelter. Most of these (75%) reported doing so only when homeless. Sex also had been traded for drugs by 11 percent of the sample. About half of the sample had ever sold drugs (52%), although many reported doing so only when homeless (21%). Although generating cash income was the principal motive for drug sales, one-fifth of the sample also sold drugs to support their own drug use.

Victimization

Studies have reported high rates of victimization among homeless youth. Runaway clients of an outpatient clinic in Hollywood sought treatment for trauma (4%) and rape (2%) at rates which were two and one-half and three times higher than non-runaway clients (Yates et al., 1988). The majority of a Hollywood street sample had been victimized in the past twelve months, including high rates of physical assault (42%) and sexual assault (13%; Greenblatt & Robertson, 1993). In their 4-state Midwestern sample, Whitbeck et al. (1997b) documented a wide range of types of victimization. While homeless, 18 percent of the boys and 12 percent of the girls had been beaten up more than once, 11 percent and 7 percent had been robbed more than once, and 11 percent and 4 percent had been assaulted with a weapon more than once. These researchers have also found evidence for a "risk-amplification" model for understanding adolescent homelessness (see Ackley & Hoyt, 1997; Whitbeck, Hoyt, & Ackley, 1997a; Whitbeck & Simons, 1990). This model proposes that a variety of background characteristics, including maltreatment, poverty, parental psychopathology, and negative parenting, all put homeless youth at risk for poor outcomes. Homelessness also puts the youth in a context conducive to further negative outcomes (e.g., through experiences on the street and with deviant peers), which amplifies the impact of the background characteristics. In some recent and disturbing findings based on a 5-month follow-up of 354 street youth from Seattle, Hoyt and Ryan (1997) found that those with a prior history of victimization were the most likely to be victimized during the follow-up period.

Long-Term Outcomes

Will These Youth Become Homeless Adults?

Since the mid-1970s, scholars and service providers have expressed concern that homeless youth would become a new generation of homeless adults (Blumberg, Shipley, & Barsky, 1978; Miller, 1991). There is no longitudinal evidence that homeless youth are, in fact, at heightened risk for homelessness later in adulthood (although a few ongoing studies are investigating this; Cauce et al., 1994b; Toro et al., 1998). Nevertheless, recent evidence does indicate that 9 percent to 26 percent of homeless adults were first homeless as children or youth (Susser, Streuning, & Conover, 1987; McChesney, 1987; Zlotnick et al., in press). These rates are higher for homeless adults than adults in the general population among whom about 7 percent have *ever* experienced homelessness (Link et al., 1994; Manrique & Toro, 1995).

Other Long-term Outcomes

In a 30-year follow-up of clients from a child guidance clinic, Robins and O'Neal (1959) found that runaways had higher rates of mental disorder, divorce, and arrest than non-runaways. Olson et al. (1980) obtained similar results in a 12-year follow-up of 96 runaways from the Washington, DC area. Those

who had run away more than once, as compared to their siblings or those who ran away only once, had poorer work histories, more involvement with the justice system, and were more likely to be single. More recently, Windle (1989) used the National Longitudinal Survey of Youth to compare 14-15 year olds who had never run away (n=1,139) to those who had run away once (n=61) or more times (n=41). After four years, he found that the repeat runaways reported more alcohol and drug use and abuse, more delinquent behaviors, lower self-esteem, and a higher rate of dropping out of school, while the one-time runaways fell about midway between the never and repeat runaways on most of these domains.

Intervention Strategies

Strategies are needed to reduce the amount of harm a youth encounters while homeless. In the short term, emergency and transitional services are needed for those who are currently homeless. Providers suggest that the younger youth and those in their first episode of homelessness are more likely to reconcile with families if the homeless episode is responded to with early intervention.

For the longer term, however, strategies are also needed to reduce the number of youth who become homeless. Homelessness itself presents physical and mental health risks to the youth. It may also represent an interruption of normative socialization and education, which will likely affect the ability to live independently in the future.

Providing Needed Services to Homeless Youth

There is little comprehensive information on model programs serving youth or young adults who are homeless or at risk of homelessness.

Comprehensive and Tailored Services

Homeless youth and young adults face many barriers to services in the larger community (Clark and Robertson, 1996). Most are survivors of difficult situations, and many are skeptical and distrustful toward adults. Many street youth in particular have become accustomed to taking care of themselves and some seem unwilling to come into service sites or eventually return to a family or foster home in which they could lose a great deal of control over their everyday lives. Many homeless youth have serious emotional or mental problems. In addition, interventions may have to take place in the context the youth's substance use and behavior problems. While many youth report only occasional drug or alcohol use, others cycle in and out of more hard core drug use, complicating any intervention effort (Clark & Robertson, 1996). In many cases providers first may want to help homeless youth meet their immediate needs. Basic services can then provide a gateway to other needed services.

Providers have suggested that since homeless youth have diverse needs which cross agency jurisdictions, they require a comprehensive service array (New York State Council, 1984). Homeless youth need many services, including housing, education, vocational training, health care, mental health care, substance abuse services, and legal assistance. Coordination among providers is needed to strengthen their ability to serve the population. Interagency cooperation could be augmented by linkages with community non-profit agencies serving youth. Bringing together stakeholders from all parts of the youth-care community can help build the needed continuum of care for homeless youth by consolidating resources and to forging service alliances (Mangano, 1999).

Based on similar interventions designed for persons with mental disorders (Morse, Calsyn, Allen, Tempelhoff, & Smith, 1992; Toro, Passero Rabideau, Bellavia, Baeschler, Wall et al., 1997), Cauce and colleagues (1993, 1994a, 1997) have developed a comprehensive approach to case management for street youth ages 13-21. The approach involves many components including careful assessment and treatment planning, linkage to a full range of needed community services, crisis counseling, flexible use of funds to support youth, small caseloads (no more than 12 cases per counselor), and open-ended service provision. Preliminary findings have suggested some modest positive gains over a 3-month follow-up period for the program youth in comparison to other street youth randomly assigned to "regular case management" (Cauce et al., 1994a).

Special Populations with Special Needs

There are many different groups among homeless youth with special needs. These include gay and bisexual youth; non-English speakers; those who have been homeless longer; those involved in sex work; pregnant teens; and youth with serious medical, emotional, behavioral, or substance use problems. Staff of shelters, drop-in centers, medical clinics and other programs might better be trained to deal with the particular circumstances, experiences, and special needs of such groups (Rotheram-Borus, 1991b; 1993). Young adults (e.g., ages 18 to 24) are another special group that often falls through the cracks between public systems of care because they are ineligible for treatment in children's service systems at the same time that the their developmental needs may not be met by adult service systems.

Shelters as Interventions Sites

Besides providing a safe place to spend the night, youth shelters have often served as sites from which to mount special programs and therapeutic interventions (Rotheram-Borus, 1991b). However, some homeless youth and young adults never use shelters or use them only intermittently (Kipke et al., 1995; Robertson, 1996). Shelters sometimes exclude youth most in need of intervention because they lack adequate staff or appropriate facilities to deal with youth who have special needs. According to anecdotal reports, youth most likely to be excluded from shelters are those who pose a threat to institutional routine or safety (i.e., those who are actively psychotic, suicidal, or intoxicated; or those with HIV or other infectious diseases). At times, appropriate or accessible shelter beds for youth are not available. In addition, many youth may choose not to use shelters because there are too many demands on their behavior or the programs are too structured (Chelimsky, 1982; Clark & Robertson, 1996; Rotheram-Borus, 1991b; Rothman & David, 1985). To reach such youth, services can be provided in sites other than shelters. Educational and treatment interventions have been located successfully within low-demand community sites such as drop-in centers as well as through outreach programs to youth on the streets.

Treatment Services

A number of studies have documented high need for treatment but low utilization of formal treatment programs for medical, mental, and substance use services (Farrow, Deisher, Brown, Kulig, & Kipke, 1992; Kennedy, 1991; Johnson, Aschkenasy, Herbers, & Gillenwater, 1993; Morey & Friedman, 1993; Robertson, Koegel, & Ferguson, 1989). In most states, minors may consent to some types of health care including treatment for alcohol, drug or mental health problems, true emergencies, or treatment for sexually transmitted diseases (Kennedy et al., 1990). Even so, few homeless youth have adequate contact with the health care system, which may result in delayed treatment for acute and chronic health problems.

Providers have identified specific barriers to treatment in formal settings. These include the youth's mistrust of health professionals, the lack of social skills to cooperate in their own care, failure to keep appointments for follow-up care, failure to follow-through in treatment once immediate distress has been relieved, and problems in transferring care when a youth gets moved to a different neighborhood (Kennedy et al., 1990). Aggressive screening of homeless youth can identify such health problems as a first step in providing proper treatment and health care. In designing treatment services, many of which have been developed for adults, it will be important to adapt the services to the specific needs of homeless youth and young adults.

Researchers have recommend that homeless youth and young adults be targeted for health education and prevention programs, given their high risk for exposure to and transmission of HIV, other STDs, and other infectious diseases (Rotheram-Borus, 1991a). Studies suggest that accessible HIV-testing services will be used by homeless youth (Greenblatt & Robertson, 1993). Because of high rates of prior suicide attempts, current ideation, plans for suicide, and depression, staff working with homeless youth should receive training in assessing suicidality (Rotheram-Borus, 1993).

Education and Job Training Opportunities

Once homeless on their own, homeless youth face extraordinary economic problems. Homeless youth and young adults often need to become part of the work force. Unfortunately, most are ill prepared for work, requiring extensive job training and placement services. Vocational and occupational programs are a fundamental part of the transition from the streets to mainstream society. Providers recommend programs that enable these young people to complete high school, college, or some alternative education, and to develop marketable skills (Morey & Friedman,1993; National Network of Runaway and Youth Services, Inc., 1985).

Interventions to Prevent Homelessness

Though there has been considerable discussion in the literature on services for youth who are already homeless, little attention has been given to how we might prevent homelessness in the first place. Below, we consider two basic approaches to accomplishing prevention of homelessness among youth.

Preventing Repeated Homelessness. For youth and young adults who have already experienced homelessness, an obvious goal of services should be to prevent any future homeless episodes. Such interventions could target youth early in their "homeless careers" (e.g., youth with a single short experience with homelessness or little or no time spent on the streets). Toro and Bukowski (1995) have recently advocated for an expanded service delivery model for youth shelters. This model would supplement the crisis intervention approach common in most youth shelters to provide a variety of long-term services for youth and their families. Many have recognized this need and have proposed intensive case management programs (e.g., Cauce et al., 1993), "full-service" shelters (e.g., Rotheram-Borus, 1991), transitional living programs for those who cannot be reunited with their families (MacAllum et al., 1997), and other ongoing services for youth after their brief stays in a shelter. Service providers often would like to offer such expanded services, but have limited resources to do so (Sedlak, Schultz, Wiener, & Cohen, 1997). Since most homeless youth eventually return to their families, providers might consider active outreach to all family members in addition to the youth themselves to help the families cope and remain intact.

Primary Prevention. Primary preventive interventions would attempt to prevent homelessness and other harmful outcomes among adolescents in the general population. Such interventions are generally consistent with a youth development approach to improving the lives of youth (Family & Youth Services Bureau, 1996) and have proven effective in dealing with a wide range of problems in children and youth (Durlak & Wells, 1997; Price, Cowen, Lorion, & Ramos-McKay, 1988). In the case of homelessness, interventions could identify youth at risk for residential instability and homelessness or could be targeted even more broadly. Based on research findings, there appear to be a number of risk factors for both youth and adult homelessness. These include socioeconomic status, problematic family environments (including family violence and substance abuse), and a history of conduct problems and delinquency. Implementation of family-based preventive interventions would be one useful approach. School-based interventions might also be effective at preventing homelessness and other harmful outcomes. Peer groups have been utilized in a number of existing effective prevention programs (e.g., Pedro-Carroll, Cowen, Hightower, & Guare, 1986) and could be useful in programs to prevent homelessness. Child-protective services in many localities, with often-limited resources, frequently seem to focus primarily on the removal of youth from abusive homes and the prosecution of abusive parents. Intervening with families earlier might help prevent homelessness for many youth.

Recent longitudinal findings of Courtney et al. (1998) and others suggest that youth with histories of residential instability, foster care, and other out-of-home placements are at heightened risk for homelessness during both adolescence and in early adulthood. Such groups could be targeted for intervention. For youth in public institutions including foster care, juvenile detention, and psychiatric institutions, more careful and effective discharge planning may be helpful in preventing subsequent homelessness. However, more knowledge is needed about what specific elements might constitute. Furthermore, it is critical that youth be tracked for a substantial period of time following discharge, since homeless episodes may not be immediate but can occur months after the discharge.

Another way to prevent homelessness is to create more alternative residential settings for youth. Policies could continue to encourage foster placement with extended family members who would take in youth who have already (or who are about to) separate from their family of origin. Some homeless youth already make use of extended family members as an occasional housing resource, suggesting their desirability as a placement. This strategy may increase the ability or motivation of extended family members to house the youth.

For foster youth, independent living skills programs could be upgraded for youth in foster care preparing for independent living (e.g., those "aging out" of the foster care system at age 18). The age of eligibility for foster care or other placements could be extended to age 21 or later. Another strategy would be to extend support services one to two years beyond the exit from foster care. A striking number of homeless youth become homeless upon separation from foster or group home placements. We suggest that special training for foster parents dealing with high-risk youth, especially those who have already been homeless, might help extend periods of residential stability.

Policy Issues

Residential Options. As is true for homeless adults, long-term housing with independent-living services is needed. Transitional services also are needed. Most services for youth and young adults are emergency or short-term, with care limited to crisis periods. Youth who lack basic skills such as money management, education, and vocational training need intensive support to achieve independent living. A recent national evaluation of the Transitional Living Program (TLP) for Homeless Youth (based on a

quasi-experimental design implemented in 10 sites with 175 homeless youth, most ages 18 to 21), found some positive program effects over a 6-month follow-up period (MacAllum, Kerttula, & Quinn, 1997).

Youth Advocacy and Legal Issues. Greater monitoring of foster homes and group homes may be needed to protect youth while they are in placement. Assigning caseworkers or special advocates to work with the individual youth may help identify and resolve problems before youth leave placements or institutional settings (English, 1991). Homeless youth who are minors often are denied services because of their legal status and the consequent need for parental consent. State laws vary considerably regarding a minor's ability to give consent. In many states, it is technically illegal to be a homeless minor not under the supervision of a guardian. In most states, unemancipated minors can legally give consent for care for some services as mentioned earlier. However, legislative guarantees are needed to delineate circumstances under which homeless minors may consent to other types of services (English, 1991; Johnson, Aschkenasy, Herbers, & Gillenwater, 1993; Kennedy et al., 1990). Requirements to establish emancipation could be simplified or could be changed to increase youth access to entitlement programs, health care, and other services, without necessarily relieving the parent of responsibility.

The recently passed federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) replaced the Aid to Dependent Children (ADC) program with the Temporary Assistance to Needy Families (TANF) program nationwide. Under provisions of TANF, teen parents receiving assistance must now live under the supervision of a guardian. While these welfare reforms have been politically popular, they may serve to make if even more difficult for homeless youth who have children to receive welfare benefits. Youth without children, even those who are legally emancipated minors, have virtually no access to public assistance in most localities. It is our view that, if the goal is to serve homeless youth better, expanding eligibility for benefits, rather than further restricting them, may be the better policy course.

Youth Leaving State Institutions. Not all homeless youth have received services from state youth-care agencies such as foster care, group homes, or juvenile detention. However, these represent an important subgroup of the larger homeless youth population (Mangano, 1999). Mangano suggests three key components for any youth-care agency that seeks to reduce and end homelessness among those it serves: discharge planning, aftercare tracking, and expanding "next-step" residential options. Early in the case-management process, agency caseworkers could develop service plans for clients that help youth establish and maintain contacts with community resources (such as health care, job training, and recreation) that would ideally continue after discharge. He also suggests that aftercare tracking (which is rarely done currently) will allow state agencies to review their effectiveness in preparing the youth for a return to their families or independent living. Finally, nn increase in the number of "next-step" residential and housing resources is needed since youth who have been in state care or institutions often have less skills or resources needed to maintain their own housing. Such residential options could include a variety of supports such as substance abuse and mental health services, life-skills training, and peer counseling.

Evidence is mounting that the lack of discharge planning and aftercare at state agencies can leave youth and young adults ill-prepared for a return to their families or for independent living. Providers suggest that increased aftercare tracking by state agencies would help inform discharge planning and other efforts to prevent homelessness among at-risk youth.

Recommendations for Future Research

Needs Assessment: Methodological Issues

Sampling and Measurement. Many studies on homeless youth provide only very sketchy information on the sampling methods used. Researchers studying homeless *adults* have recently found important differences depending on the sources of their samples (e.g., Hannappel, Calsyn, & Morse, 1989; Link et al., 1994 ; Robertson, Zlotnick, and Westerfelt, 1998; Toro et al., 1999b; Toro & Wall, 1991). Studies of homeless youth (Greene et al., 1997) reviewed in this paper suggest that sampling effects may be even greater for homeless *youth*.

We recommend that future research on homeless youth carefully document the sampling methods used. A growing number of large-scale studies of homeless adults have refined probability sampling procedures for selecting representative groups from a variety of settings across large geographical areas (e.g., Dennis, 1991; Koegel, Burnam, & Morton, 1996; Robertson, Zlotnick, and Westerfelt, 1997; Toro et al., 1999b). We recommend that future research consider adapting such methods for homeless youth (we are aware of only one ongoing study that has done this; see Toro et al., 1998).

Another common flaw in the existing research literature involves the use of standardized instruments without documented reliability and validity for use with homeless youth. In addition, very few common measures have been used across studies, making comparison of findings difficult. We recommend that researchers give more attention to documenting the psychometric properties of standardized measures they use and, where appropriate, use measures that have been used in previous studies to enhance comparability across studies.

Comparison Groups. The existing literature tends to paint a rather disturbing picture of the homeless youth population. Homeless youth seem to have multiple, often overlapping problems, including serious medical and emotional health problems, substance abuse, sexual and social risk taking, and poor educational attainment. However, without appropriate comparison groups, it is impossible to determine the degree to which these problems are unique to homeless youth. While recent studies on homeless adults and families have benefited from appropriate comparison groups (e.g., Shinn, Knickman, & Weitzman, 1991; Sosin, 1992; Toro et al., 1995; Wood, Valdez, & Hayashi, 1990), few studies on homeless youth have included appropriate comparisons (see McCaskill et al., 1998; Wolfe et al., 1999). Comparison groups are essential to get a clearer picture of the unique features that distinguish homeless youth from other youth.

Also, carefully analyzed qualitative interview data has proven useful in understanding the needs of homeless adults and families (Banyard, 1995; Koegel, 1992; Underwood, 1993) and a few such studies have been done on homeless youth (e.g., Lagloire, 1990). Similar approaches to needs assessment may be useful in studies of homeless youth. When assessing the needs of homeless youth, we believe that it is important to include the opinions of the youth themselves.

Longitudinal Research. Though there is a growing number of longitudinal studies on homeless adults and families (e.g., Shinn et al., 1998; Toro, Goldstein, Rowland, Bellavia, Wolfe, Thomas et al., 1999a; Toro et al., 1997; Zlotnick, Robertson, and Lahiff, 1999), there have been only a few such studies on homeless youth. The intervention research of Cauce et al. (1993, 1994a) represents another recent example of longitudinal research on homeless youth and there are at least three ongoing longitudinal studies (Albomoz et al., 1998; Cauce et al., 1994b; Toro et al., 1998). Much more work of this type is

needed to help us understand what happens to homeless youth over time and what services and other resources seem to help them achieve positive long-term outcomes as they approach adulthood.

Strengths Versus Deficits. The existing research and professional literature has focused intently on the problems and deficits of homeless youth. Virtually no attention has been paid to the strengths and competencies these youth may possess.

Geographic Coverage. Further research is also needed to document needs of homeless youth in rural areas, smaller urban centers and in the central US.

Program Evaluation

There is a paucity of research evidence about best practices for meeting the needs of homeless youth. We need research around the effectiveness of case management, primary care, mental health and substance abuse services much in the same way that we have research for the adult systems. We would be interested in knowing not only what works, but under what conditions, for which groups, and at what cost.

Most shelters and other services for homeless youth have not been systematically evaluated. One exception comes from work by Cauce and her colleagues who have used an experimental design to evaluate an intensive case management program for street youth in Seattle (Cauce et al., 1993, 1994a). More such rigorous designs, including control groups, are needed to determine which approaches to assisting homeless youth are most effective. Another is a recent national evaluation of the Transitional Living Program (TLP) for Homeless Youth (based on a quasi-experimental design implemented in 10 sites with 175 homeless youth, most ages 18 to 21), which found some positive program effects over a 6-month follow-up period (MacAllum, Kerttula, & Quinn, 1997).

We recommend that the organization and financing of services for homeless youth be informed by reliable information about the population and its needs. Input from service providers, policy makers, and other community leaders can also inform research on this population (Acosta & Toro, 1999).

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Making Homelessness Programs Accountable to Consumers, Funders and the Public

by
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Abstract

This paper discusses how different types of performance measurement can be used to improve the accountability of homeless programs to consumers, funders, and to the public. A distinction is made between the kinds of data used in formal research projects and data that can be practically obtained in a practice setting. Consumer outcomes are discussed in terms of accountability to consumers, program outcomes in terms of accountability to funders, and systems outcomes in terms of accountability to the public. Cost-benefit analyses are also discussed as providing another critical dimension of accountability to funders and the public.

If performance effectiveness is determined by appropriate measures of consumer need, services delivered, and outcomes attained, policy makers and practitioners can gain important insight into what policies have the greatest impact on homelessness and what practices serve homeless people the most effectively. A reliable performance accounting system will require collaboration among policy. makers, practitioners, and consumers to collect systematic consumer- and program-specific information.

Lessons for Practitioners, Policy Makers, and Researchers

- Outcome-based program evaluation uses methods that range from simple and inexpensive to complex and resource-intensive. Doing at least some basic outcome measurement provides valuable information about program effectiveness.
- Research measures and practice measures are necessarily different. For instance, there is tension between low demand clinical engagement and the intimidation of comprehensive "intake," so it may not always be possible to get a baseline measurement.
- Standardized data collection at the consumer level is a critical building block. Decisions about desired program outcomes should include consumer input and results of program evaluations should be shared with consumers.
- System-wide standards and provider information are needed to compare the relative effectiveness of program. A number of Management Information Systems (MIS) programs are available that standardize outcome.
- The homeless system must demonstrate effectiveness to compete with other public priorities. Funders are increasingly using outcome measures to evaluate programs and make choices about which programs to fund.
- The homeless system is related to performance of other systems (e.g., health, welfare, and housing) so evaluating their impact involves complex interagency data acquisition issues.

- Thorough cost-benefit analysis requires the integration of a large number of data sets that are usually not compatible, but like any evaluation research a little research concerning a program's cost-effectiveness can nevertheless be informative.

Introduction

Funding agencies at all levels of government have begun to consistently use outcome measures to evaluate the effectiveness of social services. Some local governments have been using outcome-based evaluations of their programs in their reporting and application for federal funds. The link between receipt of funding and performance has been further strengthened with the establishment of the Government Performance and Results Act which obligates federal departments to report on the performance of all funded programs in meeting their specified objectives by the year 2000.

This paper reviews the literature on homeless services outcomes and discusses how different kinds of performance measurement can be used to improve the accountability of programs to consumers, funders, and to the public. In doing so, a distinction is made between the kinds of information gathered by formal research projects and that which can be practically obtained in a practice setting. Regardless, accountability should be based on outcome measurements that provide as clear indicators as practicable that the public and private homeless services are meeting their intended objectives, for consumers, funders and the public. While each constituency may have interests that cross analytic boundaries, this paper is organized according to the primary accountability issues for each audience, and the corresponding level of analysis. Thus, consumer outcomes are discussed primarily in the section on accountability to consumers, program outcomes in the section on accountability to funders, and systems outcomes in the section on accountability to the public.

Introduction: Analysis Framework

Level of Accountability	Primary Units of Analysis
Consumers	Consumer Needs Services Received
Funders	Provider
Public	System

Cost-benefit analyses provide another critical dimension of accountability by weighing the costs of not conducting programs along with the impact of current programs. These kinds of analyses must incorporate a range of data, typically in different units of analysis, with varying degrees of reliability, and from a variety of service systems that use different data management systems. Thus, even less literature in this area is available than in homelessness outcome measurement evaluation generally, providing provisional guidance at best. However, this methodology may help to increase accountability and has been given particular attention in this paper for the potential benefits it offers to policy analysts, program administrators, and state and local officials.

When performance effectiveness is determined by outcome measures, policy makers and practitioners gain important insight into what policies have the greatest impact on homelessness and what practices serve homeless people the most effectively. It must be noted that the needs of consumers and the limited resources of providers can interfere with the types and extent of measurements that can be reasonably and reliably gathered. Thus, an active collaboration between policy makers and practitioners is required to accommodate to the clinical realities that make outcome measurement challenging. Nevertheless,

sound policy and good practice require a concerted effort to collect information on what consumers need, what they receive, and to what effect.

Accountability to Consumers

In order for programs to be accountable to consumers, they must be able to demonstrate responsiveness to consumers' needs-both as consumers' perceive them, and as may be ascertained through reliable and clinically appropriate means by service providers. Because consumers and providers often differ in their views of what consumers need, as well as the relative priority of those needs, multiple methods of assessment should be used. Correspondingly, to assess the adequacy by which consumers' needs have been served multiple methods of performance and outcome measurement should also be employed. These include measures for services provided, consumer progress in meeting service goals, and consumer satisfaction. The usefulness of these measures for achieving accountability to consumers depends in large measure on the degree to which these measures are accessible to and reviewed by program staff and program managers, as well as by consumers. The use of such measures for achieving accountability to funders and the public will be discussed in later sections; this section will review how they can be used to increase the accountability of programs to consumers.

Accountability to Consumers: Measurement Strategies

Assessment Type	Methodology
Consumer Preferences	Checklists, Likert scales (domain specific)
Standardized Assessment Tools	Standardized scales, MIS assessment instruments
Match-Mismatch	Compare consumer needs with services delivered ("appropriateness")
Outcomes	Housing stability Adequate income Social relationships/functioning Consumer satisfaction Quality of life

Consumer-Perceived Needs. Several published studies have reported attempts to gauge what consumers perceive as their needs and the relative priority of those needs. For example, in an early study of consumer-defined needs, Ball and Havassy (1984) found that homeless repeat users of psychiatric facilities in San Francisco prioritized their lack of basic resources for survival, over their lack of access to social services, as the main cause for their homelessness. Results from the 112 subjects surveyed identified the following needs: affordable housing (44%), financial entitlements (38%), alcohol treatment (9%), and counseling (7%). More recently, a needs assessment study conducted as part of the Access to Community Care and Effective Services and Supports (ACCESS) program found that among 1,482 homeless people with mental illness, 91 percent identified a need for long-term housing, including 61 percent who identified this as one of their top three needs (Rosenheck & Lam, 1997b). In each case, long term housing was the most frequently identified need. But it was clearly not the only need. Other needs, in order of importance, were for mental health services (78%), dental services (73%), medical services

(72%), financial assistance (70%), help getting a job (56%) and substance abuse treatment (28%). Other studies of consumer preferences have employed similar measures, and derived similar conclusions (see Herman, Stuening & Barrow, 1994; Moxley & Freddolino, 1991; Acosta & Toro, in press; Linn & Gelberg, 1989).

Compared to assessments of homeless consumers' psychiatric status, employment history, or substance use history, these studies of consumer-perceived needs have employed relatively simple and straightforward surveys of consumer preferences that are quick and easy to complete. Consumer-perceived needs tend to be assessed in fairly broadly conceived domains, with standard Likert-type scales, checklists, or rank ordered lists. In some cases, such as those assessing consumers' preferences for a specific type of housing placement, more detailed questions may be asked. Nevertheless, standardized, psychometrically tested (i.e., tested for reliability and validity) instruments, have not been developed in this area. This has been due to the presumption that consumers can accurately describe what they want, and how much they want it, without major threats to validity. The reliance on consumers to identify their own needs helps alter the focus of practitioners, researchers, and policy makers from measuring dysfunctions to determining survival skills and assessing consumer aspirations (Friedman, 1998).

Of course, consumers' and case managers' assessments of consumer needs are not always in concordance. One study that measured the discrepancy between these assessments is the study mentioned above from the ACCESS program (Rosenheck & Lam, 1997b). In that study assessment data gathered from consumers were matched with similar needs assessments from providers in the same domains (mental health, general health, substance abuse, public support, housing assistance/support, dental care, and employment). The greatest consumer/provider differences in perceived service needs were in dental services (identified by 73% of consumers, but only 44% of providers); medical service (identified by 72% of consumers but only 55% of providers); substance abuse services (identified by only 28% of consumers but 44% of providers) and mental health services (identified by 78% of consumers and 93% of providers). Mental health providers were thus less likely than consumers to identify needs for non-mental health services, but more likely to identify needs for mental health services. Awareness and respect for the potential discrepancies between consumer and provider needs assessments is important: it can help agencies in their self-evaluation process to reflect on their missions, and to affirm a more consumer-centered approach to policy, program design and/or advocacy. Thus, simple consumer surveys conducted periodically can offer program managers with a useful self-study tool for improving their accountability to consumers.

Standardized Assessment Tools

More traditional consumer assessment techniques usually take the form of an intake interview. Researchers, focused as they are on obtaining thorough data, have created many standardized instruments to assess a broad range of consumer characteristics. Since homeless people typically have a multiplicity of problems, consumers' needs must be assessed along multiple dimensions: housing; health status (including psychiatric illness, substance abuse, and medical and dental problems); income support; access to necessities such as food and clothing; social support; employment; involvement in the criminal justice system; and access to health care and/or social or vocational, rehabilitation services. In addition to these specific components there is also value to assessing quality of life according to a global assessment (Lehman, 1988), and general satisfaction with services (Attkisson & Greenfield, 1996; Rosenheck, Wilson & Meterko, 1997). Assessment is further complicated by the fact that each of these domains may have multiple sub-components. For example, housing status can be assessed by the number of days a consumer has been free of homelessness in the past 30 days; by the stability of their residence

(how many times they have moved in the past 6 months); by the quality of the housing (safety, state of repair, privacy, proximity to transportation etc.); or by the number and type of people with whom they reside.

In general, it is best to use standard measures of health outcome that have well-characterized validity and reliability. There are typically numerous measures to chose from. In the ACCESS program psychiatric status is assessed by self-reported symptoms of depression (Robins, Helzer, Croughan & Ratcliff, 1981), psychosis (Dohrenwend, 1976), and interviewer ratings of psychotic behavior on standardized scales. Substance use was assessed with the composite alcohol and drug indices of the Addiction Severity Index (ASI) (McLellan, Luborsky, Wood & O'Brien, 1980). Psychological distress can also be measured using the Brief Symptom Inventory, a 53-item version of the well-known Symptom Checklist-90 (Derogatis & Spencer, 1982).

One of the major dilemmas evaluators must face is the trade off between obtaining comprehensive data and consumer tolerance for participating in assessments. To paraphrase Abraham Lincoln, "You can get all of the data on some of the people, and some of the data on all of the people. But you can't get all of the data on all of the people." Only people with the least problems and the greatest willingness to cooperate wili complete assessment batteries, and the data will thus not be representative of the population being served. Moreover, from a service delivery perspective, too many questions may pose a barrier to engagement of homeless mentally ill consumers. Consequently, most agencies use relatively brief intake or assessment forms to collect basic demographic information, income status, reasons for homelessness, educational status, employment status, health status, family issues, etc. These intake interviews typically do not employ standardized instruments, and their psychometric properties have not been established. They are more commonly developed to facilitate the planning of direct services for individual consumers or to verify eligibility, as opposed to answering research questions.

That said, many public agencies, including the federal government, have encouraged the development of more standardized intake or assessment interviews. For example, for nearly ten years, cities such as New York, Philadelphia, Columbus (OH), St. Louis, and Maricopa County (Phoenix), have been collecting basic demographic and psychosocial information on nearly all persons entering emergency shelters. The Department of Veterans Affairs Health Care for Homeless Veterans (HCHV) Programs and Domiciliary Care for Homeless Veterans (DCHV) programs have conducted over 150,000 standardized assessments since beginning operation in 1987, using selected items from standardized instruments (Seibyl, Rosenheck, Medak & Corwel, 1997; Kasprow, Rosenheck & Chapdelaine, 1997). In addition, many individual shelters throughout the country have also developed their own intake and assessment tools.

The federal government has also encouraged broader use and standardization of such instruments through their support for the development of the Participant Outcomes Monitoring System (POMS) (Fosburg, Locke, Peck & Finkel, 1997), and the Runaway and Homeless Youth Management Information System. Many jurisdictions are also beginning to implement local Management Information System (MIS), or to install other consumer-tracking software applications.[1] Because of their automation and consequent standardization across providers in a jurisdiction, these systems and assessment instruments are very useful for establishing accountability of programs to funders and to the public (to be discussed later).

[1] One of the authors (D. Culhane) was involved in the development of the ANCHoR system with PRWT Services, Inc. (Philadelphia, PA). Other Homeless Services MIS systems and their vendors include, SOPHIA by Caracole, Inc. (Cincinnati, OH), Community Link by Community Services Network (Orlando, FL), Client Track by Data Systems International (Layton, UT), Homeless Prevention Network by School of ECE, Purdue University (West Lafayette, IN), Locator 2000 by Gulf Coast Software (Groves, TX), Homeless Services Network by Paradigm Systems, Inc. (Charlotte, NC), FACTORS & HelpWorks by Peter Martin Associates, Inc. (Chicago, IL), C-STAR by St. Vincent de Paul Village, CSC (San Diego, CA), Homeless Information System by Colorado Department of Human Services (Denver, CO).

Even when they do not document outcomes, they indicate that the programs are reaching their intended target population, an important performance standard that should not be taken for granted. Furthermore, to the extent that these systems assess consumer needs for housing, employment, and health services, as well as the services provided to the consumer, consumers can use such systems, or reports generated by them, to measure how well their needs are being addressed. It should be noted that the administrative data generated by MIS programs have advantages and disadvantages in terms of reliability and validity and should be used judiciously like any other kind of data.

Anecdotally, jurisdictions that have implemented automated "consumer tracking" systems or management information systems (MIS), have reported that consumers more often express appreciation than complaints that they are interviewed with a formal set of questions. A locality has to weigh the burden of information gathering against the benefits of having service planning data and outcome measures, in creating an assessment instrument or information system. However, one way to persuade consumers to tolerate an intake interview is to inform them that the information will be used to plan their services, and to keep the service system accountable to them. Consumers should also be actively involved in devising privacy controls over the personal data that is maintained in MIS programs (Friedman, 1998). Consumers can benefit directly from the use of MIS by providers because they would not have to provide the same information to multiple providers and they would be served more effectively from increased coordination of services. Providers, for example, could facilitate referrals to programs in other systems for needed services or could notify consumers where emergency shelter beds or other services are actually available.

Performance Measurement

Once consumers' needs have been identified, it is critical to record the services a consumer actually receives in order to adequately judge program outcomes. The record of services delivered and the outcomes attained-often in combination-are referred to as "performance measures." Quantifiable measures of the services a program provides are essentially the "inputs" against which outcomes can be measured. Research- and demonstration-oriented projects often have a bundle of services that comprise the intervention and are presumed to be received by the experimental or intervention group. Therefore, some demonstration projects will not collect detailed services information. However, in the non-research, or typical practice setting, consumers access a variety of services of different types and to different extents. Thus, to assess how outcomes are related to services delivered, thereby providing another measure of accountability to consumers, some method of recording units of service by type of service is' needed.

This is probably the most variable and difficult aspect of information collection by homeless services agencies. Again, some of the automated tracking systems mentioned earlier attempt to record the discrete use of services by type of service. However, this gets very complicated beyond measuring more traditional units of service, such as nights of shelter provided, and standard units of clinical services (e.g. mental health outpatient visits). Many social services are unevenly provided and have variations in intensity, duration, or in the professional level of the staff, and this variability is typically not captured in denoting a "unit of service." This area deserves more attention by agencies, cities, and researchers who should work towards a more common understanding of what services and units of services mean in different settings so that they can be more comparably measured. As one example of the utility of service use measurements, a Veterans Administration (VA) outcome study was able to demonstrate significant relationships between outcomes and the number of times consumers were seen, whether they were contacted through community outreach, the number of days of residential treatment they received, and whether they received increased public support payments (Rosenheck, Frisman & Gallup, 1995).

Whether or not discrete services are measured, programs can still be held accountable to consumers simply by showing whether or not consumers progress or achieve other intended outcomes. Again, researchers have been far more careful to collect exhaustive information when trying to assess program outcomes than is typically possible in a practice setting. In the research setting, assessment tools like those described previously are typically used as periodic follow-up measures. This would be the equivalent of repeatedly administering an intake/assessment interview to a consumer. Other instruments are explicitly designed to collect "outcome" data (i.e., housing stability). But, again, while researchers typically receive special funds to hire staff to track consumers, to interview them, and to compensate them for their participation, these are resources that a typical practice setting cannot afford. Still, it is important to be able to demonstrate to consumers that their participation has real effects in improving the homeless service system.

To some extent less rigorous outcome measurement has into some of the consumer tracking systems mentioned earlier. In the VA's HCHV and DCHV programs, mentioned above, a brief discharge form has been completed after each one of over 50,000 episodes of residential treatment. This form documents where each veteran will be residing after discharge, their employment status, whether they completed the program to a mutually agreed upon discharge or premature departure, and staff assessments of clinical improvement. While these measures lack the rigor and reliability of research-level measures, they provide useful and face-valid evidence of program results (Rosenheck, Leda & Gallup, 1992). Some of these consumer-tracking systems not only have assessment forms but also allow for collecting periodic measures of status in several domains. These relatively consumer-friendly techniques can be applied to a broader population and tend to be much more brief than an assessment interview. They can be used to assess whether programs are meeting their objectives in serving either consumer- or program-identified needs. In some cases, jurisdictions may elect to collect outcome measures on a sample of discharged consumers, given the difficulty of tracking consumers, especially after they have left a given program. Indeed, the major challenge in collecting outcomes information is finding former consumers. Doing so for all discharged consumers would require an unrealistic (and unjustifiable) expenditure of effort and resources in most cases. Alternatively, some agencies may choose to follow a sample (i.e., ten-percent) of their consumers for six months, measuring their progress once or twice over this time period.

The subject of follow-up raises another issue: how long after leaving a program should consumers be followed? Unfortunately, there are no established standards for this important consideration. Outcome data are most easily and comprehensively gathered during participation in or at the time of discharge from a program. However, while some program "graduates" may be tracked through aftercare programs, these typically represent the most successful exits from a given program. Again, research and demonstration projects may have the resources to conduct long-term follow-up (perhaps two years or more) with a broader cohort of service users, while service agencies will have to choose a more practical strategy. Nevertheless, care should be used to avoid selection biases, whereby only the successful consumers are followed (sometimes referred to as "creaming").

Accountability to Funders

While it is theoretically possible for consumers to hold programs accountable by reviewing their own services histories and progress reports, as well as aggregate reports on other consumers (indeed, such a practice might be encouraged among consumer advocacy groups), providers are more commonly held accountable by their funders. Funders, especially government funders, will usually enforce

accountability through annual or periodic reporting requirements, and through applications for new or renewed funding. Unfortunately, because of the range of funders that may be involved, providers have to struggle with widely variable and inconsistent reporting requirements. In general, funders tend to require data elements similar to those used to establish accountability to consumers described above. However, since funders often must regulate or oversee a large number of programs, and programs of different types, they may have more generic benchmarking practices. It is worth noting that to the extent that some large social service agencies have several programs that they directly manage, they might conduct similar analyses as described here, and could therefore be considered "funders." Some of the more common reporting formats and issues are discussed below.

Accountability to Funders: Performance Measurement

Components	Measures
Consumers served	Contract Performance (units of service per consumer)
Units of Service delivered	Effectiveness (maximize positive outcomes per consumer)
Outcomes	Efficiency (maximize ratio of positive outcomes :: services delivered per consumer)

Again, the research literature, where resources are available for tracking consumers and analyzing large quantities of data, offers only a few examples of detailed provider or program evaluation research. The vast majority of program evaluations measure either the relative effectiveness of two or three different program interventions, or the impact of a single program model, implemented by a number of providers. The first type of program evaluation, which typically uses an experimental or quasi-experimental design, compares models of housing or services in terms of how well they serve consumers, using aggregated consumer-level data over time: For example, Miesher and Galanter (1996) experimentally compared two programs that served homeless alcoholic men according to consumer retention in each program. (Interestingly, the authors' conclusions point to the importance of service integration, or systems-level concerns, rather than the program-level issues, in producing better outcomes.)

A second type of program evaluation in the literature derives system-level conclusions by aggregating program-level outcomes from a large project. For example, Matulef et al.'s (1995) National Evaluation of the Supportive Housing Demonstration Program evaluates the impact of 93 percent of the over 700 programs that participated in this demonstration project. While this strategy generates information on the need for systems-level interventions across sites, the relative effectiveness of each program is not evaluated. Alternatively, Huebner and Crosse (1991) used an innovative approach that combines experimental and quasi-experimental comparisons with site-level and systems-level analyses for a nine-site demonstration project evaluation. They conclude that inconsistent definitions of homelessness, problems with missing data and difficulty in measuring treatment effects were major obstacles to developing cross-project comparisons. This lack of standardization could similarly frustrate analysts working within, let alone across, jurisdictions. Finally, from a research perspective, the authors point out that common instrumentation is not a panacea, but that data-collection procedures and schedules, comparison groups, and selection into these groups are also important factors to consider in assessing program effectiveness. Another strategy that may help performance measurement is the institution of quality standards for providers that are developed in conjunction with consumers (Friedman, 1998).

In the Department of Veterans Affairs HCHV and DCHV programs reporting formats are uniform nationally. A total of 33 "critical monitors" (benchmark measures) are used to evaluate the comparative performance of over 100 programs across the country in the areas of program structure (6 measures); contacting the intended target population (7 measures); delivering intended services (8 measures) and outcomes (11 measures) (Kasprow et al., 1997; Seibyl et al., 1997). Less able or interested in funding research projects, more typically funders of homeless services will require basic data for reporting purposes, such as the number of people served, consumer characteristics, and, less often, the needs of those consumers. They also usually require some description of the program or services provided, and may even ask for the total number of units of service delivered by service category. Funders have less traditionally asked for outcomes, but, as stated previously, that is becoming more common as federal, state, and local governments are more conscious of performance, or employ performance-based auditing or contracting procedures.

Performance measures can be as crude as units of service per person (efficiency) to more complicated attempts to link units of services to some desired outcome (efficacy). For example, a funder of homeless programs may want to know the number of consumers served and the number of shelter days used, and - in combination - the average length of stay in a program. Given that the residential component of homeless programs is usually the most significant in terms of cost, the "average length of stay" (ALOS) is perhaps the most common proxy measure of what a consumer receives, or what the funder is "purchasing." For some funders, this might constitute performance in that it may document what amount of service was provided for the average consumer, or in that it may be used to compare the efficiency of providers in serving a given pool of consumers. However, even this level of reporting is only recently becoming more common in jurisdictions. To calculate an average length of stay per episode, a provider must know, at a minimum, the total number of consumer episodes (which may include duplicates of individuals) and the total number of days of service provided. To calculate average length of stay per consumer, agencies must furthermore be able to unduplicate consumers across episodes. To do so across a jurisdiction, or some other grouping of agencies, would undoubtedly require some automated information system.

Given the rather basic state of reporting at present, research is needed to develop more accurate and discriminating performance criteria, as well as organizational or service delivery..factors that can be associated with those criteria. The average length of stay is one indicator that has been discussed; still others might include units of case management delivered, hours of counseling, frequency of outreach contacts, rate of readmission to shelter, etc. For example, a recent "provider performance" analysis (Culhane, Eldridge & Metraux, 1999) chose the rate of readmission to shelter as the critical benchmark for measuring the effectiveness of transitional housing providers. Of particular interest to the funders of the research was whether or not rate of return was associated with length of stay. In other words, do shelters with longer lengths of stay have lower rates of return? In later models, length of stay was treated as a control variable, and the effect of various social services (frequency, duration, etc.) on readmission rates was assessed (i.e., Does providing case management or a certain amount of it reduce the rate of return to homelessness?). Still further models included consumer characteristics ("case mix") and discharge type (percent receiving housing subsidies) as variables. The operationalization of these variables involved a number of challenging conceptual decisions and statistical procedures. Nevertheless, the study provides a method for systematically comparing programs while taking account of variations in consumer mix, service mix, etc., and doing so based primarily on administrative records, rather than depending exclusively on costly, time-consuming survey methods.

Accountability to Funders: Benchmarking Example (Culhane, Eldridge, & Metraux, 1999)

Variables		Required Standardized Data
Dependent Variable:	Rate of Return	1. Consumer needs/characteristics 2. Services delivered 3. Discharge type 4. Provider characteristics 5. System-wide admission data
Independent Variables:	Specific services delivered	
Control Variables:	Length of Stay Exit type Case-mix adjustments Provider characteristics	

From a funder's perspective, if more days, or certain services, or more of certain services, are not associated with reductions in rate of return, one could conclude that those are either poorly performing programs or are not critically important services. Similarly, one could measure placements to housing, tenure in housing, increases in income, etc., as performance measures against which various inputs are measured. In choosing benchmarks, one must be careful that the outcome measures reflect an intended policy or programmatic objective. For example, some might argue that rate of return, while a readily available measure in some cities, is really a poor measure of how a person or family is functioning, particularly given that some persons may prefer to live on the streets instead of return to a shelter. For these persons, the lack of "return" to shelter would not indicate "success."

Also, as indicated by the preliminary study of provider performance mentioned above (Culhane et al., 1999), if funders want to be accurate in judging providers, additional sets of data are needed, beyond length of stay and rate of return. First, consumer characteristic information must be collected so that adjustments can be made for variations in case mix. Some providers may serve a more chronically disabled population, and would therefore be expected to have different performance parameters. The VA programs described previously use over ten baseline measures to risk adjust outcomes assessments that are used to compare programs seeing different types of patients across the country. Additionally, a number of provider level characteristics, which cannot be obtained through consumer-tracking systems, may be important as qualifying or control variables. These may include organizational size, auspices, funding sources, staffing levels, ownership, revenues by source, expenditures by category, etc. For example, Rosenheck and Lam (1997a) used ACCESS program data to find that geographic location of homeless services provider sites was a greater obstacle to service use than consumer characteristics among homeless persons with serious mental illness.

Thus, in addition to implementing consumer tracking information systems, funders concerned with accountability should consider the creation of provider inventories, similar to that which exists for providers of mental health services (the Inventory of Mental Health Organizations, National Institute of Mental Health, 1983 and 1986). Such periodic surveys would enable comparisons of providers' performance controlling for differences in provider characteristics. A survey developed by the U.S. Department of Commerce, Bureau of the Census (1995) on behalf of the Interagency Council on the Homeless (the National Survey of Homeless Assistance Providers and Clients) may serve as a good beginning point for such a survey.

The major problem for providers will be collecting the information necessary to measure performance, however it is measured (Huebner & Crosse, 1991). Clearly, standardization of information collection,

automation of information collection, and, in particular, explicit reporting requirements by government funders, will drive the collection of performance data. Though challenging, streamlining data and achieving unduplicated counts of consumers is doable (Friedman, 1998). A great deal of work remains, however, before the multitude of service and funding systems are fully coordinated. For example one administrator wondered how it was possible to report to multiple, and as many as fifteen or more, funders (Harris, 1998).

Besides these data collection difficulties, an equally challenging quandary for both providers and funders is that the homeless services system, is primarily reactive, and cannot always be appropriately accountable for patterns of homeless service utilization. People may stay longer in shelters because the supply of housing certificates or affordable housing shrinks, or more people may re-enter shelters because of welfare reform. Thus, the performance of homeless providers is affected by significant externalities that are beyond the control of the homeless providers, or their funders. This contingency makes any assessment of homeless providers' "performance" necessarily tentative and provisional.

Accountability to the Public

Because public funders essentially represent the public, requiring accountability for funding expenditures serves the public's interest. However, funders cannot just require reporting from providers, but must make available to the public information regarding how their systems, or networks of providers, are performing, what they cost, and what objectives they do or do not meet. In so doing, the public may be more able to hold policymakers accountable for sound public policymaking and efficient administration of programs.

Accountability to the Public: Research Strategies

Strategy	Methodology
Homeless System Performance	Services delivered and costs Effectiveness Efficiency
Program Innovations	Comparison of program types Costs/Effectiveness/Efficiency Pre-Post comparisons
Policy Changes	Pre-Post comparisons Multiple Systems Analysis (Data integration across systems, secondary impacts on health, welfare, housing and criminal justice systems.)

The Congress, state legislatures, and their administrative departments are institutions, which through their funding structures, can require local agents to report standardized information on services. Unfortunately, there are fewer requirements that obligate federal agencies to make easily available standardized, comprehensive measures of relative performance by jurisdiction. For example, while HUD and HHS and other federal departments currently require providers to report the number of consumers served, consumer characteristic information, and services received (i.e., through the Annual Performance Report (APR), through the Projects for Assistance in Transition from Homelessness (PATH) and Health Care for the Homeless (HCH) reporting requirements, and the Runaway and Homeless Youth (RHY) reporting system), they less consistently require outcome information or jurisdiction level information (which would require unduplication across the jurisdiction). The HUD APR does collect outcomes such as housing stability and changes in income, and the Center for Mental Health Services (CMHS) does

require outcomes data on persons served by PATH. These efforts will hopefully be further advanced by the Government Performance and Results Act. However, from a public accountability stand point (a system versus provider level of analysis), most Federal programs do not require jurisdiction-wide aggregation of those measures on an unduplicated consumer basis. Thus, it is difficult for the public to judge whether policies are having an intended effect (i.e., Are fewer people homeless? Are people homeless for shorter periods of time? Do peoples' incomes and quality of life improve as a result of program participation?). Policy can consequently be more often driven by anecdote, the exigencies of funding constraints, and the ideological perspective of policy makers, rather than a reasoned discussion and review of the evidence. One could argue that the inability to have institutionalized jurisdiction-wide performance measurement results in public policy being unaccountable to consumers as well as the general public.

This lack of performance information is particularly disconcerting given that many important and national initiatives have been undertaken by state, local, and federal governments. Despite their value, without information to substantiate efficiency and efficacy, good programs often remain demonstration projects and are not realized on an appropriate scale. Similarly, failed policies can remain in place because they suit the prerogatives of established interests, though they may have little evidentiary basis for continuing.

Alternatively, some service integration strategies and some large demonstration projects have been documented and there is much to be learned from them. Dennis, Cocozza and Steadman (1998) present findings from 10 different systems integration projects which used different levels of evaluation procedures, ranging from none at all to sophisticated quasi-experimental, outcome-oriented designs. Some, such as the HUD Shelter Plus Care Program, have demonstrated significant improvements in the lives of program participants in both service usage (e.g. engagement in needed treatment and reduced hospital and jail use), and material well-being (e.g. increased income, employment, and housing stability) (Fosburg et al., 1997). Similarly, the NIMH/CMHS McKinney Demonstrations showed a dramatic improvement in residential stability resulting from increased collaboration between the participating housing authorities and mental health centers. Only one project, the ACCESS Program, has built in outcome measures at the consumer, program, and systems levels. Some of the improvements demonstrated by these programs are very important, and because they have supporting evidence, arguments can be advanced for their continuation, and they are less vulnerable to legislative or departmental program cuts.

Cost-Benefit Analysis

Very little research has been published about the cost-effectiveness of services to homeless people. Studies that have been published fall into two major groups: research on small groups of homeless consumers (usually fewer than 100), and program evaluations which are usually completed by (or on behalf of) service providers and/or government agencies that fund programs serving homeless people. Research studies often use rigorous data collection strategies and powerful statistical tools, and results are published in academic journals several years after services are provided. Program evaluations tend to use routinely collected administrative data, have substantially larger sample sizes, and their results are often reported quickly in order to support program planning and decision-making about ongoing funding.

As with any consumer level, provider level and systems level analysis, cost-benefit analysis uses information that most homeless service providers have limited capacity to collect: consumer demographics, service utilization, and outcomes for the same group of consumers over time or across service settings or programs. Very few programs even use unique consumer identifiers, so they may not

have the capacity to determine how many intakes or bed nights are unique to individuals, or how many of the people served at one site are also served later in the year at another program site. The kind of data that providers do collect relates to the following program needs: (1) establishing consumers' eligibility for services, (2) documenting service utilization for billing purposes, and (3) to a very limited extent, documenting outcomes that are of interest to the source of funding for the program. While there is clearly a need for more comprehensive data collection by providers, cost-benefit analysis can utilize a variety of measures based on the kind of data that providers may already collect.

Ideally, cost-benefit analyses would compare the total costs and benefits of providing homelessness interventions with the total costs and benefits of providing no interventions, or some other standard set of services. This analysis requires measurement of costs in a wide range of systems, and we are not aware of any study that synthesizes data from every relevant system to measure the costs of not addressing homelessness at all. Instead, it is likely that we will need to patch together information from a variety of sources and methodological approaches to draw conclusions about what service models "work" to reduce homelessness and to identify both the costs and the savings benefits to consumers and to the public. Cost-benefit analysis includes the following methods: cost effectiveness, before and after comparisons, service utilization comparisons, waiting list comparisons, comparisons between groups, comparisons between programs, multivariate analysis, and multiple systems analysis. All of these approaches can provide valuable information about the relative costs of homelessness interventions.

Cost-Benefit Analysis

Strategy and Analysis Level	**Description**
Cost Effectiveness (Consumer Level)	Measures the costs for providing a unit of service to an eligible consumer.
Before and After Comparison (Consumer Level)	Compares service utilization costs by homeless consumers before entering program with costs after leaving program.
Service Utilization Comparison (Consumer Level)	Compares service utilization costs by homeless consumers with non-homeless consumers.
Waiting List Comparison (Consumer Level)	Compares service utilization costs and benefits by currently served consumers with eligible consumers on waiting list.
Programs Comparison (Program Level)	Compares service utilization costs and benefits between two or more of the same kind of programs or between programs that offer different kinds of intervention.
Multiple Systems Analysis (System Level)	Measures costs and benefits of services to consumers relative to not providing those services using data from the homeless-ness, housing, health care, mental health and substance abuse treatment, criminal, and welfare and employment systems.

Cost ***Effectiveness.*** Some studies simply measure the costs for providing a unit of services to an eligible person. If the costs appear to be "reasonable" and the projects appear to achieve desired outcomes for most consumers, the report concludes that services are "cost effective" (Matulef et al., 1995). While not

a complete picture of cost-effectiveness, this measure may be meaningful if a desired outcome is the engagement of the project's target population. This is particularly true in the case of projects serving consumers who have not consistently participated in treatment. It can also be a useful indicator of the efficiency and effectiveness of program implementation in terms of evaluating such program activities as filling vacancies, or providing outreach to maintain program capacity.

Before and After Comparison. Costs of services utilized by homeless individuals before they enter a program are compared to costs and benefits during and after program participation. For example, the evaluation of the Minnesota Supportive Housing Demonstration Program (Tilsen, 1998) found that average monthly costs for a range of services, including hospitals, jails, state institutions, and income support, were reduced from an average of $2,168 to $1,370 per month, resulting in annualized savings of $1.7 million a year for 180 units of supportive housing. Changes in residential stability, consumer functioning, and consumer satisfaction are also reported. Because some homeless people might have achieved some improvements in functioning or reduced utilization of other services without program assistance, it has been suggested that changes measured using this approach may be useful as an estimate of the upper boundary of program impacts (Rosenheck et al., 1995).

Service Utilization Comparison. In a recent study which examined hospital discharge data from New York City's public hospitals, Salit et al. (1998) found that homeless patients stayed 36 percent longer than other patients, after adjustments were made for clinical and demographic characteristics. Rosenheck and Seibyl (1998) reached similar conclusions after comparing a national study of the health service use and costs for homeless and domiciled veterans hospitalized in psychiatric and substance abuse units at VA medical centers. The authors found that 13.3 percent more money was spent serving homeless veterans than domiciled veterans. Measurements of the costs associated with homelessness are one way of identifying the savings that could be achieved by successful interventions. Ideally this information can be linked to data from programs serving homeless people to compare the costs of programs that are successfully targeting and retaining people with the same clinical and demographic characteristics. Programs to prevent homelessness can use a similar approach by creating models to project what would have happened to program participants if services had not been provided. The New York State Department of Social Services (1990) used this method to estimate the cost effectiveness of programs that intervened to prevent evictions, and estimated that the late stage eviction component of their Homeless Prevention Program saves approximately $11.6 million in averted homeless costs.

Waiting List Comparison. Another strategy that has been discussed but not fully pursued is to compare costs and benefits for program participants with those for homeless individuals who are eligible for the program but on wait lists because of limited program capacity. Where participants are selected by lottery, (as is often the case in housing for homeless people), there is *de facto* random selection into a treatment group and a control group. Comparison between the service utilization costs and program benefits between these groups may yield valuable cost-benefit data. While it would be very difficult to track homeless individuals who do not receive services, information from public data systems such as public hospitals and clinics, mental health services, and other systems of care could be used to gather longitudinal data on wait list subjects.

Program Comparison. A number of research studies compare two or more programs which use interventions that are based on different service models. For example, Wolff et al. (1997) compared costs and outcomes for three types of case management after randomly assigning consumers to each service model. The authors found that higher average costs for two assertive community treatment approaches were associated with increases in financial assistance (vocational/educational, residential, and income support) and decreases in costs for inpatient psychiatric services, when compared to less

intensive and less expensive brokered case management services. Dickey, Latimer, Powers, Gonzalez and Goldfinger (1997) compared two types of housing with services and found that treatment and case management costs did not vary by housing type, but that one housing program was significantly more costly than independent living arrangements, without producing significantly different outcomes. Rosenheck et al. (1995) used multivariate analysis to assess relationships between specific treatment elements and outcome measures in VA homeless programs. Using this approach, the researchers measured the costs for determining a standardized amount of improvement for different outcomes (housing stability, symptoms, employment), using different service strategies (e.g., case management, residential treatment, and income supports). They found that the cost of residential treatment was three to five times the cost of case management for achieving a standardized amount of improvement in outcomes, but that the interventions were associated with improvements in different areas of functioning. Residential treatment was associated in improvements in the number of days housed and days employed, while case management was associated with improvements in days of substance abuse and psychological distress. Income transfer payments were associated with improvements in days homeless but worse outcomes in paid employment.

Multiple Systems Analysis. Because homeless people often face a number of additional problems, such as mental illness and drug and alcohol addiction, it is important to compare costs from many different service systems. These data include utilization of shelter, housing, and other "homeless" services; utilization of health care, mental health and substance abuse treatment; utilization of welfare and employment services; and involvement with the police and jail systems. For families, we need to also consider costs of child protective services and foster care. We know anecdotally that effectively stabilizing the lives of homeless people can prevent or reduce the costs of services in each of these systems. A number of the program comparisons cited above (Wolff et al., 1997; Dickey et al., 1997; Tilsen, 1998) combine data from several of these systems, but to date there have been no published studies that have been successful in accessing and matching data from all of these systems.

Challenges. The limited availability of cost-benefit information is a result of a variety of challenges frequently encountered during cost-benefit analyses. These challenges include: high attrition rates, small sample sizes, imprecise measurement of service utilization costs, inconsistent data over time and across systems, and lack of provider commitment to and resources for data collection.' "'A description of the extent of these challenges is followed by a description of strategies that providers can use to meet them and conduct effective cost-benefit studies.

Attrition rates in most studies are very high, reflecting the instability in the lives of many homeless people. In some studies plans to track participants over an extended time period are abandoned when findings are compromised by high rates of attrition. After 12 months, Rosenheck et al. (1995) were able to conduct follow-up interviews with only 37 percent of homeless veterans who had agreed to participate in the study at entry into the program. Wolff et al. (1997) found that between 33 percent and 63 percent of participants assigned to case management dropped out, and that higher rates of attrition in brokered case management compared to assertive community treatment may have resulted in unknown bias that compromised the study's conclusions. Attrition is particularly problematic if participation in data collection is dependent upon participation in services, as is the case in most data collection by programs that serve homeless people. Because our current research does a poor job of tracking outcomes for homeless people who discontinue treatment, findings can be generalized only to those who are most successfully engaged in services. Better outcomes for consumers are usually associated with more consistent participation in services, but it is hard to tell if this is cause or effect. It is possible that both participation and outcomes such as residential stability, employment, or improved quality of life, are associated with other variables that are not identified upon intake. For example, people who experience

substance abuse relapse problems are likely to discontinue participation in services and have worse outcomes that are not included in study results because they drop out of data collection.

Another challenge for cost-benefit analysis is sample size. Sample sizes that are too small will not yield statistically valid results. Consequently, it is often very difficult to identify statistically significant differences between program outcomes, even when there appear to be changes in the expected direction. Compounding this problem, observed changes are often small and progress for many homeless people is unsteady and rarely linear. In addition, service utilization after intervention is often strongly correlated with prior service utilization (Wolff et al., 1997). Large sample sizes would resolve these two problems, because the larger the sample size the easier it is to detect small or non-linear changes and the easier it is to control such variables as prior service utilization.

A third challenge to conducting cost-benefit analysis is the difficulties with using billing records data. Public data systems that have been created for billing purposes usually report charges which may be much higher than actual costs, while payment rates from Medicaid or other programs may be lower than costs. Services which are not reimbursed (e.g. jail medical care) are often not recorded in a way that is easy to assign costs. One partial solution is to use data systems to gather information about the types and quantity of services used by consumers, and then use other budget information to get average costs for each type of service. This is particularly appropriate when variability in the costs of other services, (e.g., regional variations in the cost of a hospital day), is not relevant to measuring the effectiveness of different programs (Dickey et. al., 1997).

The inconsistent reliability of billing records is related to the wider problem of "messy data." People who are homeless are often not identified consistently when they use services, and many will have more than one "unique identifier" in public data systems. If it is not possible to gather data from all of these systems, significant cost shifting may not be identified in the analysis. For example, a reduction in hospital use may be a benefit, or may reflect increased rate of incarceration for study participants. Another source of data problems is the changes in the data systems of public health departments, hospitals and mental health systems data systems that has accompanied the recent transition to managed health care. This often results in significant year-to-year differences in data quality, format, and availability, making it extremely difficult to get consistent information about service utilization over time.

Homeless service provider capacity and willingness to participate in data collection may also limit the availability of data. Direct service providers have challenging jobs, are often required to use creative strategies to engage consumers who may be resistant to the offer of services, and often deliver services in unconventional settings. This leaves little time to fill out paperwork, particularly when providers do not see analysis of the data they collect data collection as helping their front-line efforts. This problem can be mitigated to some degree if the collected data is analyzed and given back to program staff quickly and in a format that is useful to them and their consumers. Administrators can provide incentives for the collection of data by proving a link between cost-benefit analysis and improvement in consumer outcomes and/or in the acquisition of additional funding.

Because of the above challenges, powerful statistical techniques and a very significant investment of resources are needed to achieve ideal levels of scientific validity and reliability. However, this sort of research usually takes years to complete, requires resources outside of the reach of most homeless programs, and the results may not be published until three to five years after the program intervention has been tested. Homeless advocates, then, must be prepared to utilize a number of less thorough cost-benefit analyses to develop an understanding of the savings represented by various approaches to addressing homelessness. Fortunately, there are a variety of strategies advocates can use that will

increase the rigor of their cost-benefit analyses. Forging partnerships with providers in other service systems, for example, can address the problem of attrition by facilitating longitudinal tracking of their consumers. Utilizing the MIS programs discussed above can help standardize routine data collection and increase sample size for studies that include multiple providers and multiple service systems. These MIS systems can also facilitate speedy feedback from program administrators and funders that both providers and consumers could use to measure and improve consumer outcomes.

The importance of system-wide cost-benefit analysis is evident when considering programs whose consumers have multiple problems and utilize multiple programs. For example, those people who visit public hospital emergency rooms 12 to 50 (or more) times a year and the visible homeless people in our streets and parks tend to have similar characteristics-chronically homeless, out-of-treatment addicts, out-of-treatment mentally ill, and often living with chronic health problems and at very high risk for HIV/AIDS. As we move toward establishing new systems of accountability which measure outcomes and cost-effectiveness, we need to be sure that we do not create fiscal or other incentives for programs to "cream" and to exclude those most at risk of failure. For example, programs that require 60 days of sobriety before intake may achieve better outcomes related to employment and housing stability, but may be completely inaccessible to most of the homeless people who are seen in public hospital emergency rooms or city doorways.

As described earlier, to get a complete picture of cost effectiveness, we need to look across systems and funding streams (e.g., federal, state, and local, as well as "homeless," health care, criminal justice, and welfare). However, program and funding decisions are almost never made from this global perspective. For example, it is hard to convince a county mental health department to allocate funds for interventions that will create savings in other systems by reducing entry into shelters, hospitals, or jails and that may result in increased demand for the limited resources available within the mental health system. Homelessness does not occur in isolation and so must not be addressed as an isolated phenomenon. The need for cost-benefit analysis that integrates data from a variety of systems, then, reflects the need for policies that bring providers from a wide number of systems together to solve homelessness.

Finally, cost-benefit analyses can provide powerful tools for homeless advocates in the policy arena. Any intervention designed to reduce or end homelessness requires funding, and quantitative arguments that a given intervention can save money relative to not investing in that intervention can go a long way to obtaining that funding. The matter of funding is perhaps the clearest aspect of accountability to the public whose taxes fund the vast majority of homeless programs and who has a vested interest in eliminating homelessness.

Next Steps

The assessment of consumer needs, reporting of services, and the measurement of consumer outcomes are where policy and practice meet. Policymakers need information to drive decisions such as the allocation of resources and the design of programs, and practitioners need data to understand who they are serving, how they serve them, and to what effect. Thus, information collection represents an intersection of interests and around which there could be concerted effort to improve upon current practice. Consumers, providers, funders, and the public, all stand to gain by a system of mutual accountability that can be enabled by reasonable and accurate data collection.

At the most basic level, providers and consumers can be the keystone for such an effort through their initiation or cooperation with the development and/or implementation of standardized information

collection. Organizations of providers or "service systems" (i.e., local government) can foster such standardization by establishing agreed upon protocols or through adoption of existing mechanisms for collecting information. Service systems can use the goal of accountability as one way to encourage participation in such arrangements. Local government can also demonstrate their conviction and value for such efforts by supporting the functions of assessment, tracking and outcome assessment, financially and materially through equipment and technical support.

Similarly, the federal government can support accountability for consumers, funders, and the public by funding and even mandating the establishment of minimum data collection requirements. At a minimum, homeless programs can begin to be accountable to the public if jurisdictions were required to report basic information such as: unduplicated counts of consumers served, units of service by consumer type, and direct (i.e., housing stability, reduced hospitalization, improved quality of life, even if just on a sample) and indirect (i.e., rate of readmission) measures of service utilization. The extensive data collection that has been part of the Department of Veteran Affairs national homeless program has clearly demonstrated the possibility of generating higher levels of accountability on a national scale in integrated service systems (Kasprow et al., 1997; Seibyl et al., 1997). If inducements to collect standardized information were in place, local, state and federal government as well as consumer and provider advocacy groups and other interested parties could exploit information technologies and establish monitoring systems. These systems could be used to gauge demand for emergency shelter, and measure duration of shelter stays, rate of shelter exit and return, and assessment of consumer satisfaction.

With these tools at hand, an evidentiary discussion of the merits of existing or proposed policies could ensue. Perhaps even more importantly, the system of homeless services from a policy perspective can become more proactive and apply such information technologies as an accountability check and as a critical performance measurement for the larger social welfare and insurance systems. For example, if welfare reform produces increases in shelter admission or longer shelter stays, homeless providers and consumers would be in a position to prove it. If increases in the development of support housing units yield increases in the rate of shelter exits, local governments can show it. If managed care of Medicaid programs is leading to premature discharge of hospital patients, some of whom end up in the shelters, regulators can prove it. In this way, the homeless system can become an accountability check on the larger arena of public policy related to poverty.

Recommended Research Initiatives

- Develop new instruments that measure consumer outcomes, provider performance, and systems effectiveness and efficiency. These instruments should be brief, reliable and valid so they can be used by practitioners without interfering with their ability to meet their consumers' needs and at the same time can provide useful evaluative data. Such instruments should capture a variety of data including: performance variables that measure inputs (services provided), outputs (placements to housing, tenure in housing, increases in income), ALOS (average length of stay), and organizational characteristics (size, auspice, funding sources, staffing levels, ownership, revenues by source, expenditure by category, etc.).
- Forge a closer relationship between providers and researchers so that provider-identified trends could become the source of formal research projects.
- Develop techniques and guidelines for tracking the outcomes of consumers longitudinally. Protocols should be established for sample sizes and periodicity of follow-up.
- Develop benchmarking measures for performance. These include ratios of inputs to outputs, which may include cost-benefit analyses. A crucial component to these benchmarks is the development of a

more common understanding of what services and units of services mean in different settings so that they can be more comparably measured. This common understanding should include input from consumers, providers, funders, and researchers.

- Conduct system-wide analysis that provides the "bigger" picture policy effectiveness to answer the following questions: Do expenditures yield reductions in costs in other systems? Do broad policy initiatives yield overall gains in housing stability, costs, etc.?
- Devise creative strategies (e.g., data integration strategies, interagency task forces, or case reviews) to use data from different systems that take different forms.
- Adopt automated systems (e.g., software programs, or management information systems) more widely in order to track consumers at the site of service delivery.

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Giving Voice to Homeless People in Policy, Practice and Research

by
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Abstract

Consumer involvement in programs that serve homeless people has been growing in the past ten to fifteen years. There is a growing body of literature that supports the benefits of consumer involvement on the programmatic, policy, and administrative levels. Consumer empowerment ranges from participation in a community meeting or on an advisory board, to hiring consumer staff, to completely consumer-run programs and organizations.

While there is resistance within any system to hand over power to a stigmatized group, once done, the system may find that it has higher quality and more responsive services. Research finds that consumers can perform as well as non-consumer staff and are especially skilled at engaging potential clients. Within consumer-run organizations, the focus of service delivery is on choice, dignity and respect. There are a number of things that federal, state and local governments can do to encourage consumer involvement in decision-making, staff hiring, and the creation and survival of consumer-run organizations.

Lessons for Practitioners, Policy Makers, and Researchers

- Organizations and agencies must plan for consumer involvement carefully. Through allocation of adequate resources and education and preparation of non-consumer staff, the organization will be laying the groundwork for true empowerment.
- The concept of choice and tailoring assistance to individual needs is central to the success of consumer-run programs. They are indispensable to any program that truly serves its constituents.
- Research finds that formerly homeless consumers employed as staff, including those with serious mental illness and persons in recovery from substance abuse, can perform as well as non-consumer staff and may be especially skilled at engaging other homeless persons in services and treatment.
- Programs that incorporate consumer involvement tend to be more "user-friendly" or "consumer-friendly" than agencies with no consumer involvement.
- Consumer-run organizations may be more able and willing to "do what it takes" to serve their clients. In practice this might mean doing system advocacy, offering new types of services, and/or having to find more funding.
- Everyone benefits with consumer involvement: providers may increase the quality and effectiveness of their services; consumers become empowered through employment, advocacy and helping their peers; and clients learn the value of peer support.

Having personally walked many high roads and low roads as a consumer of mental health and homeless services, nothing makes more sense to me than allowing clients, or consumers of services, to have a greater say in their services-from the direct provision of services, to policy, administration and evaluation. Who, after all, knows better what they need and want but consumers themselves? Research has, indeed, found that homeless consumers are eager to define their goals and clarify their support needs (Camardese & Youngman, 1996). But due to the stigma associated with homelessness, which is greater if one happens to be mentally ill and homeless, the public and providers have had a tendency to assume consumers do not know what they need, or that what they want is not 'clinically' appropriate.

Housing and services for people who are homeless have become more "user-friendly" as systems and programs involve people who are homeless or formerly homeless in decisions about the services they receive. For years, substance abuse treatment providers have employed persons with addictive disorders and rehabilitative agencies have assisted persons with various disabilities to find and maintain employment. With the passage of the Americans with Disabilities Act in 1990, mental health agencies have made similar efforts to employ persons with serious mental illness marking an important advance in the field of mental health care (Fisk, et al., in press).

Homeless people do not have a long history of organized advocacy efforts on their own behalf. The larger self-help or consumer empowerment movement, a movement where individuals organized into groups to help one another, has come a long way since its roots some 30 years ago. But over the past decade, this movement has begun to really make its presence felt among programs for homeless persons. Among mental health consumers, for example, the early period of the self-help movement was a backlash against what consumers saw as an authoritarian and abusive psychiatric treatment system. Former patients banded together into self-help and advocacy groups to heal from the damages sustained while in "treatment," and to change the system. Some early groups felt the only way to really help each other was through separate, peer-run services.

More recently, the mental health field has grown rich with self-help groups and consumer-run programs which, rather than competing with professionally run programs, are reaching out to a population that professionals have largely left alone-people who are homeless and mentally ill. In many cases, they are working cooperatively with professionals and/or are funded by public mental health agencies. Instead of letting "the system" off the hook for not providing adequate services, many of these programs are involved in advocacy efforts to make the system more responsive (Long, 1988). Because of this movement, much of the literature on consumer[1] involvement addresses homeless persons with serious mental illness, who account for approximately one-third of the total homeless population (Federal Task Force on Homelessness and Mental Illness, 1992).

The National Association of State Mental Health Program Directors (NASMHPD) recognized that mental health consumers have a unique contribution to make to the improvement of the quality of mental health services in many arenas of the service delivery system. In their policy statement, NASMHPD said that the contribution of consumers "should be valued and sought in areas of program development, policy formation, program evaluation, quality assurance, system designs, education of mental health service providers, and the provision of direct services (employees of the provider system). In order to maximize their potential contributions, their involvement should be supported in ways that promote

[1] For the purposes of this paper, "consumer" will mean any person who has experienced being homeless. For clarity's sake, when I use "clients" I will be specifically talking about individuals receiving services from a particular organization, program or agency.

dignity, respect, acceptance, integration, and choice. Support provided should include whatever financial, educational, or social assistance is required to enable their participation" (Wilson, 1990).

When consumers have the opportunity to be involved and have a voice in the organizations that serve them, either through decision-making/policy involvement or employment, everyone wins: service recipients, agency staff, the programs designed to help homeless people, and the systems in which they operate.

Why Consumer Involvement Matters

What can happen when providers overlook the importance of consumer input is that many will refuse services or treatment outright due to lack of choices. The dehumanization and depersonalization that can happen while receiving services can make what is already a bad situation, intolerable. Not only do consumers experience a lack of dignity and respect from providers, but they feel that many of these agencies do not meet their needs. And many do not. At best, traditional services tend to treat people in a regimented and impersonal manner (Howie the Harp, 1988). At worst, they are coercive, lacking dignity and without opportunity for self-determination (Van Tosh, 1994).

The phrase "treatment-resistant" is often used to describe homeless persons who refuse mental health treatment and other services. But there are often good reasons for the refusal to accept assistance. From the perspective of homeless people, the services that are offered, and in some cases forced upon them, may be completely undesirable and inappropriate. At other times they may not be enough.

The concept of choice is central to the success of consumer-run programs and is an indispensable part of any program that truly serves its clients. Consumer-run programs have found that when these "resistors" of traditional services are offered services and choices by peer/consumer providers, in a non-coercive, voluntary environment, many of them become cooperative and eager to turn their lives around. Everyone benefits with consumer involvement: providers have a chance to increase the quality of services; consumers can step up to empowerment through employment and helping their peers; and clients can learn the value of peer support.

Project OATS (Outreach, Advocacy and Training Services for the Mentally Ill Homeless), an entirely consumer-run organization, is a perfect example of peer support at its best. Laura Van Tosh, former Project OATS Director, tells of her experience doing street outreach with Mr. Smith (not his real name). It reveals the type of commitment consumers, and consumer-operated programs make to help consumers in need. In part, she writes:

> *In repeated, informal contacts with Mr. Smith I interacted with him as a peer, not as a "professional" relating to a "client". This approach helped to gain his trust because we interacted as equals. For example, I sat next to him on the ground. I helped him with immediate needs on the streets like obtaining plastic bags to hold his belongings. I accompanied him sometimes for hours at a time during his efforts to obtain assistance from the system. I was available to assist him 24 hours a day, seven days a week. . Although it was my belief that his most immediate need was housing, I respect his judgment of which area of his life should be addressedjirst. he trusted me to advocate on his behalf, and my commitment to stand by him was an important part of his decision to seek help"* (Van Tosh, 1990).

Mr. Smith, after 14 years of falling through the cracks of the traditional service system and being homeless on and off, is now living in supervised housing and obtaining case management services. It should also be noted that, at the time, Ms. Van Tosh was not an outreach worker for Project OATS, but the Project Director. Nevertheless, given the opportunity to connect with a potential client, she did not let her formal job duties deter her from helping this individual. Such is the flexibility and lack of top down structure inherent in many consumer-run programs.

In a similar example, Laura Van Tosh writes about another homeless individual:

> *"David (not his real name), a homeless man, has suffered from severe mental illness for over IO years. When I first met David, he was withdrawn, depressed and incoherent. He was also living on the cold streets in the city. At first he would not communicate with me, but over a period of a few days and nights he began to speak to me. Our "conversations" consisted of my listening to bizarre stories of situations he had been in. My simply being with him and listening meant something to David, for he continued to talk to me each day I stopped by to see him. He understood my compassion and desire to help him.*
>
> *Since I, too, had been homeless and mentally ill, I knew that it mattered whether or not someone took the time to talk to David. I told David that I also had been without a place to live for a while and also had been hospitalizedfor mental illness. At first he didn't believe me, but after I showed him the medication I had in my purse, he did. And he smiled. Suddenly I had gained the trust of David and his willingness to try to improve his life. Through our many hours of conversations, David began to understand what empowerment meant. He learned that helping himself was an integral part of good health and that only he could truly help himself My help was merely a step in the empowerment process"* (Van Tosh, 1988).

Soon David had secured housing, rehabilitation support, and part-time employment. David became a valuable member of a consumer-run project. The peer-support process came full circle when David was able to assist a homeless person who wanted services. Moreover, David's record of recidivism, which was costly to the system, has been supplanted by stability in the community.

These examples stand in sharp contrast to the structure of many service programs that homeless people need. Professionally-driven services are often office-centered and appointment-driven. They put clients on waiting lists for continuing service and require clients to fit into the routines of structured activities. They focus on clinical rather than survival needs. Moreover, many service providers are often reluctant to serve homeless people due to reimbursement issues or stigma (Long, 1988). Clearly, consumer-run services have the potential to fill some very large gaps in the current service system for people who are homeless.

Literature Review and Program Examples

The research literature on the involvement and roles of formerly homeless consumers in policy, research and service delivery is scant. What is there, is drawn largely from the area of mental health where researchers have examined the effectiveness of consumer staff (Dixon, Krauss, & Lehman 1994;~

Solomon & Draine 1995; Fisk et al., in press; Chinman et al., in press), the impact of honoring consumer preferences for housing on outcomes for residential stability (e.g., Goldfinger & Schutt 1996), and efforts to empower consumers (Cohen 1994; Ware et al., 1992).

Despite the lack of more extensive research in this area, there is a substantial body of descriptive material in the form of articles, reports, and technical assistance manuals that provides the base for knowledge in this new and developing area. What follows is a review of the available literature as it addresses many levels of consumer involvement, from creating consumer advisory boards, to hiring consumer staff to developing consumer-run organizations. Additional evaluation and outcome-based research are needed to confirm and refine the practices and models that are recommended from the field.

Consumer Advisory Boards and Consumers on Advisory Boards

One of the first efforts an agency might make to develop empowerment-oriented approaches is to create a consumer advisory board. Ideally, such an effort will emphasize the shifting of power and resources to the consumers of services. By giving clients a voice in policy formation, a consumer advisory board is a logical extension to empowerment. But groups aimed at increasing client power are likely to encounter organizational resistance, particularly when clients are members of a stigmatized group. Researchers have found that it is one thing for agency staff to support empowerment as an abstract goal but quite another to shift power to clients, away from themselves. This often feels problematic to staff (Cohen, 1994). Moreover, many attempts to empower clients will fall short of transferring power to consumers, yet administrators and staff will report that they now "empower" their consumers (Salzer, 1997).

One way to overcome professional resistance (due to ignorance and stigma associated with being homeless) is through staff training and education. The most effective training will have consumers involved as part of the training staff. Unless managers include consumers in these activities, their presentations will be limited to their own perspective. Joint leadership between consumer staff and non-consumer staff in education and training efforts will also demonstrate an important partnership between the two groups (Fisk, et al., in press). Non-consumer staff needs to be adequately prepared for the shifting of power to consumers before involving consumers.

Once an organization makes a commitment to involve consumers by educating and preparing staff and creating a mechanism for input (i.e., consumer advisory board or adding consumers to its board), administrators need to:

- ensure real response and tangible outcomes to consumer input, suggestions and complaints;
- avoid "tokenism;"
- allocate adequate staff time for consumer recruitment and follow-up; and
- provide financial stipends to consumers willing to sit on boards and committees.

Cohen's study of a consumer advisory board in a New England agency serving homeless and low-income clients found that the inadequate preparation of staff and lack of real response to consumer complaints resulted in consumer interest in the group falling off quickly. The agency also failed to appoint a staff person who would be responsible for contacting specific individuals for recruitment and follow-up.

Tokenism, defined as one person on a board or committee to represent an entire class of people, is probably the most common error committed by well-intentioned organizations (Van Tosh, 1993; Wilson,

1990). Limiting consumer involvement on boards or committees to one person means that the consumer has no natural allies on the committee, making involvement, an intimidating or potentially threatening experience. Lastly, given that staff are paid for their time when they formulate policy and make administrative decisions, so too, must consumers be compensated to being involved in such matters. Consumers are the experts when it comes to their needs and desires. Financial compensation is an absolute necessity for consumers sitting on policy boards and other administrative committees.

Surveying clients is another good way to include consumer input in program implementation and evaluation. These surveys are an important step in the development and maintenance of "quality" services and programs (Van Tosh, 1993). But using surveys to substitute for true consumer involvement is not meaningful empowerment. They must be used in conjunction with other types of consumer involvement - on the programmatic, policy and administration levels. Moreover, true consumer empowerment would also involve consumers in interpreting the input and feedback on the development of interventions that result from the input. Anything less than participation in the whole process is not empowerment (Salzer, 1997).

Below are three examples of how consumers are involved in advisory groups or on the boards of national and local organizations.

> ***National Coalition for the Homeless*** *was founded in 1982 by local and state homeless coalitions who felt the need for a national voice to address issues related to homelessness and poverty. The organization, which has a total of eight staff persons, employs two formerly homeless individuals, and mandates that 30% of their policy-making board be consumers. In addition to offering technical and support services to local and state homeless groups, the Coalition trains consumers on how to get involved in HUD's Continuum of Care planning process and general advocacy skills, including how to be an effective board member. "We feel strongly that consumers must lead the way" states Mary Ann Gleason, Executive Director of the Coalition. The organization recently demonstrated this commitment by raising funds to provide scholarships for nearly 100 consumers to attend the Coalition 's annual meeting.*
>
> ***St. Francis House*** *in Boston is a professionally-run day shelter open from 7:30 AM to 3 PA4 every day. The day shelter offers an array of services to 150-I 70 "guests " each day, The Guest Advisory Council was the idea of employees at the shelter who asked "how do we know what our guests need here?" and decided the only proper way to answer that question was to ask the guests themselves. The Council is an open weekly forum in which guests can voice any issue they might have. The group is facilitated by staff, although Harrison Fowlkes, one of the facilitators, explains that they encourage guests to take charge as much as possible.*
>
> *When the Council meetings first started there were a lot of complaints about staff, the food and clothing distribution, "but over time the group has begun to take on the flavor of a mini-political arena " states Harrison. Because the shelter has been able to respond in tangible ways to guest concerns, the Council is now able to look beyond their individual situations and into issues affecting them as a community. Guests are currently planning to be involved in a march and rally in Boston for more affordable housing because, as Harrison notes, many guests have jobs but still cannot afford the high price of rent in Boston,*

The Central Massachusetts Housing Alliance *is committed to helping the communities of Greater Worcester and Worcester County respond to the needs of homeless, and near homeless, people by supporting prevention programs, ensuring the availability of high quality and appropriate sheltering and support services, working to increase the supply of affordable housing, and empowering people through education. The Alliance involves consumers at a policy level by encouraging homeless families to join local and state task forces and committees. They also advocate for consumer representation in the Continuum of Care planning process. They are committed to having consumers on their Board of Directors even though it has been difficult for consumers to stay involved for extended periods of time. The Alliance 's sub-committees, such as welfare reform and the emergency assistance campaign, are totally guided by consumers (Farrell, personal communication, I999).*

Consumers as Staff

The research to date suggests that consumers can make a unique and valuable contribution as program and agency staff. This is particularly the case when agencies are trying to engage homeless persons who have serious mental illnesses and/or substance abuse problems, or multi-problem homeless families. Consumers working as staff possess experiences and characteristics that enhance their ability to provide services to individuals who are homeless (Van Tosh, 1993; Fisk et al., in press; Dixon, Krauss, Lehman 1994; Solomon et al., 1994; Solomon & Draine, 1995; Chinman, Lam, Davidson, Rosenheck, under review). In *Working For a Change* (Van Tosh, 1993) describes some of the unique characteristics of consumer staff, including:

- **Systems Knowledge –** Persons who are currently receiving services, or who have previously received services, are intimately familiar with many aspects of treatment, quality of care, agencies, service models, housing opportunities and other information.
- **Street Smart,-** They can provide street knowledge and understand the nuances intrinsic to the outreach and engagement processes. For example, they are extremely knowledgeable of the locations where persons who are currently homeless tend to congregate.
- **Developing Alternative Approaches –** Consumer workers are amenable to the exploration of alternative service approaches because they have been homeless themselves and know how difficult it can sometimes be to access services.
- **Flexibility and Patience –** Having "been there," consumer workers often know when flexibility and patience is called for when providing time-intensive services.
- **Responsiveness and Creativity –** Consumer workers can be creative in developing solutions based on client-expressed preferences and needs.
- **Team Work –** Consumer workers have a keen understanding of how teamwork is needed to provide services to homeless persons with disabilities.
- **Understands Basic Needs/Preferences –** Consumer workers have been through similar experiences while homeless and connect with others based on their common shared experiences. They can identify with a client's need for a shower, locating a food source and bathroom facilities, safety issues and knowledge of shelters. Often not viewed as essential skills by traditional providers, workers who can help meet these basic requests foster the process of engagement.
- **Engagement/Peer Support –** Frequently, workers know persons who are homeless. They have an already established rapport that is key to the engagement process. Part of this rapport is a shared

understanding of what it means to be homeless, and the resulting anger, frustration and feelings of despair.

- **Positive Role Modeling** – Workers who have experienced the trauma of homelessness and are now gainfully employed bring a certain inspiration to others, especially among persons who are homeless. Having a positive role model can promote healing and well-being. It can also raise the level of optimism toward recovery. *Positive role modeling can have an overwhelmingly positive impact on individuals, programs and systems.*
- **Fighting Stigma** – Consumer workers are a major force in the elimination of stigma and discrimination. Stigma in our society continues to plague the efficacy of responses to homelessness and mental illness. Stigma, in its most virulent form, can impact the development of housing opportunities and other services required to end homelessness.

Other unique characteristics of consumer staff include the fact that consumer workers are more tolerant of unusual behavior, do not maintain a rigid distance from the people they serve, and show more empathy for individuals' struggles. Employing consumers as staff can increase the sensitivity of non-consumer staff to their clients, educate co-workers, can help to locate hard-to-find individuals and to devise creative strategies to engage homeless persons who are resistant to services. Consumers as staff have also shown a special ability to sensitively relate to and help solve problems clients face, identify with client issues and offer coping strategies, and overcome obstacles with information and referral due to their personal experience receiving services and facing these obstacles.

But as Laura Van Tosh warns, "Consumer involvement carries with it certain risks and must be done in a thoughtful manner. When the involvement is implemented correctly, such involvement greatly enhances the quality of services the patients receive." (Van Tosh, 1993). Any agency hiring consumer staff must be adequately prepared for the commitment of hiring consumer staff.

Newly hired consumer staff are faced immediately with three challenging issues: disclosure of consumer status, client-staff boundaries, and workplace discrimination (Fisk et al., in press). Due to the stigma associated with having been homeless, disclosure of consumer status to non-consumer staff and clients is an important issue for the consumer and his or her supervisor to discuss in advance. How does the consumer wish to be known? Does he or she want to disclose themselves or do they mind being identified by others. Disclosure must be carefully and creatively timed and will vary from one situation to the next. As a genera1 rule, it is suggested that disclosure not happen until one has proven his or her ability to do the job.

Second, client-staff boundaries can be a source of stress for consumer staff especially if they are a former client with the agency. This change can be hard for non-consumer staff and clinicians as well. Other difficulties include having friends who are still clients, not feeling competent enough to do the job as a former client, and other clients wanting to develop a persona1 relationship with the consumer staff person. Lastly, and unfortunately, it can be quite common for disclosed consumer staff to face some sort of discrimination – whether overt or subtle. Non-consumer staff has been known to treat consumer staff differently, with less respect, than other co-workers.

In order to help the agency and consumer staff to overcome these complications, it is important that administrators actively support unit-based or agency-wide implementation of a number of concrete strategies for encouraging consumer employment. These are: (1) education and training of non-consumer staff, (2) increased individual supervision for consumer staff, and (3) paying special attention

to the need to offer reasonable accommodation (ADA) or otherwise modify work responsibilities to meet the needs of consumer staff with disabilities (Fisk et al., under review).

While professional staff working in programs may have the ability to connect in a meaningful way with clients, they cannot replace the sense of "having been there" which consumer staff can provide. Especially for clients who have had negative experiences in the service system, many of whom have given up on getting help or are unable to trust, consumer/peer staff might mean the difference between getting off the streets and recovering or never getting off the streets and never recovering. In the homeless services industry, where so much effort is put into finding ways to reach people who are "help-resistant," I wonder why there are not more consumer-operated and/or staffed street outreach programs.

Below are two examples of programs that employ consumers as staff.

> ***Vita Nueva,*** *a Shelter* ***Plus*** *Care housing program in Arizona, is a program of Compass Health Care, a large health care facility in Tucson, Arizona. In existence for more than Jive years, the program serves 44 women and men. The 22 women in the program are in early recovery from addiction and have dependent children. All the women work including a few women who are dually diagnosed. They pay 30%* ***of*** *their income to rent.* ***Nora*** *Stark, Program Coordinator, is a formerly homeless mental health consumer who has hired two former clients* ***of*** *Vita Nueva* ***women's*** *program, one as Facility Manager, and another as a case manager. Residents meet about every six weeks to, as Stark explains, "'go over the rules, regulations and expectations we have* ***for*** *them. If there is an item that is not working* ***for*** *them we discuss it and then vote on it." Residents can vote to change such things as their own curfews, their children's* ***curfews,*** *swimming pool hours, and the laundry room rotation schedule.*
>
> ***The McCormick Institute's Center for Social Policy*** *at the University* ***of*** *Massachusetts-Boston has a central computer server connecting shelters across the state to a common computer system. "So policies formulated from this information will be based on real people who have shared information about themselves withtheir case workers," explains Donna Haig Friedman, Director* ***of*** *the Center. In* ***setting*** *up this system, privacy protection was a major issue. Consumers were engaged and paid to participate in setting up the privacy protections. They are also a part* ***of*** *the statewide steering committee. Consumers "advise us on privacy protections and have played a major role in developing our information security system," states Friedman.*
>
> *Consumer* ***staff*** *also plan and co-lead forums where case managers are trained in sensitive interviewing and in privacy protection. Recently, two consumer* ***staff*** *presented at a national conference on the role* ***of*** *consumers in data collection and analysis. The two consumers are writing a paper on consumer involvement in this project and one* ***of*** *them has developed a focus group module to inform and empower shelter residents.*
>
> *In another research project at the Center, four* ***of*** *the researchers are woman with children who have been homeless. The study will survey families on the brink* ***of*** *homelessness to find out what it would take to prevent them* ***from*** *becoming homeless. "The women really knew what questions needed to be asked and how to sensitively ask them, due to their awareness* ***of*** *the particular realities* ***of*** *the families' lives when in this situation," states Friedman. "The consumers provided something very important to the*

project. They also put a human face on the numbers." The Center does not pre-assign roles to consumers. "Each person is a very rich, complex person with lots of experiences. It is unfair to pigeon-hole them due to just one of these experiences."

Consumer-Run Programs and Organizations

Consumer-run programs for homeless people offer consumers a sense of belonging and an opportunity for growth. Consumer-run programs are empowering, offering staff and participants a wealth of information and experience. These programs show participating consumers that they can function independently and with dignity. The empowerment aspect of these programs goes beyond the staff to the people served. Consumer-run programs often cost-effective and can provide an oversight or quality control function for the systems in which they operate (Van Tosh, 1988).

Because consumers have had personal experience in the service system-getting or trying to get services-when they put together their own service organization, they try hard to tailor the system to the client's needs rather than the client's needs to the system (Van Tosh, 1990). Flexibility is key. It might mean allowing consumers the dignity to make mistakes. Instead of telling clients "no" or "we can't do that here," consumer-run programs try to find creative ways to fulfill those needs.

In practice this might mean doing system advocacy, offering new types of services, or having to find specialized funding for something no one else offers. When Project OATS in Pennsylvania, a consumer-run organization, was finding it difficult to locate adequate housing resources for clients they decided to do some system advocacy. They organized a "sleepout" to encourage the state of Pennsylvania to develop more housing for people who are homeless and have mental illnesses. The "sleepout" and related activities helped secure $5 million for residential programs for homeless persons with serious mental illnesses in Pennsylvania. When Project OATS identified a need for training and employment for homeless persons, they raised additional funds for the new project, ACT NOW.

The key principles of consumer-operated organizations as follows (Mowbray, Chamberlain, Jennings, & Reed, 1984):

- The service must provide help with needs as defined by clients.
- Participation in the service must be completely voluntary.
- Clients must be able to choose to participate in some aspects of the service without being required to participate in others.
- Help is provided by the clients of the service to one another and may also be provided by others as selected by the clients. The ability to give help is seen as a human attribute and not something acquired by education or professional degree.
- Overall direction of the service, including responsibility for financial and policy decisions, is in the hand of the service recipients.
- The responsibility of the service is to the client, and not to relatives, other providers or funding agencies. Information about the client must not be transmitted to any other party without the consent of the client, and such information must be available to the client.

These principles show a great sensitivity to the issue of consumer control, an important issue for people who, while homeless, had no control over such basic decisions as where they were going to sleep, what

they were going to eat, or when they could take a shower (Long, 1988). The following examples of consumer-run programs illustrate many of these principles.

> ***National Union for the Homeless*** *was founded in I985 by three homeless men in Philadelphia, Pennsylvania. The organization was started as an organized response to a drop-in center that was not consumer-friendly. Through successful media coverage of the demonstration, the seeds for the National Union for the Homeless were sown. Following the demonstration, a Philadelphia clergyman offered them a facility to run their own shelter. With the support of a local provider who wrote a grant proposal for them, the group received $23,000 to operate the shelter. "The men vowed that this shelter would be different," states Leona Smith, current President of the National Union for the Homeless. "What really set it apart was the fact that they focused on advocacy and social andpolitical change. "*
>
> *One of their first political victories was winning the right to vote for homeless people in Philadelphia in 1985. In 1986 they held their first national conference, where some 3,000 clergy, elected officials, homeless people, and unions came together to elect an executive director for the emerging organization. In 1989, they started the national "Housing Now " movement to challenge governments nation-wide to provide housing for homeless people. Out of this struggle, the Union founded several consumer-run housing programs. Three of these programs are currently operating: Dignity Housing West in Oakland California; Up and Out Housing in Minneapolis, Minnesota; and Dignity Housing East in Philadelphia. All three programs offer housing opportunities, job opportunities, home ownership and life skills services. The Union is also involved in doing public education and has a professionally-produced video entitled "Take Over, " funded in part by Bruce Springstein and Michael Moore, that is shown every year on PBS television.*
>
> ***The PS Project*** *in Parkersburg, West Virginia, started in 1994 as a consumer-run support group. "But from the very first meeting what kept being brought up was the lack of supportive housing. " explains Jackie Scott, Director of the program. The only options people had were groups homes where their whole life would be controlled or independent living with no supports. One and a half years later, the PS Project became a consumer-run residence for homeless persons with serious mental illness. The house, which can accommodate eight people, has no staff other than Scott who oversees the finances of the project and does not provide any mental health services. Ten hours per month of volunteer work is required of each resident to maintain the residence. Residents also help each other with daily living skills, plan community and other fun events, and encourage each other to prepare for independent living.*
>
> ***INCube.*** *Another innovative idea that has arisen in response to the need for more consumer-run organizations is the creation of organizations whose goal is to help other consumer-run projects get off the ground. One such example is INCube, a not-for-profit agency in New York City whose purpose is to "incubate " consumer-run businesses and non-profit service organizations. Since its inception in 1988, INCube has assisted more than 80 consumer-run businesses to provide full or part-time employment for persons with serious mental illness. Several of these new projects are focused on homeless people, both families and single adults. With 14 paid staff and finding from the state*

and city departments of mental health as well as foundations, INCube is completely consumer-run.

One program supported by INCube is **INCA Housing.** INCA Housing is a consumer-run 50-unit scattered site housing program for homeless families and individuals in the Bronx. Run directly by consumers of mental health services, INCA 's highly trained managers assist clients with public benefits, finding and keeping housing, interfacing with treatment teams, and providing oversight to ensure quality of living for tenants. INCA also sponsors a community program to provide networking, linkage and employment opportunities through involvement in small enterprises such as a thrift shop and a catering business (Conrad, 1993).

Hands on **the Homeless** in Columbus, Ohio, is an all-volunteer, consumer-run, non-profit founded by a formerly homeless woman, Stacey Wright. The organization's mission is to support people who are homeless by going into shelters to give self-esteem talks, help with job training and referral, and offer follow up once a family or individual leaves the shelter. "We are their best supporters because we have been there," states Wright. "People tend to trust us and open up with us more than with the shelter staff." The organization, founded in 1997, currently has 30 volunteers and offers support only to people who are receptive. Wright serves on a city-wide board for homeless providers which helps her learn about new ways for Hands on the Homeless to help. "The providers are very welcoming," Wright adds. "Some come to us and ask us to give a speech or talk to someone."

The Homeless Empowerment Advisory Project (HEAP) is a program run by homeless, or formerly homeless persons, with serious mental illness. Funded by the Massachusetts Department of Mental Health through a $20,000 grant, HEAP has been in existence for about six years and is affiliated with the Ruby Rogers Drop-In Center (see below). The project operates with one paid staff person and IO stipend positions. Members make all decisions regarding activities and other projects of HEAP. Weekly advisory board meetings are held for members to discuss issues related to living in the shelters. HEAP sponsors a number of social and recreational activities for members and organized a consumer-run smoking cessation program. HEAP also has an arrangement with the Cambridge Adult Education Center where members can take courses at no charge.

Since **1985,** the **Ruby Rogers Drop-In Center** in Somerville, MA, has provided a comfortable, safe and non-threatening place where Center members can find mutual support and advocacy for each other. Open seven days a week, the Center has approximately 200 members-nearly half of whom are homeless-and receives between 20 and 45 people each day. The Center offers a variety of social and educational opportunities for its members. There are currently three paid staff and 16 stipend positions. Workers will accompany members if they need support during a court appearance, a visit to the Social Security office or some other kind of support. The Center will also work with members to help them learn how to work while receiving Social Security benefits. All the rules and decision-making for the Center are made by the membership during weekly business meetings. The Center is funded through the Massachusetts Department of Mental Health andprivate donations.

Consumer-run organizations will face considerable barriers when blazing their way onto the human services scene. Many of these barriers are faced by all programs for homeless persons, but they may be made even more difficult due to public skepticism about the ability of consumers to operate programs. One of the most common difficulties is finding a location for consumer-run programs in the face of resistance and stigma from the surrounding community. Communities do not want those "crazies" or "bums" in their neighborhood. Unfortunately, the "not in my backyard" syndrome is still with us when it comes to people who are homeless. But when communities find out that former clients will be running the program as well, community resistance may grow even stronger.

In Parkersburg, West Virginia, the PS Project is faced with the fact that the local authorities do not want to fund the program (once the three-year demonstration grants end) simply because they are consumer-run. In Sacramento, California, the only drop-in center for homeless people was closed because of neighborhood pressure. In Portland, Maine, it took two years for the Portland Coalition to find handicapped accessible office space. From the perspective of the public, "it was bad enough that the program was for people who were mentally ill, but it was run by people who were mentally ill, too," Director Dianne Cote has reported (Long, 1988).

While there has been a good deal of experience in siting residential programs for people who are mentally ill in communities, there is little experience in establishing consumer-run programs against local opposition. Although most programs build good relations with surrounding communities once they are established, discrimination based on fear continues to be a serious challenge to the ability of consumer-run programs to establish themselves (Long, 1988).

Other challenges consumer-run programs face include (Long, 1988):

- **Severe shortage of low-cost housing coupled with supportive services.** In Philadelphia, Hikmah Gardiner, Director of the consumer-run Dew Drop-In Center, estimates there are 45,000 vacant properties in the city and about 15,000- 20,000 homeless or near homeless people in need of adequate and affordable housing. In Massachusetts, there are over 3,000 people awaiting housing from the Department of Mental Health alone. This is a nation-wide phenomena. Clearly, not enough is being done to alleviate the problem.

- **A lack of a steady, adequate income for clients.** Even when a client has an income, in most communities there is little or no housing that can be afforded at the income levels provided by either entitlements or low-paying jobs, hence they may be forced to live in shelters or on the streets. Although food may be available through food programs, scheduled meals may be intermittent rather than regular, and essential personal sundries cannot be bought without cash, nor can they be purchased with food stamps.

- **Difficulty in obtaining adequate and secure funding for the programs.** Consumer-run programs tend to be funded either inadequately or on a demonstration basis. Programs funded on a shoestring budget often depend on staff members to work full-time on a one-quarter salary. Other staff members on Supplemental Security Income work for stipends. If they took the small salary offered for full-time work, they would have to forsake their benefits, and would be unable to pay for housing, food, medication, health care and other necessities.

  Programs funded adequately on a demonstration basis, face little prospect of being renewed by the same funding source at the end of the period and they are left with no replacement source in sight.

Moreover, due to a lack of information and technical support for these newly emerging programs, many are not adequately prepared to deal with how to access ongoing funding. Also, receipt of funds for some of these projects is often delayed while the payment voucher snakes its way through the bureaucracy. New programs, especially those that are consumer-run, are much less able to find ways to carry staff members, landlords and suppliers until the funds arrive.

- **Gaining cooperation from traditional mental health and social service agencies.** Being accepted as colleagues by professionally-staffed organizations and agencies can be a major challenge. All new organizations must find this acceptance, but consumer-run organizations probably face this challenge to a greater degree than others.

Recommendations For Increasing Consumer Involvement

The recommendations below are designed to increase the level of involvement by homeless and formerly homeless persons in policy, practice and research on homelessness. The recommendations are clustered around the four key themes found in the literature: (1) increasing consumer involvement on decision-making boards, (2) hiring consumers as staff, (3) funding consumer-run programs, and (4) providing technical assistance on how to involve consumers.

Increase Consumer Involvement on Decision-Making Boards

- Require funding sources on the local, state and national level, such as HUD and the McKinney grants, to require substantive consumer participation in the dispersion of these moneys.

- When involving consumers on boards or community meetings, there should always be more than one consumer present. To ensure that organizations receiving McKinney funds involve consumers, the federal government could: (1) require it as part of the application procedure, (2) make it part of the scoring process, (3) add penalties to organizations that do not involve consumers in a meaningful way, and (4) discuss the issue when monitoring grantees.

Hire Consumers as Staff

Broaden employment opportunities for persons who are or have been homeless at the local, state and federal level. This is especially important for homeless people with mental illness or substance abuse problems who have the greatest difficulty exiting homelessness and are most at-risk for becoming homeless again.

- Examine and modify Medicaid regulations to allow formerly homeless persons with mental illnesses and persons recovering from substance abuse to be hired to perform Medicaid reimbursable services (Van Tosh, 1993).

- Include employment of consumers in the affirmative action statements of organizations serving homeless persons (Van Tosh, 1993).

- Offer incentives, including financial, to private non-profits serving homeless people who successfully involve consumers in their agency. Good consumer involvement means the

organization employs consumers at all levels of management and solicits consumer input on policy, programs, administration, and evaluation.

- Make it easier for formerly homeless persons with disabilities to work by gradually working their way off SSI/SSDI benefits. Eliminate work disincentives, while ensuring that should they become ill again, they will be able to receive benefits. This is especially important for people who have mental illnesses, which can be cyclical (i.e., symptom-free for months or years with on-going treatment) and life-long.

- Enable homeless people with disabilities who go back to work (and no longer receive a benefits check), to keep Medicaid/Medicare for as long as they need it. Many disabled persons cannot go back to work because their employer's health insurance will not cover the costs of treatment for their chronic physical or mental disorder.

Fund Consumer-Run Programs

- Mandate that state and local agencies allocate a minimum proportion of all federal funds for homeless housing and services to consumer-run initiatives, programs and organizations, including money targeted for the development, research, evaluation and replication of these programs and services.

- Mandate that county, state and federal continuation funding be assured for consumer-run demonstration projects that are successful and meet the goals and objectives set forth by funding agencies (Van Tosh, 1990).

Provide Technical Assistance on How to Increase Consumer Involvement

- Organize a federal task force to develop a framework for increasing consumer involvement in federally-funded programs (Salzer, 1997).

- Create federally-funded non-governmental organizations to provide support and technical assistance to consumer-run organizations when requested (Tyler, 1976; Van Tosh, 1993).

- Create an annual consumer involvement award to recognize consumer-run and professionally-run organizations for outstanding achievements in the area of consumer involvement.

- Sponsor a booklet put together by people who have experience starting consumer-run program?. The booklet should provide a listing of groups that have been through the process and are willing to talk to others who are just beginning. The booklet can also present problems groups can expect to run into and how to overcome these problems

- Sponsor federal public education campaigns to reduce stigma and to promote greater awareness and understanding of homelessness. Allocate adequate funding to these campaigns so that promotional material and events (i.e., brochures, posters, stickers, radio and television commercials, speakers bureau) are available free of charge nationwide to interested parties wanting to promote the campaign.

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To Dance With Grace: Outreach & Engagement To Persons On The Street

by
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Abstract

Outreach and engagement strategies are critical in helping homeless persons transition from the streets into housing and services. A literature review was conducted and commonalities across populations were found (although the preponderance of literature describes homeless persons with mental illnesses). Definitions, exemplary practice models, values/principles, worker stances, measurable outcomes, and multi-level factors relating to outreach and engagement are presented as well as issues related to research and funding.

Lessons for Practitioners, Policy Makers, and Researchers

- Outreach work is based on a foundation of strong values, principles and unique worker stances
- Engagement is the key in Outreach
- The homeless persons outreach is designed for are those who unserved or underserved by existing agencies and who aren't able or willing to seek services from those agencies
- The goals of outreach are to develop trust, care for immediate needs, provide linkages to services and resources, and to help people get connected to mainstream services and ultimately into the community through a series of phased strategies
- Effective outreach has been demonstrated, with positive outcomes
- Peer based outreach and the use of the expertise of homeless and formerly homeless persons and consumers are valued and should be actively sought out
- Discrimination and marginalization are part of the experience of both outreach clients and workers; as a result, advocacy must take place at all levels
- Outreach services cannot exist in isolation from larger systems: both homeless systems and mainstream systems at community, state, and federal levels
- Outreach services must be included, required, valued, and funded as part of a national and local continuum of care
- More research, including controlled and longitudinal studies, are needed particularly in answering the question of what factors promote success in helping people access mainstream services and resources across homeless outreach populations

The process of outreach and engagement is an art, best described as a dance. Outreach workers take one step toward a potential client, not knowing what their response will be-will the client join in or walk away? Do they like to lead or follow? Every outreach worker has a different style and is better at some steps than others. To dance with grace, when the stakes are high, is the challenge for all of us.

In the U.S., we now have the benefit of more than ten years of McKinney funding which has made possible scores of outreach programs across the country. Rural and urban, small and large, comprehensive or finite, they reach out to people who are homeless and challenged by poverty, violence, marginalization, poor health, mental illness, substance abuse, and other issues.

This paper will provide definitions; exemplary practice models, including worker stances, values/principles, outreach functions and services, outreach across populations; measurable outcomes; and an extensive bibliography for further inquiry. The preponderance of available literature was published in the late 1980s and early 1990s, and focuses on mental health-related outreach programs. The few outreach-related articles published in recent years perhaps reflect the greater use, acceptance, and integration of existing outreach programs as part of a community's effort to provide a "continuum of care" to persons in need. This paper will present both a review of the literature and experiential information relating to best practices.

Priority Home! (1994) describes the federal plan to break the cycle of homelessness by "public and private mental health, medical, and substance abuse service-providers to initiate street outreach efforts, the utilization of safe havens . . . and implementation of a continuum of care..." This federal validation of outreach as an accepted and expected part of a community solution to homelessness, which includes access to housing and services, recognizes the unique efforts of outreach workers across the country.

Definitions

Outreach is the initial and most critical step in connecting, or reconnecting a homeless individual to needed health, mental health, recovery, social welfare, and housing services. Outreach is primarily directed toward finding homeless people who might not use services due to lack of awareness or active avoidance (ICH, 1991; McMurray-Avila, 1997), and who would otherwise be ignored or underserved (Morse, 1987). Outreach is viewed as a process rather than an outcome, with a focus on establishing rapport and a goal of eventually engaging people in the services they need and will accept (ICH, 1991; McMurray-Avila, 1997). Outreach is first and foremost a process of relationship-building (Rosnow, 1988) and that is where the dance begins.

Engagement is a crucial process for successful outreach. It is described as the process by which a trusting relationship between worker and client is established. This provides a context for assessing needs, defining service goals and agreeing on a plan for delivering these services (Barrow, 1988, 1991; ICH, 1991; Winarski, 1994). Some clients require slower and more cautious service approaches (Morse, 1987). The engagement period can be lengthy-and the time from initial contact to engagement can range from a few hours to two years (ICH, 1991) or longer. Effective workers can "establish a personal connection that provides a spark for the journey back to a vital and dignified life" (Winarski, 1998).

Assumptions Of Exemplary Programs

Based on a review of the literature and best practices found in the field, the following are important elements to address in a good outreach program: characteristics of the population served, values and principles, worker stances/characteristics, and goals of outreach.

Programs cannot assume is that all communities have the same percentages of "types" of homeless people. There is a range in the population that may differ from one region to the next. Rather than basing interventions on formulaic assumptions such as "1/3 mentally ill, 1/3 veterans, 1/4 families," each community needs to assess the characteristics of it's homeless persons, identify service gaps, and develop effective responses. For example, in one city 80 'percent of the homeless were single men, while in another, 65 percent were families with children (U.S. News & World Report, 1988).

Characteristics Of Homeless Persons Needing Outreach

Outreach programs attempt to engage individuals who are unserved or underserved by existing agencies (Axelroad, 1987). This distinction is significant because the outreach model was developed to meet the large service gap found among this unique population. An outreach model is unnecessary and even counter-productive with other populations.

Outreach programs serve persons who may have psychiatric disorders and/or substance abuse issues. They may be highly vulnerable and considered "difficult to serve" (Rog, D.J., 1988). They usually cannot negotiate the requirements of or trust traditional service-providers. These persons may have poor health, lack insurance, and are unable to make or keep medical appointments and follow through with complex medical regimes. Homeless youth may be those who are estranged from family and fearful of adult service-providers. Homeless youth are perhaps the most vulnerable group of youths, and are in need of creative and early interventions, in order to prevent an acclimation to street life which includes prostitution, substance abuse, and crime. Further, homeless teems with children are viewed as perhaps the most vulnerable of homeless families (Bronstein, 1996).

Two factors commonly associated with homelessness among women include pregnancy and the recent birth of a baby. Homeless pregnant women experience a range of problems including poverty, isolation, substance abuse, and histories or past and present victimization. A lack of prenatal care and poor nutrition may also exacerbate health problems (Weinreb, et al., 1995).

Other groups include the elderly, women escaping domestic violence, families, and marginalized persons such as those who are transgendered and those in the sex industry.

Many of the people outreach programs attempt to serve are isolated, have minimal resources, minimal access to social services (Sullivan-Mintz, 1995; ICH, 1991), have had negative experiences with service-providers (McMurray-Avila, 1997), and have been victims of violence (Goodman, et al., 1995; Weinreb, et al., 1995). Workers give priority to those who are most at-risk who are least likely to seek out and successfully access available services, for whatever reason: fear, mental status, lack of insight and motivation, or low self-esteem. Rog (1988) describes the need to reduce barriers to service-utilization and facilitate the engagement process. Workers may also encounter persons who are able to access services and can help by providing one-time information and direction, but the focus is on the former group.

Values & Principles Of Outreach

Successful outreach programs must be based on a core set of values and principles which drive interventions. Values and principles also serve to set the stage for developing realistic goals in an arena of limited resources and potentially slow progress.

- A person orientation: Exemplary programs possess a philosophy which aims to restore the dignity of homeless persons, dealing with clients as people (Axelroad, 1987; Wobido, 1990).
- Recognizing clients' strengths, uniqueness, and survival skills.
- Empowerment & self-determination: (Sullivan-Mintz, 1995) Workers can facilitate this by presenting options and potential consequences, rather than solutions (Rosnow, 1988), by listening to homeless persons rather than "doing" for them, and by ensuring a balance of power between homeless individuals and outreach workers (Rosnow, 1988).
- Respect for the recovery process (Winarski, 1994): Behavior change is on a continuum. Small successes are recognized. Any move toward safer/healthier activities is viewed as a success. Clients need to recognize for themselves how change may be beneficial, in relation to their own goals.
- Client-driven goals (Winarski, 1994): Services and strategies are tailored to meet the individuals' unique needs and characteristics (Morse, 1987). Workers start with clients' perceived needs and go from there.
- Respect (Cohen and Marcos, 1992): Workers are respectful of people, including their territory and culture. Outreach workers view themselves as a guest and make sure they are invited, welcome, or at least tolerated. Workers must take care not to interrupt the lifestyle of the people they are trying to help. Lopez (1996) makes the point that clients don't lose the right to be left alone in the privacy of their home even when that client calls the streets home. Clients are viewed as the experts in their life and on the streets. The worker takes the role of consultant into that lifestyle.
- Hope: Workers instill a sense of hope for clients while helping them maintain positive, realistic expectations. Unrealistic expectations may bring on clients' cycles of frustration, despair, and hopelessness, as well as anger at the outreach worker. The worker restores hope in clients who have faced years of disappointment as well as reframes raised expectations. The worker needs to communicate to the client that changes may take considerable time, effort, and patience (Morse, 1991).
- Kindness: People are always treated with warmth, empathy and positive regard, regardless of their behavior or presentation.
- Advocacy: Workers advocate for social justice on many levels.

Outreach Worker Stances/Characteristics

There are common worker stances/characteristics found among successful outreach workers and programs. These characteristics are critical because successful engagement will largely be determined by the relationship between clients and workers. Effective worker stances/characteristics include:

- Good judgment, intuition and street sense: this includes safety for themselves and the client-being observant and vigilant, as well as using good common sense. Strategies include going out with a partner, avoiding closed, remote or dangerous areas, developing a relationship with local police (Winarski, 1998), carrying a cellular phone, dressing appropriately, and assessing situations before acting.
- Non-judgmental attitude (ICH, 1991): Regardless of the worker's personal beliefs, no behavior on the part of the client is morally judged.

- Team player: Workers must know when to ask for help, from getting backup on the streets to a second opinion in clinical assessments. Outreach staff must have a strong commitment to the "team" approach to service delivery (Axelroad, 1987; Wobido, 1990).
- Flexibility (Rosnow, 1988;ICH, 1991): Outreach workers are flexible in reassessing daily work priorities, in setting work schedules, and in the treatment planning process (Morse, 1987), and content.
- Realistic expectations: Workers have an "expectation of non-results." They understand that they will not be able to "cure" or "save" clients (Axelroad, 1987; ICH, 1991), and at the same time continue to persevere.
- Commitment: Outreach workers are both consistent and persistent in their dealings with clients (Axelroad, 1987; Wobido, 1990). They do what they say they are going to do and only make promises they can keep (Sullivan-Mintz, 1995). They are in it "for the long haul" and continue to persevere.
- Less is more. At the outset of intervention, there is less application of intensive and costly treatment, less professional distancing, less rigidity, less intrusiveness, and less directiveness (Rosnow, 1988). Services offered are purely voluntary (Cohen, 1989).
- Altruism: Staff find rewards in doing outreach work, such as a spiritual commitment to helping others, furthering an academic interest, or simply enjoying the process of working with individuals (Axelroad, 1987).
- Sense of humor: the ability to use humor at appropriate times, as well as maintaining as sense of humor during difficult times is essential.
- Creativity & resourcefulness are strengths that outreach workers tap into daily.
- Cultural competency: Workers demonstrate competence across ethnicity, gender, transgender, lifestyle, and age spectrums.
- Resilience: Workers are resilient and patient in a work environment marked by high turnover, difficulty tracking clients (McQuistion, et al., 1996), high stress, lack of resources, and lack of immediate improvement in the clients they serve. Effective workers are able to continue working despite the difficulties endured by their clients, without personalizing them.

Outreach programs vary in relation to considering credentials, ethnicity, or gender when hiring outreach workers. People with a variety of backgrounds may function as mental health outreach workers: physicians, social workers, nurses, nurse-practitioners, and para-professionals. Some programs employ formerly homeless persons with mental illnesses (Axelroad, 1987; Morse, 1987). A survey of ACCESS programs reported that 75 percent of programs do not require a bachelor's degree for an outreach worker. More important were characteristics such as a personal commitment to the work, flexibility, and a willingness to adjust schedules to the needs of the clients (Wasmer, 1998).

Some programs state that it is not necessary to have workers of the same ethnicity, cultural background or gender as the clients, nor who have a lot of street experience. They further state that the only essential characteristic is a common language (Axelroad, 1987; Nasper, 1992). However, an outreach team of two males in Milwaukee found that they had served 80-90 percent men and had difficulty establishing trust with homeless women. As a result, they now have mixed gender teams (Rosnow, 1988). Agencies promote an equal opportunity atmosphere, and the staff composition mirrors that of the general population.

Many outreach programs successfully use mental health consumers as outreach workers (Tosh, 1990 and 1993, and Lieberman, et al., 1991) and/or formerly homeless persons (Mullins, 1994). The benefits of such peer models allow for effective outreach, sharing of their personal expertise, fostering of partnerships between consumers and non-consumers, increased self-esteem of the working peers, and the

evolution of consumers becoming active in changing services throughout the country. **Consumers/peers/formerly homeless persons can contribute significantly in the development of program design, implementation, and evaluation. Their expertise should be actively sought out by outreach programs. To be sure, homeless persons and formerly homeless persons have expertise, skills, and insight that professionals who have never experienced homelessness lack.** Programs recognize that peers working in homeless and mental health fields often endure the pressures of maintaining their own housing and overcoming stigma (Tosh, 1993), allow for reasonable accommodations to assist them, and offer training and on-going meetings (Leiberman, et al., 1991).

Goals of Outreach

There are four main goals of outreach found across different areas of outreach client populations. The first is to care for immediate needs (Plescia, 1997), including to ensure safety, provide crisis intervention, refer to immediate medical care, and help clients with immediate clothes, food, and shelter needs. Workers must develop a trusting relationship (Plescia, 1997; Cohen and Marcos, 1992; Sullivan-Mintz, 1995) in order to achieve the additional goals of providing services and resources, whenever and for as long as needed (Winarski, 1998). Lastly, workers aid in connecting clients to mainstream services (Plescia, 1997).

An inherent factor related to these goals is the notion of phasing. Objectives are developed and reached over a period of time with small steps that are directed to a more structured, service-oriented goal. Persons often phase from accepting food from the outreach worker, to developing trust, to discussing a goal that in part can be achieved through services provided in the community and to accepting those services. Case management goals are gradually developed by both the client and worker. Outreach and engagement principles carry over into case management and are viewed as an ongoing process. As trust develops, clients take a more active role in setting and achieving case management goals. Ultimately, the goal is to successfully phase or integrate persons into the community and/or into a social service agency (ies) which would assume the task of promoting community integration. Just as clients are phased into outreach services from the streets, they are phased into the community from outreach.

Outreach Service Structure

There are at least three ways of classifying outreach models found in the literature. One set looks at a linkage model versus a continuous relationship model. A second set looks at a mobile versus fixed model. A third set describes models based on a service continuum.

Linkage vs. Continuous Relationship Model

Some outreach programs serve as linkages, referring clients to mainstream mental health or other service-providers. Examples of "find and link" programs are New York's Project HELP, which conducts in-vivo assessments and delivers people to the psychiatric hospital by voluntary and involuntary means, and Chicago's Mobile Assessment Unit (MAU), that visits shelters and streets to identify mentally ill persons and link them to resources (Wasmer, 1998). Other examples may include linking temporarily displaced families with housing.

Linkage-only programs that do not provide follow-up tracking have been determined to be ineffective for some disabled populations. A 1986-87 study of 13 federally funded homeless mental health demonstration programs reported that most outreach programs were running ineffective models. Many spent the majority of their time in screening and identifying individuals and providing verbal referrals,

but little follow-up assistance. One project contacted 430 eligible persons, yet only 22 received follow-up mental health treatment. Five found housing and three received entitlements (Hopper, et al., 1990 in Morse, 1996).

Providing linkage-only services to certain homeless populations can lead to barriers and service gaps, resulting in lost clients. Morse (1991, 1996) suggests strategies to increase the effectiveness of this model: incorporate the expectation of an eventual service-provider transition early in the engagement and service-planning with a client; remain involved and actively involve the client in the referral process, including scheduling appointments, arranging transportation, and providing emotional support; work with the linkage site staff, informing them about client needs and characteristics; provide follow-up support as needed to both client and new staff; and provide advocacy on behalf of the client if needed.

In a continuous relationship model, workers perform outreach and continue on as the person's case manager. Outreach has been shown to be a necessary component of ongoing case management for mentally ill clients. Axelroad and Toff (1987), point out the difficulty in distinguishing outreach from case management for homeless mentally ill persons for two reasons. First, the fragility of the population requires trust and continuity of care when helping clients move from an outreach phase to a treatment phase. Second, outreach workers must often provide case management services because of the frequent shortage of appropriate and relevant case management services for which to refer clients.

The drawbacks to the continuous relationship model are small recommended caseloads, 10: 1, which may be unrealistic for many agencies, and little capacity to outreach with new clients (Morse, 1991, 1996). However, the approach has been shown to be effective at maintaining contact with clients and housing retention (Morse, 1996). In addition, outreach workers may prefer the excitement, lack of structure, and immediacy of outreach. For this and other reasons related to individual personality traits, some outreach workers may not be as effective as case managers.

At Safe Haven in Honolulu, outreach workers opted for the continuous relationship model out of necessity when they were unable to transition "graduated" residents to case managers at the community mental health centers. Historically, the engagement strategies used in interaction between clients and outreach workers have been substantially different from strategies used at traditional service settings, leaving clients with little incentive to transition to a less user-friendly service-provider. Outreach roles expanded to encompass case management and advocacy, and they remained connected with clients through follow-up. Perhaps as a result, a majority of Safe Haven clients have successfully transitioned into the community. In Safe Haven's first 28 months, 43 residents transitioned from the program-63 percent into permanent independent housing, with 98 percent of these retaining their housing.

Mobile vs. Fixed

Outreach may be mobile or fixed depending on the needs of the target population (Sullivan-Mintz, 1995). Outreach may take place on the streets, as well as in shelters, drop-in centers, emergency rooms, hospitals, and jails (Axelroad, 1987; Morse, 1987). The mobile model requires that the projects be "equipment heavy," including agency vehicles/vans, employee cars, and communication systems such as pagers, cellular phones, and walkie-talkies (Wasmer, 1998).

Fixed-site outreach programs such as drop-in centers or day programs for the mentally ill, within high-density homeless areas, can be more easily accessed by greater numbers of clients, increase staff efficiency, and can provide additional incentive services. Many outreach programs have both a mobile

and fixed-site component (Morse, 1987). In a survey of eight ACCESS programs, 77 percent of clients were engaged by mobile methods and the balance at drop-in centers. (Wasmer, 1998)

For certain clients with primary substance abuse issues, mobile outreach is more successful for several reasons. There is less stigma and community opposition when outreach workers meet clients individually on the streets rather than having clients come to a centralized location. Another reason is that clients who are high or intoxicated are often asked to leave fixed service sites.

Outreach Continuum

Wasmer (1998) describes a link/serve continuum, with outreach programs that "find and link" or "find and serve." The latter include case management programs, assertive community treatment and intensive case management programs, drop-in centers, shelter-based programs, and low demand residences/safe havens. Of eight ACCESS outreach programs Wasmer surveyed, all were the "find and serve" type.

The Team Approach

Different types of team approaches are described in the literature, depending on the mission of the team. They may focus on emergency psychiatric intervention, case management, health care, HIV education/prevention, harm reduction for sex industry workers, substance users, and others.

With mentally ill persons, using a team approach after engagement has been established assures that a client will learn to develop trusting relationships with several staff people. It also increases the likelihood of being able to attain assistance when necessary. Teams can include or have access to social workers, nurses, nurse-practitioners, substance abuse staff, medical and psychiatric consultants, and other outreach specialists. The team approach can also aid in combating bum-out and expanding caseloads (Axelroad & Toff, 1987) **and the inherent sense of isolation individual outreach workers can feel.** A study of five New York outreach programs showed that 98 percent of homeless mentally ill clients had a significant relationship with more than one staff member, indicating that involvement with the programs did not consist only of the client's relationship with a single worker (Barrow, 1988).

One survey of eight ACCESS-funded outreach programs reported that all sites used a team approach, with majority of first contacts made by two mental health professionals, one taking the lead and one observing (Wasmer, 1998).

Exemplary Outreach Functions/Services

Based on a review of the literature (Winarski, 1994, 1998; ICH 1991; Morse, 1996) and review of best practices in the field, several outreach functions/services are common among exemplary outreach programs.

Determine the Target Population

Outreach programs cannot serve all potential clients. Exemplary programs have clearly defined program goals and objectives. Some programs target a subset of the population, such as persons with mental illnesses, and others limit outreach to a particular geographic or "catchment" area (ICH, 1991).

If geographic limits or catchment areas are a defining factor in determining the target population, then the size of the area allows for repetitive contact. Knowing fewer clients better is the goal. Workers have the

flexibility to leave this zone and follow their potential clients elsewhere (McQuistion, 1996). If a client is determined to be out of the mission of the outreach program, provisions can be made for referring non-target clients to the appropriate programs. (ICH, 1991).

Locate Street Dwellers

Once workers identify the target population, the next task is to locate them. Individuals can be found under bridges and freeway overpasses, alleys, parks, and vacant lots. In rural areas or on the fringes of urban areas, outreach workers may go to the beaches, riverbanks, foothills, wooded areas or desert. They may be in public facilities such as libraries, airports, and bus stations. They may be in places where people live on the edge of homelessness, such as welfare hotels, cheap motels, and SROs. Some teams have special arrangements with jails, detox/treatment programs or other institutions, to enter and make contact with ongoing clients or potential clients regarding available services on their release (McMurray-Avila, 1997).

Sometimes homeless persons will serve as voluntary scouts for outreach workers, alerting them to homeless persons who appear to be in need of intervention. Volunteer homeless persons can also help outreach workers locate clients who have been missing for some time. Outreach coalitions, comprised of outreach workers from different agencies, can meet periodically and help each other locate missing clients, as well as help each other stay on top of recent trends in geographic concentrations of homeless persons.

Outreach conducted by peers, such as youth, substance users, or sex industry workers, can be effective in locating, engaging, and completing assessments of the clients perceived needs. When going out in teams with non-peer professionals, they are able to introduce professionals to participants on the streets. **Youth who serve as peers/mentors for other homeless youth, for example, help convey a sense of understanding of the factors that may have led them to becomes homeless such as abuse and share resource information, teach safety, and help make a bridge between street life and the world of "professional" adults whom they generally don't initially trust.** Hiring program participants encourages increased feelings of self-esteem and empowerment on the part of participants and generates empathetic, effective outreach staff (Mullins, nd). **An effective outreach program for at-risk HIV youth in the sex industry in New York provides training to peer youth outreach workers, a support group, an active and real voice in program development, and a stipend for their work. These youth outreach workers have been successful in saving lives and reducing risk associated with their lifestyle and that of their peers in a way that adults could not have.**

Engagement

Engagement is a crucial, on-going, long-term process necessary for successful outreach (Morse, 1991, 1997). In a study of five New York outreach programs, homeless mentally ill clients first contacted by outreach workers were engaged an average of 3.9 months before intensive services began (Barrow, 1988).

Engagement reduces fear, builds trust, and sets the stage for "the real work" to begin (Cohen, 1987). Morse (1991) classifies engagement in terms of four "stages": 1) setting the stage, 2) initial engagement tactics, 3) ongoing engagement tactics, and 4) proceeding with the outreach/maintaining the relationship.

Setting the stage: Workers become a familiar face and begin to establish credibility in places where homeless persons frequent (Morse, 1991). They use a non-threatening stance/approach (Cohen and

Marcos, 1992), and get some kind of permission from the client, either verbal or non-verbal, before approaching. In these early stages, workers gently cease interactions that appear too overwhelming to clients and try again later.

Initial engagement tactics: Workers attempt to engage the potential client in conversation, beginning with non-threatening small talk (Morse, 1991). This allows workers to assess for signs of problems and also the impact of the interaction. Is the client feeling intruded upon (Morse, 1991)? Workers provide incentive items (Cohen, 1989; Cohen and Marcos, 1992) such as food, drinks, condoms, cigarettes, vitamins, toiletries, etc., with real and perceived benefits that promote trust.

Ongoing engagement tactics: Workers begin to "hang out" and "share space" with clients (Morse, 1987). As clients become more comfortable, workers begin to provide or help the client to meet some important needs that can be easily solved or obtained. This might include providing transportation to get clothes, linking the client with medical care, and providing incentive services that are based on clients' perceived needs (Cohen, 1989). Engagement strategies used in the initial phase continue.

Proceeding with outreach/maintaining the relationship: As trust is established, workers help clients define service goals and activities, which may include the pursuit of housing, income, and medication (Morse, 1991). Staff accompany clients to appointments, help them prepare for upcoming tasks, and assist in the negotiation of service settings.

At Honolulu's Health Care for the Homeless Project, staff use six simple engagement strategies in their interactions with diverse groups.

- Treating people with positive regard, by demonstrating that workers are glad to see them and care about them. Workers remember details of past encounters and discussions. Workers are honest, humble, and share information about themselves when appropriate, to equalize power and respect.
- Working with their perceived needs
- Providing incentive items and services, as listed above.
- Letting clients set the pace whenever possible
- Communicating effectively, both verbally and non-verbally. For example, workers get to the client's level. If the client is sitting on the curb, the worker sits on the curb. Workers gauge the expression of language so that it fits with that of the client's in terms of vocabulary, speed, eye contact, and culturally relevant responses.
- Being creative. For example, an outreach dog is used by one worker. A pet is a great ice-breaker and has been effective in connecting with some paranoid and very isolated mentally ill persons. One woman who would previously never speak to workers, will now talk to the dog (but still not to the worker), providing opportunities for ongoing assessments, and topics for future discussions. Staff use art as an engagement tool, and incorporate client interests, like hobbies, books, and collections, in incentive items and discussions. When possible, outreach workers transfer engagement strategies on the streets to the clinics, where clients can receive further care. For example, a drawing by a client on the streets might be displayed in the clinic where pertinent services are offered. **Other effective programs use creativity as an outreach foundation and reach out and engage homeless persons through such non-traditional approaches as the use of theater, the arts, and creative grass-roots community organizing.**

Assessment

Workers need to conduct an assessment of an individual's comprehensive, holistic needs before providing services and linkages to meet these needs (Morse, 1987). The assessment process is informal and usually takes place over time. Outreach workers, rather than asking direct questions, may make inferences (Cohen and Marcos, 1992) about an individuals' mental and physical state. As the relationship builds, workers may be able to ask more direct questions as they try to get more history.

The crises faced by many homeless persons are usually related to basic survival, such as lack of food and water, lack of clothing, exposure, poor health, and deteriorated mental status. Outreach workers must initially provide basic triage assessment to help identify and respond to potential life-threatening problems.

When clients are experiencing potentially life-threatening problems such as dangerousness to self or others, serious medical problems, or exposure to extreme cold or heat, outreach workers must be prepared to intervene. Whenever possible, workers should encourage clients to voluntarily accept treatment, and present this treatment within the context of the client's perceived needs. When the situation is life-threatening, workers should be prepared to initiate involuntary treatment or interventions that will reduce harm. Clinical supervision in this situation is highly recommended so as to not infringe upon clients' rights and self-determination.

Provide Basic Support

In response to a lack of homeless persons being able to get their basic needs met, workers help them to access food, clothing, shelter (Axelroad, 1987), showers, laundry, and basic medical care. **In some cases, homeless persons may not perceive these as basic needs, particularly in the case of those with severe mental illness who have decompensated and/or those with chronic substance use problems. They may perceive other needs as more important. In these cases, workers can educate people about the resources available when they're ready for them, encourage them to use them when needed, accompany them to the service sites, and suggest what may be a marriage of the worker's perception of what the homeless person may need, and what the person him/herself feels they need.**

Linkage

Outreach programs should attempt to engage individuals who are unserved or underserved by existing agencies, and link them to resources. Many persons who are homeless are unaware of what is available (McMurray-Avila, 1997). Effective workers learn about available resources and establish working relationships with the people who provide these resources. Workers also tap into the knowledge of other homeless persons, who are often more aware of details and subtleties of changing resources. **Effective workers are able to make durable linkages across systems: homeless/non-homeless systems, youth to adult systems, and across private and public systems. When these systems aren't user friendly to homeless persons, workers advocate for change.**

Advocacy

Clients who are disenfranchised and discriminated against, often need outreach workers to assume an advocacy role on their behalf. **This occurs on many levels such as when helping clients access benefits and services to which they are entitled, within the outreach worker's own agency, and within the criminal justice system. Indeed, in many communities, political views about**

homelessness are resulting in what may be perceived as meaner streets where persons are criminalized because of their homelessness. This can be seen in arrests for trespassing, criminal littering, and loitering. Legislation is increasingly pursued as a vehicle to continue criminalization of homeless persons, the effects of which are devestating to the homeless person and counterproductive to the outreach process.

Follow-up

Effective workers provide short-term follow up with respect to immediate tasks at hand and long-term follow-up with clients to ensure that they remain in a stable situation.

Outreach Across Populations

Primary health, mental health, and substance abuse treatment approaches similarities in outreach approaches are found in different treatment areas and client populations including families, veterans, mentally ill and transgendered persons, sex industry workers, substance users, HIV+ persons, and youth.

Health

A significant characteristic of homeless persons is poor health. A one-year study of 300 mentally ill homeless persons in New York City, revealed that 73 percent suffered from at least one medical condition in addition to a psychiatric diagnosis. The most common medical conditions were peripheral vascular diseases, anemia, infestations, and respiratory diseases, particularly tuberculosis. 35 percent had a secondary diagnosis of substance abuse (Marcos, 1988).

A two-year study of 1,751 homeless clients in Honolulu showed exceptionally high rates of mortality, with an average life expectancy of 48 years. Death rates have long been used as a measure of deprivation and as a guideline for public health resource allocation. With that in mind, homeless populations are in urgent need of increased attention and health care spending (Martell, 1992). A Philadelphia study of mortality rates for homeless people was 3.5 times that of the general population (Hibbs, 1994). Another study showed that causes of death varied by age group: (1) homicide: men ages 18-24; (2) HIV/AIDS: persons 25-44; and (3) heart disease and cancer: persons 45-64 (Hwang, 1997). In a study of hospitalizations of homeless persons, admissions to acute care hospitals were five times greater than the general population. They were admitted nearly one hundred times more often to the state psychiatric hospital (Martell, 1992).

Health care delivery to homeless persons can be challenging due to: lack of insurance, distrust of service-providers, bad experiences with health care in the past, difficulty making and keeping appointments, difficulty with complex medical and follow up care routines, and lack of understanding or interest in health problems in relation to seemingly more important issues at hand.

As with mental health and substance abuse, health care approaches for homeless persons are based on a process of engagement, assessment, planning, advocacy, education/motivation, and follow up. There are different models of health care approaches to serving persons who are homeless. Health care services may be provided at either permanent or mobile clinics and at rotating sites, some of which may be near homeless shelters. Health care providers may include salaried or voluntary physicians, physician assistants, nurses, and/or nurse practitioners who comprise a medical team. They reach out to homeless persons at sites where they have agreements with the host agencies. The goal is to provide care and help

clients access a more mainstream medical system that will continue to be available to them. Staff make referrals and arrange transportation and an escort if needed (Plescia, et al 1997).

Escorting clients to appointments can be critical if a person is unable to go on his/her own. Staff can help clients by making medical appointments, preparing them for the appointment (getting insurance card/paperwork in order, educating them about what might be expected), advocating for them if needed, translating medical jargon, and helping them follow through with aftercare instructions and appointments. Further, outreach workers can be the "eyes" and "ears" on the streets for health care providers who are monitoring clients from afar. When clients reach a dangerous state of health, outreach workers can elicit assistance from mobile medical outreach staff, or stationary medical staff who are willing to leave a clinic and provide in-vivo services.

Often, homeless persons are more willing to address health problems because of decreased stigma, compared to willingness to address mental health or substance abuse issues. As outreach workers continue to engage clients during the health care process, they can begin to slowly and gently address other issues. For example, they may work toward obtaining clinical history and the client's thoughts and perspectives regarding their experiences with mental illness, substance abuse, and other areas.

Outreach workers play a key role in illness prevention, from providing blankets and socks, helping clients access insurance and free medication/medical care, and educating them about topics like safe sex, hepatitis, TB, harm reduction, and nutrition. They can help clients get food and vitamins, and help them obtain past medical records and reconnect with previous service providers who may be familiar with their medical case(s). Outreach workers can also help by being aware of other organizations' involvement in medical care so that there can be nd ears" for psychiatrists and clinicians making decisions about the direction of mental health care.

Effective outreach workers are able to demonstrate flexibility in their treatment responses. For example, with some clients, the connection can be so tenuous that the engagement phase can take months or even years of gentle, slow, and careful interactions. Other clients' mental status may indicate the need to set limits. For clients who lack insight into their mental illness, workers take an education and normalizing approach, emphasizing the stressful nature of homelessness (Morse, 1991). Work& can help clients make connections between homelessness and their perception of the bad things that happen to them, hoping to spark some motivation to consider housing and other related social services. Workers can also help clients make connections between negative symptoms and the potential relief that medications or other interventions might offer. However, discussion about medication can only occur after sufficient trust has been established. For many people, the only mental health involvement they recall has been involuntary and coercive, usually resulting in unwanted medication and treatment.

Some clients may persist in denying the existence of a mental illness, but become successful in housing (Barrow, 1991). Workers can help clients translate street skills into independent living skills while treatment and referrals progress. Engagement strategies can help with linkage to services. For example, one client on the streets liked jewelry, and a lot of it. The outreach worker invited her to the clinic where health and mental health services are provided, stating that they had "a lot of jewelry there." The outreach worker alerted staff, who the next day brought in jewelry from home and from thrift stores. The client enjoyed picking out one piece of jewelry every time she came to the clinic. This allowed linkage to services in a clinic where she learned to trust service-providers. Similar creative linkages are required to ensure success.

Outreach workers can help prepare clients as they begin to access services, at the same time informing staff at those agencies about the client's unique needs, strengths, and interests to help ensure successful transition.

Substance Abuse

Outreach to substance users crosses many sub-groups, such as those with dual diagnoses, sex industry workers, and persons with HIV/AIDS. One major gap in services to persons with substance abuse problems is the lack of an entry point into services for those who don't want formal treatment (Bonham, et al., 1990). A sub-group of this population are the "public inebriates" (Willenberg, et al., 1990). Three errors in treatment modalities have contributed to failures with this population. One is that the population is severely and chronically disabled. Second, programs often have unrealistic and high goals. Third, treatment models used are those that are more successful with middle-class, non-alienated alcoholics (Willenberg, et al., 1990). Moreover, treatment programs often fail to take into consideration cultural factors and fail to address the serious marginalization of disenfranchised groups. Engagement strategies are much the same as with health or mental health outreach-a non-judgmental stance, listening, educating, and linking. Project Connect's service model is based on principles that services fit client needs, focus on their strength rather than weaknesses, and that the worker/client relationship is primary and essential (Bonham, et al., 1990). Worker activities can include education about safe sex and safer drug use and newsletters, and connecting clients to support groups and sobering up stations (Bonham, et al. 1990). Incentive items may include vitamins, condoms, bleach kits, and clean needles. Alcoholics and drug users who are homeless frequently lack the motivation or skill to seek out currently available services. They often distrust service-providers because of real or imagined poor treatment in the past, or difficulty negotiating the system (McCarty, et al., 1990).

Since many street users do not have insight into the harmfulness of their drug use, outreach workers may implement the use of a "Motivational Interviewing" (Miller and Rollnick, 1991) or "Stages of Change" (Prochaska, et al., 1994) approach. Programs may want to consider training in these models for all staff, rather than having one designated substance abuse counselor. Homeless persons with co-occurring substance abuse issues will be better served by outreach workers with a working familiarity with these models. Workers are familiar with and provide linkage to community resources or support groups, when the person begins to express interest. A Harm Reduction approach is generally the best engagement strategy.

The main tenets of Harm Reduction are:

- a non-judgmental and respectful approach
- helping residents to identify harmful effects of drug and alcohol use and the benefits of decreasing and/or ceasing use
- exploring alternate, safer routes and patterns of use
- praising small successes
- developing flexible plans that address substance abuse issues.

Common strategies successfully used to help addicted homeless persons include:

- Stabilization services like detox centers (McCarty, et al., 1990), inebriate reception centers (Bennett, 1990), and sobering-up stations (Bonham, et al., 1990) help to address immediate needs, provide respite, and an entry to substance abuse services.

- Case management services (McCarty, et al., 1990, Bonham, et al., 1990, and Willenberg, et al., 1990) help link persons to services, provide support, and help clients reach decisions regarding their own recovery. Persons can move back and forth between basic and intensive case management based on their needs (Bonham, et al., 1990).
- Jail liaisons (Bonham, et al., 1990) help explain services and link clients to them, identify those in need of case management, track clients, and advocate for mandated treatment rather than incarceration for revolving "public inebriates."
- Vocational training (Bonham, et al., 1990 and Ridlen, et al., 1990) in a variety of areas is offered to homeless men and women who are ready for such services.
- Housing in conjunction with supportive services (Willenberg, et al., 1990 and Ridlen, et al., 1990) are offered along with education in areas of housing management like tenant rights, budgeting, and problem-solving. Families are further assisted in areas of childcare and linkage to schools (Ridlen, et al., 1990).
- Drop-in centers (Bennett, et al., 1990) which offer showers, meals, information and referral services, on-site substance abuse services, benefits counseling, telephone, transportation, a warm, homelike environment, and friendly faces.
- Access to treatment (Bennett, et al., 1990). Successful programs reduce barriers for homeless persons needing substance abuse treatment. This may include reserving a percentage of beds for homeless persons, reducing waitlists, and improving inter-agency relationships.

Measurable Outcomes

Successful Outreach and Engagement Strategies

Studies have shown that outreach and engagement strategies, while initially time-consuming and slow-moving, are successful because they reach more severely impaired persons who are less motivated to seek out services (Lam and Rosenheck, 1998). Three month outcome data compiled via the ACCESS study (Lam and Rosenheck, 1998), showed that clients reached in outreach on the streets experienced improvement on nearly all outcome measures equivalent to clients who were contacted in other services agencies and shelters. Outreach clients did equally well in areas of housing outcomes, quality of housing, improved mental health and decrease of psychiatric admissions, substance abuse, employment, social support, reduced victimization, and quality of life. This suggests that this hard-to-reach population has the same capacity for improvement as groups more connected to services and who may be more high-functioning.

The ACCESS program has demonstrated that people will use services if they are accessible and relevent and that effective outreach will lead to an increase in access to other services. Although helping homeless persons access mainstream services is difficult nationwide, ACCESS has shown that programs with sufficient resources can help people to be successfully treated in a community setting and that the bridge from homeless services to mainstream services is possible.

Positive housing outcomes, a major focus of homeless services, was also found by Bybee, et al., to be linked to outreach services (1994 and 1995). The likelihood of success in independent living was impacted by the amount of services, and a wide range of interventions and the intensity of those interventions and services. Recruitment sources also impacted housing success, in that those recruited from inpatient psychiatric settings were more likely to experience housing success than long-term Community Mental Health clients, suggesting that greater stabilization possibilities follow acute psychiatric episodes across populations. Anyone may have the opportunity for successful housing

placement following a crisis. Those recruited from shelters also had greater likelihood of successful independent living, but also may continue to live in temporary settings, suggesting the variance of the degree to which persons from shelters can be easily housed. There was a smaller, yet significant predictability between housing status and client functioning, symptomatology, and substance abuse problems.

Quantitative Measures

Improvement is often so subtle that it doesn't register on typical functional improvement scales. One program measures number of days per month spent in housing, number of times victimized, level of hygiene, number of contacts with other service providers, and so on (Axelroad, 1987).

In some cases, quantitative measures can be deceptive, as evidenced in Barrow's 1988 survey. After a six month survey of completed referrals, only a small minority were successful, such as only 24 percent of entitlement referrals, 42 percent of housing referrals, and 13 percent of psychiatric referrals. While this appeared to be a reflection of ineffective services, it also reflected a short study period, discrepancies between client and program perceived needs, and lack of resources.

One outreach program measures success by four criteria: present living arrangement, receipt of financial aid or other income, enrollment in a program for the treatment of alcohol abuse of mental illness when appropriate, and receipt of treatment for other medical conditions. The first year's data suggest that about four out of five persons have made at least one significant change (Rosnow, 1988).

Project Connect uses quantitative methods including face to face pre- and post-interview data with clients, monthly program data on clients, self-administered pre- and post-questionnaire data for community agency staff, and selected administrative record data from Project Connect agencies (Bonham, et al., 1990).

As part of the continuum of care delivery, workers can implement successful strategies described in Critical Time Intervention (CTI) to prevent recurrent homelessness and promote successful transitions to housing. One component of CTI is to strengthen the relationship between the individual and family, friends, and services, and secondly to provide emotional and practical support during the critical time after discharge from a shelter. Outcomes of CTI included significant reduction in homelessness and a preliminary indication that CTI is cost-effective (Jones et al., 1994, Susser, et al., 1997). Interventions are short in duration, simple, can be implemented by nonprofessional staff, and can be implemented in marginal settings (Susser et al., 1997).

A series of studies of homeless veterans by Rosenheck et al. (1989, 1993, 1995) evaluated the impact of outreach programs for homeless veterans with mental illness and found that outreach services are successful. The 1993 study found that outreach services increased access to outpatient and domiciliary services and reduced inpatient services. The 1989 study found outreach to be successful in that a significant number of homeless vets eventually wanted services and that outreach and advocacy efforts enhanced access to health care services. Outreach services have been found to be costly although there was a slight reduction in inpatient costs. Rosenheck, et al. (1995) caution that one cannot conclude, on the basis of cost alone, that less expensive treatments should replace more expensive ones. Many outreach programs have found that the initial cost of outreach and engagement pays off in the end.

Studies evaluating substance abuse programs found that offering an array of stabilization services along with case management services, contributed to recovery and utilization of services (McCarty, et al., 1990, Willenberg, et al., 1990, and Ridlen, et al., 1990).

Qualitative Measures

Qualitative measures are useful for service providers in evaluating program functioning (Axelroad, 1987). One helpful technique is questioning formerly homeless individuals who have been outreach clients to find out which elements in the outreach team's approach were appealing or useful and which were perceived as negative. Project Connect uses ethnographic observations, interviews, and journals maintained by immediate program personnel (Bonham, et al., 1990). Qualitative evaluations can also be helpful in demonstrating to potential funders the complex nature of clients, outreach efforts, linkages, and length of engagement periods (Axelroad, 1987).

Challenges and Limitations In Determining Effectiveness

The very factors which contribute to a successful outreach effort-flexibility, ability to alter service systems-may impede evaluations which strive to concretely measure their effectiveness (Axelroad, 1987). There is a lack of controlled studies that demonstrate effectiveness and a lack of longitudinal studies. These are critical evaluation designs, yet are often difficult to implement with outreach clients who may be difficult to track.

Evaluations aimed at measuring the overall effectiveness of an outreach program must focus on the extent to which services and resources are available to outreach clients. In addition to evaluating effectiveness of services provided by the program, programs must also determine who is not being served by the program (Axelroad, 1987), why they are not being served, and how they might be served in the future.

Successful outcomes are not necessarily related to program services and should be considered in evaluating those programs. In one study, for example, success in obtaining housing and remaining housed were found to be related to socioeconomic background, defined by education and past employment, and level of functioning. Program services that were related to positive housing outcomes included an early focus on entitlements and housing-related services and participation on the part of the homeless person in defining housing goals were critical to their long-term success (Barrow, 1991).

While it is difficult to generalize outcome parameters across populations, regions, culture, and other factors across the country, a standard set of street outreach outcome measures is desirable at the national level. These standard outcomes should be different from standard outcomes used for other homeless populations which may be unrealistic for outreach populations. Outcome standards should also be set by individual programs. HUD requires Supportive Housing applicants to provide goals and objectives and later the extent to which goals were attained.

Future research and programmatic goals might include: identifying what national homeless outreach measureable outcomes might be; identifying specific factors that allow for successful transition from homeless to mainstream systems for the general outreach homeless population and for specific populations; the extent to which outreach teams are successfully used; the extent to which peer based outreach models and consumer involvement in program planning, implementation, and evaluation are successful; the development of more controlled and longitudinal studies; how the use of data-tracking within information systems might be implemented ethically and effectively; incorporating outreach

outcomes within the managed care system; and the cost-effectiveness of providing outreach services and answering whether or not exemplary practices should be equated with effectiveness.

To Dance In A Bigger Ballroom—Toward Exemplary Practice At All Levels

There are effective strategies for influencing the adoption of exemplary practices and policies on each major administrative level-agency, local community, state and federal. There are also many questions still open for discussion. Outreach workers rarely can be successful unless exemplary practices exist at other levels.

Agency

Effective administrators or program directors must educate the agency board about outreach activities and philosophy and advocate on behalf of outreach staff at the board level. Directors must also support the outreach team and advocate for their efforts with other service providers in the community; (Axelroad, 1987; Wobido, 1990).

Outreach staff must be given flexibility in work schedules so they can seek out and find persons in the evening and on weekends. Funds must be available for incentive and basic need items, as well as equipment. Providing outreach workers with on-call medical and psychiatric consultants is critical as is promoting a sense of teamwork-preferably a multi-disciplinary one. This helps workers feel supported and provides them with tools with which they can provide better services. Exemplary agencies, with outreach as a component, make provisions in service delivery for outreach clients, like allowing clients to receive medical/ psychiatric/substance abuse services when needed rather than by appointment. They allow bypassing of unnecessary forms and paperwork, and adopt the engagement stance.

Orientation and training of new outreach staff is critical particularly in the area of street safety. Training should include: street safety, characteristics of the target population, substance abuse/dual diagnosis, the criminal justice system, benefits and entitlements, community resources, involuntary hospitalization, client rights, harm reduction, confidentiality, de-escalation, boundaries, CPR, basic first aid, regional laws regarding child and elder abuse, engagement strategies, cultural competency, and infection control. Safety training should require that new staff sign a document indicating that they understand safety guidelines. This makes worker risks clear prior to hiring, while protecting the worker from injury and the agency from future liability.

Outreach workers often feel a sense of isolation in the field, from other homeless and non-homeless service providers and are likely to be viewed as marginalized themselves. As a result, agencies need to ensure a system of support, advocacy, and inclusion for their outreach staff.

Exemplary agencies provide opportunity for ongoing discussion around ethical issues. Clinical supervision and/or peer supervision is recommended for outreach staff who need to get second opinions on implementation of their ideas to creatively engage persons. The question must always be asked, to what extent are the engagement strategies used by workers non-coercive and non-deceptive (Lopez, 1996)? Supervision can also address issues like engagement versus enabling, boundaries, legal issues, and service-provision.

Outreach workers sometimes get harassed and are discriminated against along with their clients. If outreach workers function as service and/or rights advocates, their agency needs to determine which

parameters of advocacy efforts are allowed and encouraged. They should also develop positive relationships with police and security personnel. Finally, outreach workers should attempt to develop positive relationships with intake workers and staff at other agencies where they might refer clients.

Community

In addition to direct services, outreach workers and administrators can enhance the knowledge base of effective outreach practices on a community-wide level, by providing consultation, education, training and referrals (Morse, 1991; Slagg, et al., 1994). Outreach workers can start an "outreach coalition," sharing resources, ideas, information, client tracking efforts, and mutual support. This process is essential in providing linkages to resources. In many communities, there are a dearth of resources, and outreach workers end up providing intensive case management, in a continuous relationship model.

Outreach workers can share success stories-they encourage other workers, combat the community's "compassion fatigue," and give hope to those clients still in crisis. Success stories are an essential part of informing funders, politicians, and policy-makers that services work.

Outreach programs cannot be designed in isolation from other service programs (Axelroad, 1987; Morse, 1987; Barrow, 1988). Survival depends upon community networking: providing referrals, sharing resources, pooling knowledge, and participating in community-wide groups (Nasper, 1992). In discussing outreach, it is essential to discuss the gaps and barriers in these systems (Axelroad, 1987). The most flexible, well-staffed and funded outreach program will have little impact if the mental health, health, housing and social service systems in a community are not capable of serving people linked through outreach efforts.

One urban outreach program made efforts to minimize coordination problems by expanding the makeup of a coalition with representatives of human service organizations in both the public and private sector; getting active participation with various planning and coordination bodies concerned with homelessness; and structuring the outreach program so that the workers could become familiar enough with their counterparts in other service-provider agencies (Rosnow, 1988).

Public-private partnerships can lead to effective service-provision. One example is the Times Square Consortium (TSC). This is a partnering of the Times Square Business Improvement District and social service agencies to provide outreach and a drop-in center for homeless persons in the Times Square area. Rather than a business-community attempting to simply arrest and move along persons who are homeless, they provided the impetus for social services. Together the TSC has applied for and received funds from state and HUD (Porter, 1997).

Project Respond in Portland, Oregon, won the 1997 Gold Achievement Award by the American Psychiatric Association for its exemplary outreach program. Exemplary community practices cited include successful and collaborative relationships with "community partners" like police, housing managers, service-providers, and businesses. Also cited was the reduction of stigma, seeking of missing persons, consultation, community education, including police education, and diversion (Talbot, 1997).

These approaches are heartening in an apparent climate toward the criminalization of homeless people. There has been an increase in anti-vagrancy laws which prohibit sitting, panhandling, or being in an airport during certain hours. Outreach is one of the few formal contacts where service professionals connect with homeless people who may be breaking laws. Outreach workers and their agencies could be held legally accountable because of their association with these homeless persons.

State/Federal

One outstanding issues that still needs to be addressed at the state/federal level is funding. Who should pay for outreach? Through the Continuum of Care process, communities are encouraged to include outreach as part of the continuum. On a national level, service-providers must advocate that managed care plans make point-of-access exceptions for homeless persons, and the homeless Medicaid population must be carved out of Medicaid managed care and financed separately (Plescia, 1997).

The cost-effectiveness of outreach programs often comes into question. One reason is related to the comparison of numbers of people served on outreach versus the number of people served in homeless shelters. If funders think of effectiveness in terms of the numbers of people served, then homeless shelters will be viewed as more effective. The people outreach programs tries to serve are those who don't readily come to and accept services and who need a period, sometimes a lengthy one, of engagement. The positive outcomes of outreach services may not be readily seen. Yet, the cost of providing outreach services may divert costs from other systems such as emergency rooms, hospitals, psychiatric units, jails, and other crisis systems of care. This issue also reflects a structural obstacle to demonstrating cost savings between systems. For example, at the federal level, HUD funds many outreach programs, but the cost savings are realized in other systems such as Medicaid, the mental health system and substance abuse system. The same obstacles to demonstrating cost savings exists at state and community levels as well.

Agencies and communities need to ask what more could be done on a federal level to support outreach programs. One possibility could be a requirement of outreach services in states' Medicaid plans. HUD does not fund emergency services or prevention of homelessness, and perhaps they should. Another possibility, could be a mandate that all Continuum of Care proposals include a strong outreach component, with penalties if outreach is not included.

More publications and guidelines for outreach are needed. Federal departments charged with addressing homelessness could provide "how to" information for service providers, and present options for service delivery based on research findings. Exploration of the range of services could be done nationally to determine specific trends related to successful outreach. Inquiry into what is optimal and what should be expected of outreach programs can take place federally. For example, the authors are familiar with outreach programs with a range of hours-from weekdays only to 7 days/week 16 hours/day. What have we learned about optimal services delivery? Several cities combine outreach with police escorts. Does this implied concern for worker safety in fact drive away potential clients and eliminate a Harm Reduction approach? Expertise is needed in this area if outreach programs decide to try and build collaborative relationships with police and security.

Homelessness among severely mentally ill persons, and chronic substance abusers represents a failure of state and federal policy to adequately address or sustain long-term community support systems. Rather than stimulating new funding mechanisms and service delivery systems, they should be preventing homelessness by bolstering basic community resources for the long-term care of disabled persons (Rosnow, 1988). In the long run, prevention efforts should be incorporated in structural measures to prevent homelessness and provide appropriate services to those with chronic disabilities.

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A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research

by
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Abstract

Case management programs for homeless people have proliferated since the 1980s but some have questioned the meaning and clarity of the term case management while others have questioned its effectiveness for serving clients. This paper first attends to conceptual issues, identifying primary functions and process variables for understanding and describing case management services. The paper next describes models and approaches to case management for various client subgroups and specialty areas.

The paper also reviews the empirical literature on homelessness and case management, especially as it relates to treatment effectiveness and critical factors. Several conclusions are postulated, including that some case management approaches, especially assertive community treatment (ACT), are effective for helping people who are homeless with severe mental illness; frequent service contact is a critical ingredient leading to positive treatment retention and housing outcomes; case management is more effective with some clients than others. A number of gaps in our knowledge of case management are also identified.

The final section of the paper presents recommendations on exemplary practices. These include recommendations related to critical staff skills and abilities, service principles, case management models, and organizational practices.

Lessons for Practitioners, Policy Makers, and Researchers

Recommendations for homeless case management practitioners include focusing service delivery efforts upon:

- Conducting assertive, community-based outreach;
- Nurturing trusting, caring relationships with clients;
- Respecting client autonomy;
- Prioritizing client self-determined needs;
- Providing clients with active assistance to obtain needed resources;
- Maintaining small case loads; and
- Implementing ACT approaches.

The federal government is also encouraged to promote exemplary practices through knowledge dissemination, advocacy, and financing actions and to promote new research and knowledge on case management services for people who are homeless.

Introduction

Within the past two decades, case management has functioned as a cornerstone of efforts to serve people who are homeless. During that period, providers and researchers have recommended case management services for homeless people, policy makers have facilitated the development of case management programs through grant announcements, and Congress has encouraged States to provide case management through legislative initiatives (McKinney Act, PATH, mental health block grants). Program developers have adapted case management services for a variety of subgroups of homeless people, including those with severe mental illness, substance abuse disorders, people with dual diagnoses, pregnant women, and homeless families. Case management services need to be considered within a broad perspective that recognizes the multiple and serious needs of people who are homeless, the varying subgroups, the need for multiple interventions at various levels of society, and the crucial importance of adequate housing resources (Dennis et al., 1991; Federal Task Force on Homelessness and Severe Mental Illness, 1992; Morse, 1992). Undoubtedly, however, case management has become in practice one of the most common services to people who are homeless.

Why have case management services been recommended and implemented so frequently in the area of homelessness? In part, there is a general zeitgeist of case management within human services. More specifically, however, the initial development of case management services has resulted in part from several interrelated, key assumptions about the problems, causes, and solutions of homelessness:

1. People who are homeless have serious and multiple problems and unmet service needs and problems (Ball & Havassy, 1984; Morse & Calsyn, 1986).

2. The services and resources necessary to met these human needs are contained within a fragmented system of disparate service organizations (Rog, 1988).

3. Additionally, the service system is often structured and operated in such a manner that it poses a number of obstacles and barriers for clients in need; clients, therefore, often have difficulty accessing needed services and resources (Goldfinger & Chavatz, 1984; Rog et al., 1987).

4: Case managers are thought to be necessary to "facilitate access," "coordinate," "negotiate," and ensure services for client needs (e.g., Francis & Goldfinger 1984; Levine & Fleming; 1986; Oakley & Dennis, 1996; Rog et al., 1987).

Note the service system function inherent in these assumptions. As Hopper, Mauch, and Morse (1989), framed it, case managers perform "microsurgery on the service system." Not surprisingly, some have considered case management to be one intervention strategy for changing and improving the entire service system as well as improving individual client outcomes (Mechanic, 1991; Raif & Shore, 1993; Surles, Blanch, Shem, & Donahue, 1992).

An additional set of beliefs about people who are homeless also facilitated the development of case management programs. Specifically, homeless people have often been described as markedly mistrustful and suspicious of service providers, and to highly value their autonomy (e.g., Francis & Goldfinger, 1986). Case managers have been conceptualized as workers whose first task is to engage people who are homeless, developing and nurturing trust and a working alliance (Francis & Goldfinger, 1986).

While compelling arguments have been for case management services, significant questions and concerns have also arisen. Confusion about exactly what constitutes case management has been common. Others have questioned the effectiveness of case management.

The remainder of this paper will attend to these and related issues. Specifically, the following sections will:

- Discuss definitional and conceptual issues related to case management.
- Identify and briefly discuss different case management models or approaches used with homeless clients.
- Review the research literature related to the empirical study of case management approaches for people who are homeless, with a special emphasis upon the effectiveness of case management services. Conclusions will also be discussed and knowledge gaps identified.
- Draw from the literature to identify exemplary case management practices with people who are homeless. This section will also provide recommendations about how agencies can promote exemplary services.
- Conclude by providing additional recommendations on ways the federal government can promote exemplary practices.

Definitional and Conceptual Considerations: What is Case Management?

Across all health and human services, case management remains a loosely defined service which is less well understood than one might expect, given its widespread application and popularity" (Willenbring, Ridgely, Stinchfield, & Rose, 1991, p. 14). This statement applies equally to the field of homelessness, where case management has been characterized as "a much discussed but poorly defined concept" (National Resource Center on Homelessness and Mental Illness, 1990, p. 1). The conceptual confusion has resulted in part from a lack of definitional specificity. In the past decade, some theorists and researchers have focused increased attention on conceptualizing and defining case management (e.g., Raif & Shore, 1993; Willenbring et al., 1991). Particularly useful is the review and conceptualization of Willenbring and colleagues. They suggest that case management services can be defined in terms of their specific service functions. They identify six primary functions that characterize case management (see also Joint Commission on Accreditation of Hospitals, 1979):

- Client identification and outreach: to attempt to enroll clients not using normal services
- Assessment: to determine a person's current and potential strengths, weaknesses and needs
- Planning: to develop a specific, comprehensive, individualized treatment and service plan
- Linkage: to refer or transfer clients to necessary services and treatments and informal support systems
- Monitoring: to conduct ongoing evaluation of client progress and needs
- Client advocacy: to intercede on behalf of a specific client or a class of clients to ensure equity and appropriate services

They also note four additional functions which are common but variable across case management services:

- Direct service: provision of clinical services directly to the client

- Crisis intervention: assisting clients in crisis to stabilize through direct interventions and mobilizing needed supports and services
- System advocacy: intervening with organizations or larger systems of care in order to promote more effective, equitable, and accountable services to a target client group
- Resource development: attempting to create additional services or resources to address the needs of clients

Another common additional function of case management is discharge planning. Discharge planning often incorporates many of the above functions as case managers help clients plan to transition from one type of setting or service program to another.

The description of functions helps to provide more specificity to the definition of case management. However, as Bachrach (1992) noted in the broader area of mental health services, there is still a lack of consensus "about the precise meaning of case management" (p. 209; see also Rog et al., 1996). In part, this results from the practice of a number of different models or approaches to providing case management. Different case management models generally (but not always) perform the primary functions identified above; however, they vary not only in the presence or absence of the additional functions listed above, but also in other important ways. Especially important are the ***operational or process*** characteristics of case management programs, which Willenbring and colleagues distinguish from the functions of case management. The process characteristics measure more how case management services operate, rather than ***what*** they do. The following list of seven process variables, selected and modified from Willenbring and colleagues, are relevant for understanding similarities and differences between specific case management services.

- Duration of services (varying from brief, time limited to ongoing and open-ended)
- Intensity of services (involving frequency of client contact, and client-staff ratios)
- Focus of services (from narrow and targeted to comprehensive)
- Resource responsibility (from system gatekeeper responsible for limiting utilization to client advocate for accessing or utilizing multiple and frequent services)
- Availability (from scheduled office hours to 24-hour availability)
- Location of services (from all services delivered in office to all delivered in vivo)
- Staffing pattern (from individual case loads to interdisciplinary teams with shared caseloads).

In addition to these seven variables related to how case management programs operate, it is useful to consider who is involved in case management:

- Who is the client target population?
- Who are the staff, and especially what are their disciplines?

Case Management Approaches and Models

Table 1 provides a listing of case management models and approaches which have been described in the published scientific or practice literature (or included in widely circulated government monographs or reports). The phrase models and approaches are used to include both (a) programs that are well-established in theory or research as well as (b) programs that represent emerging methods that are commonly used in clinical practice, even in the absence of an extensive, preexisting theoretical or research basis. Table 1 includes data, where available, considering several of the key operational or process variables described above. These case management approaches are briefly described below

under five client subgroups: people with severe mental illness, people with severe mental illness and co-occurring substance abuse disorders (dual diagnoses), people with substance abuse disorders, people with primary health disorders, and homeless children and families. The majority of the published literature concerns case management approaches for people with severe mental illness; thus, the following discussion is more developed in this area, and, unfortunately, underdeveloped in other areas.

Severe Mental Illness

As shown in Table 1, *intensive case management (ICM)* approaches (see Rog et al., 1987) have been widely used with a variety of homeless subpopulations, including people with substance abuse disorders, homeless families, and especially with people with severe mental illnesses. ICM is illustrative of an approach that has emerged from the field in the absence of an extensive, preexisting theoretical or research basis. Its popularity for homeless clients has in part probably arisen from clinical principles– assertive and persistent outreach, reduced case loads, active assistance in accessing needed resources– that are compelling given the nature of clients' needs and system characteristics. Not surprisingly, however, ICM approaches are sometimes mentioned without extensive description of their programmatic functions or process characteristics. Further, the comparability of ICM across programs or homeless subgroups is unclear and questionable; there appears to be significant operational differences across ICM programs but these are often not systematically described or assessed.

Assertive community treatment (ACT) programs represent another common approach for homeless people with serious mental illness. (For this review, the ACT approach is meant to encompass programs identified in the literature as Continuous Treatment Teams or CTTs. The terms ACT and CTT are sometimes may represent subtle programmatic differences but often in practice and research they are synonymous terms, or indistinguishable from one another.) The ACT model has been highly researched and well-established as an effective community-based intervention for non-homeless people with severe mental illness (see Stein & Test, 1985; Bums & Santos, 1995). It has also been widely disseminated throughout a number of states as a model program for some people with severe mental illness (Deci et al, 1995). ACT proponents eschew the term case management (e.g., Stein, 1992); despite the validity of these objections, ACT is often included within reviews of case management and will be considered within this rubric in this paper as well. The model does indeed differ significantly from many case management approaches, especially in its emphasis on direct treatment and services, shared caseloads, and use of an interdisciplinary team that includes specialists such as psychiatrists and nurses.

The ACT model has been adapted in various ways to improve its relevance to a homeless population. These adaptations parallel many of the principles followed by homeless outreach and ICM programs; they include assertive outreach, engagement strategies, and an increased emphasis on clients' resource and housing needs (Dixon et al., 1995; Morse et al., 1992). Investigators have also added new innovations to the basic ACT model by adding both adjunct lay citizen community workers (Morse et al., 1997) and mental health consumers (Dixon et al., 1994) to the treatment team. Despite these modifications, one advantage to the ACT approach is its clarity and specificity in program principles, functions, and operations. The model is well described, and researchers have developed an instrument to measure the degree of fidelity of any one program to the ideal ACT program (McGrew & Bond, 1995; Teague et al., 1998). ACT teams for homeless clients with severe mental illness have recently been widely promoted and replicated through the CMHS ACCESS program (Johnsen, Samberg, Calsyn, Blasinsky, Landow, & Goldman, 1998).

A review of the literature (see also Table 1) suggests that a number of other case management approaches have also been developed for homeless people with serious mental illness. In addition to ICM and ACT approaches, two additional models are *Clinical Case Management* and *Social Network Case Management.* Both provide sound theoretical justifications for their clinical and social network components, respectively, while also incorporating basic ICM principles and characteristics, At present, however, neither model appears to be widely practiced.

The *Strengths Model* is often advocated and implemented for the broad (non-homeless) population of people with severe mental illness (Rapp, 1993). Features of this model include a focus on the environment as well as the individual client, use of paraprofessional staff, emphasis on client strengths rather than deficits, and a priority placed on following client directed interventions. The Strengths Model has recently been implemented in a large demonstration for homeless clients in Kansas under the ACCESS grant (Johnsen et al., 1988).

The *Critical Time Intervention* (CTI) is a new approach developed and tested for people who are homeless with severe mental illness (Susser, Valencia, Conover, Felix, Tsai, and Wyatt, 1997). The CTI approach focuses upon strengthening a person's long-term ties to other services and supports while providing emotional and practical support during the critical period of a transition from shelter to housing.

Also appearing within the literature are approaches which are noteworthy for their use of consumers as case management staff. The use of consumers and peers has been incorporated within various models of case management, including homeless ACT teams that include a consumer advocate (Dixon et al, 1994) and ACT teams which are almost exclusively comprised of consumer staff (see Herinckx, Kinney, Clarke, & Paulson, 1997). *Consumer Case Management* approaches have advocacy support, offer important work roles for former patients, and may be helpful for engaging clients suspicious of traditional mental health providers.

Finally, *Broker Case Management* approaches, meanwhile, are also commonly provided. Broker models emphasize assessment, planning, referral, and monitoring functions without extensive outreach, linkage or direct service contacts. While common, they are not recommended for homeless clients (Morse, Calsyn, Klinkenberg, Trusty, Gerber, Smith, Templehoff, & Ahmad, 1997).

Dual Diagnosis

Many case management programs for homeless people with severe mental illness have also served large number of persons who also have a co-occurring substance abuse disorder. Often, this has been a defacto rather than planned intervention, given the high prevalence of co-occurring substance abuse disorders among homeless people with severe mental illness (Federal Task Force on Homelessness and Severe Mental Illness, 1992). More recently, there have been increased efforts to address the specialized needs and problems of people with these dual diagnoses, especially among the non-homeless dually diagnosed population (e.g., Durell, Lechtenberg, Corse, & Frances, 1993; Jansen, Masterton, Norwood, & Viventi, 1992; Jerrell & Ridgely, 1995; Osher & Kofoed, 1989; Young & Grella, 1998). These services often follow the principles of *Integrated Treatment* (e.g., Mercer, Mueser, & Drake, 1998; Minkoff & Drake, 1991), which focuses upon an interdisciplinary, concurrent treatment approach to substance abuse, mental health, and other related client needs. A recent review of the treatment outcome research for all dually diagnosed clients recommended that integrated treatment approaches be comprehensive and incorporate assertive outreach, case management, individual and group and family interventions, while

assuming a longitudinal, step-wise motivational enhancement approach to substance abuse treatment (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, in press).

There have been relatively few case management interventions for dually diagnosed homeless persons, although there is a recent trend toward increased program development and research. The literature includes an example of social network therapy/intensive case management which promotes referral and linkage to existing substance abuse treatment providers rather than integrated treatment (Kline, Harris, Bebout, & Drake, 1991). Additional publications describe integrated treatment-case management approaches for homeless clients. Blankertz and White (1990) described a model of case management incorporated within a residential program for dually diagnosed homeless clients. In this model, case managers provided initial outreach and engagement, individualized service and rehabilitation planning, linkage for needed resources and services, and facilitated psychoeducational substance abuse treatment groups. Case management services were designed to follow clients whether or not they successfully completed the residential program. Intensive/clinical case management programs (Drake et al., 1997) and ACT programs (Meisler, Blankertz, Santos, & McKay, 1997) have also been modified to incorporate integrated treatment concepts and methods for people who are homeless and dually diagnosed. Additional projects are currently under development and research.

Substance Abuse

Case management is regarded as an important component in substance abuse services but there are few studies specifying program models and elements (see U.S. DHHS, 1992). Similarly, case management approaches have also been recommended and implemented for homeless clients with substance abuse problems, although apparently not with the same frequency as for homeless people with serious mental illness. Notable exceptions were three homeless case management demonstration programs funded by NIAAA. McCarty, Argeriou, Krakow, and Mulvey (1990) designed and described an intensive case management service in Boston as a key component within a stabilization project for homeless people with substance abuse disorders. The intensive case management service was designed to assist clients overcome their distrust of service providers, coordinate needed treatment and support needs, and "guide them along the recovery continuum" (p. 39). The case management role emphasized linkage and monitoring activities as well as support. Similarly, in the Louisville project, Bonham, Hague, Abel, Cummings, and Deutsch (1990) emphasized the role of intensive case managers in the Louisville project as connecting clients with community resources, especially AA and NA meetings, rather than as direct service provision. The Louisville project followed other common case management practices (e.g., individualized planning, monitoring) while also focusing on the need for outreach. The Minneapolis project, meanwhile, adapted the ACT model to serve homeless people considered as chronic public inebriates (Willenbring, Whelan, Dahlquist, & O'Neal, 1990). This team was designed to provide services and continuity of care in addition to conducting assessments, planning, and other common functions. It is important to note that the above descriptions reflect the intended program models; in actual practice, some significant discrepancies occurred (high client to staff ratios, considerable staff turnover, and other implementation problems-see above references as well as Orwin et al., 1994, and Willenbring et al., 1991).

Primary Health

Case management for homeless people has also been recommended as an effective strategy for enhancing and supplementing primary health care services (Savarese et al., 1990; Stephens et al., 1991). In practice, case management has been an important element in Health Care for the Homeless projects across the

United States (Savarese et al., Stephens et al). However, few detailed descriptions appear in the literature concerning the specifics of homeless health care case management services. Savarese and colleagues have illustrated how core case management functions have been integrated within normal homeless health care teams activities in a myriad of ways. Stephens and colleagues, meanwhile, also emphasize the integration of case management within a multidisciplinary team, while stressing the importance of a case manager to monitor and broker the system. They also argue that:

> *health care providers need to focus more on case management activities, which may include activities not necessarily associated with the provision of health care services (for example, finding and providing food, clothing, shelter, and accessing entitlement eligibility) to achieve the ultimate goal-stabilization-and when possible, reintegration of the homeless person back into society (p. 15).*

Kuczenski (1992), writing about a Health Care for the Homeless project in Minnesota, provides one illustration of how nurses can perform outreach and follow-up home visits to provide support and help clients with parenting and accessing needed resources. Steward (1992), meanwhile, described the role of specialized case managers in the same HCH project in helping homeless people set and keep health appointments, track specialized health information (e.g., immunization records), and access new resources as they transition into stable housing.

In general, however, the literature, lacks detailed models of case management with primary health, especially for specialized client subgroups. Homeless children have been identified as one high risk group in need of intensive case management health services (Roth & Fox, 1990). More attention is also needed for homeless people with poly-disorders, such as mental health, substance abuse, and HIV or AIDS; one such project stresses the importance of case management in creating linkages across multiple systems of care (Brindis, Pfeffer, & Wolfe, 1995). Worley and colleagues (1990) recommendations for integrated approaches for non-homeless people with severe mental illness appear equally applicable to homeless people with severe mental illness. Specifically, case management teams, such as ACT teams, could incorporate psychiatric nurse specialists to perform health screenings, health monitoring, education and disease prevention activities, while performing specialized medical linkage and coordination functions with other providers. Nurse practitioners could also be employed for providing primary care as well medical referral and monitoring.

Homeless Children and Families

Although the literature is very limited, case management services for homeless children and families should be considered on the basis of the specific subgroup targeted for services. Specifically, case management services have been described for young children (Car-man, 1991); runaway and homeless youths (Cauce, Morgan, Shantinath, Wagner, Wurzbacher, Tornlin, & Blanchard, 1993; Yates, Pennbridge, Swofford, & Mackenzie, 1991), including pregnant teens (Borgford-Parnell, Hope, & Deisher, 1994); and the entire homeless family (Rog et al., 1996).

Bassuk (1991) noted "there is a shortage of innovative programs" nationwide for homeless children. The Kidstart Program was developed as a case management model for homeless children by the Better Homes Foundation and IBM (Cat-man, 1991). There is a special emphasis on case managers engaging and networking the various agencies involved with homeless children (shelters, schools, social services) and in assessing the developmental progress and delays of young homeless children in social, emotional, and cognitive domains. Kidstart incorporates common features of most case management programs including

service planning, linkage, and monitoring. Similar to other approaches for homeless people, Kidstart emphasizes personalized and comprehensive care (Bassuk, 1991).

Two programs for runaways and homeless youths implemented intensive case management programs (Borgford-Parnell et al., 1994; Cauce et al., 1993). The program by Cauce and colleagues was guided by a comprehensive focus, recognizing "that although many of these youths have mental health problems, their problems do not begin or end there" (p. 34). Emphasis was also placed on providing emotional support and nurture, assisting clients to master developmental tasks, active involvement in the multiple systems affecting adolescents, and intervention and support for the utilized social support networks of clients, which often involved peers. The specialized intensive case management program for pregnant homeless teens employed both nurses and social workers (Borgford-Parnell et al., 1994). In addition to providing health and social services the program philosophy stressed outreach and engagement, employing "unique strategies . . . to meet the complex and ever changing needs of this difficult-to-serve population" (p. 1030), building a trusting relationship, providing services in the field, concrete and active assistance, consistent support, and long-term interventions. Services included health assessments, social service assistance, and skill training and assistance with infant care. In addition to these mobile intensive case management programs, case management services connected with long-term residential shelters have also been developed for homeless teens (Yates et al.).

As Rog and her colleagues (1996) noted, despite its increasing popularity, there has been little explicit study of case management's operations or effectiveness with (homeless) families (p. 68). Rog et al.'s description of a joint Robert Wood Johnson Foundation and HUD initiative provides a rare discussion of case management services for homeless families. The project recommended intensive case management for families with intensive support, frequent in vivo contacts, on going services, and close linkages with housing services (Rog et al., 1996).

Research Findings: What We Know and What We Don't Know

This section of the paper reviews the empirical research on case management for homeless people in four areas : treatment specification and implementation evaluation, effectiveness, cost-effectiveness, and critical factors influencing client outcomes. Subsequently, the paper will summarize conclusions from the research about our knowledge of case management services for homeless people and also highlight gaps in the current knowledge base.

Treatment Specification and Implementation Evaluations

Programs need to be carefully described and measured in order to understand the nature of the intervention, properly interpret results, and assist replication efforts (e.g., Brekke, 1988). This is especially relevant for case management programs, given the considerable confusion and uncertainty in the field about the meaning of a case management program and since there are rarely pure models in actual practice. It is also important to evaluate how closely an operation measures to an ideal model or the intended program, since negative findings may result from implementation deviations rather than an ineffective model. Unfortunately, however, many case management interventions are poorly described, and fewer are observed or measured (for notable exceptions, see Johnsen et al., 1998; Mercier & Racine, 1991; Roget al., 1996).

Specifying the treatment and measuring its implementation may reveal surprising if sometimes disturbing insights. Rog and colleagues, for example, found in a large multi-site study that an intervention intended

as an intensive case management approach (with frequent client contact) actually only produced an average of 15 hours of direct client services and 15 client contacts during the first year of service. Similarly, First, Rife, & Kraus (1990) found that within a demonstration intensive case management program that "37 percent of the clients received either minimal or no linkage with needed services" (p. 90; see also Barrow et al., 1996). Also, Johnsen and colleagues (1998) adapted a standardized instrument measuring the treatment fidelity of six ACT programs and seven "modified" ACT programs included in the ACCESS demonstration grant. They found, however, several significant deviations from the ideal ACT model (time-limited instead of ongoing service commitment; lack of multidisciplinary staff) and that "(n)one of the programs . . . achieved fidelity scores as high as the traditional ACT programs" (p. 17).

Treatment Effectiveness

Experimental Studies. All other research variables being constant, the most valid conclusions about the effectiveness of case management services must be derived from experimental studies using random assignment. Table 2 summarizes ten completed randomized studies assessing the effectiveness of case management approaches for homeless people. Note that all ten studies involved homeless clients who had serious mental illness (some persons also had a co-occurring substance abuse disorder).

Eight of the ten studies found that positive client outcomes occurred for the experimental case management approach. In seven of these eight studies, the significant results included less time spent homeless/more days stably housed in the community (the other study measured only treatment engagement and retention and not housing outcomes). Five of the six studies using an ACT approach found positive client outcomes. ACT interventions also sometimes produced other positive outcomes, such as improved service utilization or treatment retention and reduced psychiatric symptoms.

Two of the three intensive (or assertive) case management approaches reported positive outcomes (improved housing and, from one study that included psychosocial rehabilitation services, reduced symptoms). The one study of the CTI approach found positive outcomes on the housing/homelessness variables.

Note that the above paragraph summaries the *differential treatment* effectiveness of the case management approaches against comparison treatments, which in some cases were other case management program. In addition, several studies reported *time effects* whereby clients in all conditions improved over time in certain areas, but without differential effectiveness between the experimental case management approach and the comparison services (see Table 2). These improvements over time included positive outcomes in family contacts, life satisfaction, income, self-esteem, and interpersonal adjustment. The use of other treatment comparison groups makes the interpretation of these results unclear. Case management-as well as the comparison conditions-may in fact be affecting these positive client outcomes, but they are difficult to detect without a no-treatment control group.

Quasi-Experimental Studies. In addition to the experimental studies, some investigators have studied the effects of case management interventions using quasi-experimental designs, including comparison groups without random assignment, simple pre-post-analysis, and retrospective reviews. The findings from such studies, however, should be considered much more cautiously, given a number of possible threats to the validity of the conclusions that are inherent in non-experimental designs (see Cook & Campbell, 1979). Table 3 summarizes eight homeless case management studies (one involved three separate projects) relying upon non-experimental designs or analyses. As shown, four of these studies

involved subjects with severe mental illness, three with dually diagnoses subjects, and one (analyzing the three separate NIAAA projects) involved persons with substance abuse disorders.

Three of the four studies involving people with severe mental illness used ICM approaches, the fourth used ACT. The ACT study reported improvements in a number of areas, including in residential stability, social adjustment, vocational functioning, and decreased symptoms. The three ICM studies reported housing rates ranging between 5 1 percent and 63 percent over one year to 27 months assessment intervals. A relatively high rate (71 percent) of mental health service utilization was reported in one study, but two studies found surprisingly low rates of retention in case management services over time (30 percent in one study, 16 to 57 percent depending upon the criterion in another).

The three studies of services for dually diagnosed clients each integrated substance abuse services into mental services (one project used ACT, the other ICM/social network and clinical case management models and the third a combined residential and case management program.) The ACT and CCM/Social Network studies both reported some positive findings, especially for improved housing stability, but only equivocal or minimal effects for substance abuse. The case management-residential program clients were more likely than comparison clients to achieve successful discharge on a composite variable related to stable housing, abstinence, and absence of rehospitalization; however, the overall rate of success was still low (29 percent to 8 percent).

Orwin and colleagues (1994) reported on three NIAAA-funded research demonstration projects involving case management interventions for homeless people with substance abuse problems. Using multivariate analysis, Orwin et al. found evidence of significant treatment effects for only one intensive case management intervention on housing permanence and independence variables. This same study showed equivocal results and time-limited results on economic, employment, and substance abuse variables. In the other two case management studies, Orwin and colleagues found at best minimal or equivocal results. Orwin et al., however, noted that the absence of more powerful results may have resulted from a number of research design and methodological problems (e.g., differential attrition) or from ineffective or low intensity case management approaches.

Cost-Effectiveness

This review of the literature found only one completed study on the cost-effectiveness of any case management approach for homeless people (Wolff, Helminiak, Morse, Calsyn, Klinkenberg, & Trusty 1997). Wolff and colleagues were able to collect cost data for a subsample of clients involved in the randomized design of three conditions: ACT-only, ACT with community workers, and broker case management (Morse et al., 1997). Results found that there were no significant costs differences between the three programs when a comprehensive cost analysis was conducted although the ACT programs produced better client outcomes (client contact, psychiatric symptoms, and client satisfaction); thus, both ACT interventions were more cost-effective than broker case management.

Critical Factors

Service Factors or Mediators. The research literature provides some support for the proposition that at least certain case management approaches, especially ACT, are effective ways of serving homeless people, especially those with serious mental illness. A subsequent question then arises as to whether there are particular factors that are critical for the success of effective case management interventions. From a research perspective, one of the best and most rigorous methods for answering this question is to

conduct process evaluations that use multivariate analyses to specify the mediating variables or critical ingredients that are correlated with positive client outcomes within experimental studies showing positive effects. Unfortunately, very little of this type of research has been conducted in this field. Process or correlational analyses from quasi-experimental and simple pre-post studies also provide some useful information, though there are more possible threats to the validity of the conclusions. Table 4 provides information on five experimental and quasi-experimental studies providing data on service factors that may lead to positive client outcomes. It is worth noting that across three studies, frequency of contact was associated with better client outcomes, specifically in the areas of housing stability (Barrow et al., 1996), retention in case management and housing (Rife et al., 1991), and positive client satisfaction (Morse et al., 1994). More frequent supportive services and mental health service contacts were associated with both stable housing and also positive client satisfaction (Morse et al.).

Client Characteristics or Moderators. A related question asks: what client characteristics moderate client outcomes? The answers to the question are important in order to identify clients who may be at high risk of poor outcomes and where further service innovations may be necessary to develop more effective approaches. Table 4 also describes six homeless studies that have identified client characteristics associated with outcomes. Four findings have occurred in two or more studies:

- Lower lengths of time homeless are sometimes associated with better housing and treatment retention outcomes
- Clients with fewer psychotic symptoms tend to have better outcomes
- Women tend to have better outcomes
- Clients without substance abuse problems tend to have better housing and treatment retention outcomes

Conclusions and Knowledge Gaps

Primary Conclusions. The review of the literature leads to several primary conclusions, including:

- Although more effectiveness research needs to be conducted, there is strong support to indicate that some case management approaches are effective for helping homeless people with severe mental illness into needed services and, more importantly, into stable housing.
- ACT has the most extensive body of supportive research; results consistently indicate its effectiveness for assisting homeless clients with severe mental illness to achieve stable housing and to maintain needed services. There is also some but less research to indicate that ACT is effective in a few other client outcome domains, including for reducing psychiatric symptoms.
- A very small set of studies suggest that ICM can be effective for helping clients to achieve stable housing.
- Frequent service contact tends to be an important critical ingredient leading to positive treatment retention and housing outcomes.
- Case management services tend to be less effective with certain clients: men, persons with more psychotic symptoms, persons with longer homelessness histories, and people with co-occurring substance abuse disorders.

Knowledge Gaps. While research studies have yielded important knowledge, there still remains significant gaps in the literature and in our knowledge. These limitations and knowledge gaps include:

- Little demonstrated research knowledge about how case management services can effectively serve homeless people who:
  - have substance abuse disorders
  - have dual diagnoses of severe mental illness and substance abuse disorders (see also Drake et al., in press, who concluded after a comprehensive a review of outcomes studies of integrated treatment for all populations of dually diagnosed clients that "from a research perspective, the status of integrated treatment for dual disorders remains that of a working hypothesis with only modest empirical support. Given the magnitude of the problem of dual disorders, more controlled research is needed.")
  - have primary health problems
  - are children, youths, women, or families.
  - have mental health disorders that do not qualify as severe mental illness

- A scarcity of information about the cost-effectiveness of homeless case management services
- A lack of knowledge about the most commonly used case management approaches in clinical practice especially in areas outside of mental health.
- A lack of innovations and experimentation about how case management approaches may be modified or supplemented to create *greater* levels of cost-effectiveness
- A lack of empirical and outcome research on consumer case management approaches.
- Little research on how current or adapted case management services can effectively produce outcomes for clients in domains other than housing and treatment retention, such as in employment, social support, substance abuse, and recovery and wellness.
- Relatively little information specifying the specific service factors or critical ingredients leading to positive outcomes, and
- Relatively little data specifying the exact nature and fidelity of case management programs.
- Little research on how case management services can be combined with other interventions-for example, various housing options-to improve outcomes.
- Little information of the impact of case management on *system* problems. In appears that case management performs the systemic "microsurgery" needed by individual clients (Hopper et al.) but at present there is little data to assess overall system change.

Lessons Learned for Exemplary Practices: Agency Level and Practitioner Recommendations

Criteria

A central question arises: what should be the criteria for determining exemplary case management practices for homeless people ? Clinical wisdom that emerges from the field should play a part in determining exemplary practices. Additionally, however, consideration of empirical research, especially as it relates to effectiveness and cost-effectiveness, should be a second important criterion. This is especially important in the current era of accountability (Freeman & Trabin, 1994) where payers ask for documented, hard outcomes for continued support of services. The recommendations provided below draw upon clinical wisdom within the field, empirical research (when possible), as well as the author's own beliefs. These recommendations are discussed within four categories: critical staff skills and abilities, specific service principles, case management models, and organizational practices.

Staff Skills and Abilities

While much more empirical research needs to be conducted, the literature does provide some impressions and recommendations on critical factors for successful case management staff. Most of these recommendations are related to knowledge, skills, and abilities that case managers working with homeless clients with severe mental illness should possess. As noted elsewhere (Swayze, 1992), it is important that case managers have a thorough knowledge of homelessness; obviously, those working in mental health also need a thorough understanding of severe mental health disorders. Most importantly, perhaps, workers need to be able to engage homeless clients with severe mental illness (Kline, 1993). Engagement requires a complicated set of skills and attitudes. It includes being able to establish and develop trusting and caring relationships, responding quickly to client need priorities, being dependable but flexible, and being adept at covertly assessing a client's often changing needs for intensive services or personal space (see Kline, 1993; Morse et al., 1996).

Agencies need to recruit, select, train, and supervise staff to develop skills and knowledge in the following areas:

- Homelessness.
- The specific content area or discipline: e.g., mental health, or substance abuse, or health, or youths, or families. Additionally, beyond their area of specialization, it is important that case managers receive training on the needs and services for prevalent co-occurring needs, such as substance abuse and health for mental health case managers.
- Engaging homeless clients and developing trusting relationships; this appears to be a crucial core skill that cuts across all specialty areas.
- Psychosocial assessments.
- Individualized service planning.
- Crisis intervention.
- Suicide assessment and prevention.
- Therapeutic physical management.
- A comprehensive review of local services and resources.
- The specific case management approach and methods.
- HIV/AIDS education and prevention.
- Burnout prevention.

Training should be intensive with periodic ongoing review and the addition of specialized, needed topics.

Service Principles

Programmatic recommendations and clinical experience (e.g., Dixon et al., 1995; Francis & Goldfinger, 1986; Kline, 1993; Morse et al., 1992, 1997; Rog et al., 1987) suggests that to be maximally effective case management services for homeless people should be guided by a core set of service principles that include:

- Assertive and persistent outreach to meet homeless people on their own turf (as well as on their own terms)
- Active assistance to help clients access needed resources
- Following the client's own self-directed priorities and timing for services

- Respecting client autonomy
- Nurturing trust and a therapeutic working alliance
- Small case loads for case management staff

Additionally, the research on service factors related to client outcomes for homeless people with severe mental illness suggests that staff should seek to provide frequent service contact. Higher levels of supportive services and mental health service contacts are also facilitative of better outcomes for clients with severe mental illness. Agencies should incorporate these principles and findings into case management programs for the homeless.

Case Management Models

Local agencies should ensure that their case management services for homeless clients are consistent with research findings on treatment effectiveness. As noted earlier, the research strongly supports ACT as a best practice for homeless people with severe mental illness. Some support also exists for ICM approaches as well as Critical Time Interventions (CTI).

Organizational Practices

Organizational and system practices and policies are also important, as others have commented. In part, organizations and systems need to empower case managers, giving them authority to access needed client resources (Swayze, 1992). Organizations also need to provide case managers with competent and regular clinical supervision (Rog et al., 1987). Further, it has also been observed that organizational policies can significantly affect homeless clients and case management services (Hopper et al., 1989). In particular, it is important for organizations and systems to provide flexible admission requirements, accommodating clients who are mistrustful or simply unable to comply with normal admission procedures (which sometimes routinely include requiring clients to undergo long office-based intake interviews, produce personal identification and records, or to admit to having psychiatric problems).

It is also likely that agencies can support and foster exemplary case management services by:

- Providing thorough initial training and frequent on-going educational opportunities.
- Focusing case management interventions on specific and realistic targets. As previously stated: "If expectations are too grand, case management will always fall short of its presumed capacity" (U.S. DHHS, 1992, p. 8).
- Conducting QA activities that include treatment specification and implementation evaluations (include treatment fidelity monitoring of ACT programs).
- Conducting outcome evaluations; this is important internally to assess the needs and progress of clients served, and it will be increasingly important to funders and policy makers who are more likely to require outcome evaluations in the future as a condition for continued funding.
- Using data to regularly engage in quality improvements
- Fostering attitudes and practices that promote further service adaptations and innovations.
- Developing, in partnership with state and local government, ongoing funding support for case management services (instead of relying on additional demonstration grants to continue services).

Promoting Exemplary Practices: Federal Level Recommendations

Given the current state of the research and knowledge base, the federal government should passionately pursue two broad courses of action: (a) promoting the adoption of existing exemplary practices, and (b) foster and encourage the development of new knowledge through additional research. The latter action is as necessary as the former, given that there is still much we do not know about effective and cost-effective case management practices for homeless people. Recommendations in each of these two areas are presented below.

Promoting Exemplary Practices

The federal government should promote exemplary case management practices through at least three activities: knowledge dissemination, advocacy, and financing.

Knowledge Dissemination. The federal government should promote exemplary practices through:

- A wide and timely distribution of current state-of-the papers
- The planning and implementation of regional or state conferences on exemplary practices
- The development and distribution of relevant training materials (manuals, videos, CD-ROMS)
- The development and distribution of a Best Practices for Homeless People Guidelines

Advocacy. The federal government should join forces with other groups to advocate for the wide spread implementation of exemplary practices. One current example is for the federal government to collaborate with NAMI on the schizophrenia PORT project, especially since the PORT treatment recommendations call for increased ACT services.

Financing. Federal officials should seek to revise policies, regulations, and legislation as necessary to use federal funding to promote exemplary practices. In particular, regulations and policies related to mainstream funding programs (Medicaid, Medicare, Block Grant, PATH grant) should be reviewed and revised to not only allow but to create incentives for the delivery of exemplary services. The growth of managed care within the public sector (especially Medicaid and Medicare) will exert increasing influence on the direction and extent of case management services; the federal government, both within HHS and through consultation to states and local government, should encourage or require the funding of exemplary practices through managed care contracts. HHS should also collaborate with HUD to emphasize the development and funding of exemplary practices through SHP supportive services grants. It addition to encouraging exemplary practices, the federal government should also require monitoring to ensure that delivered services are consistent with exemplary practices (e.g., by requiring treatment specification data, or treatment fidelity assessments). Finally, as noted elsewhere (U.S. DHHS, 1992), the federal government supports case management services through various programs and funding mechanisms, but "each funding source usually requires agencies to develop separate financial and service reporting requirements. The more funding sources, the more complex, costly, and inefficient it becomes to comply with and supply requisite information. Greater effort should be made to pursue development of coordinated data and reporting requirements, particularly among the Federal agencies that will increasing support and influence the scope of case management services" (pp 8-9).

Promoting New Research

Exemplary practices for the beginning of the next millennium need to be developed from new program development and research efforts. As noted earlier, there is a critical shortage of research knowledge in a number of important areas. The federal government should place a priority on generating new knowledge by supporting program development and research in the following key areas.

- Research demonstrations of case management services targeted to subgroups of homeless people where current treatment effectiveness data is lacking. Specifically, this should include:
  - People with severe mental illness and co-occurring substance abuse disorders. This is a very prevalent set of conditions and yet little current research exists about approaches that improve substance abuse. Further, the dually diagnosed also suffer poorer outcomes in other areas (i.e., treatment retention, housing stability).
  - People with substance abuse disorders (only, or with milder mental health disorders). Approaches that re-engineer ACT teams for this population and that integrate motivational enhancement therapy (Miller, 1995) may be promising for development and testing.
  - Women with children and homeless families, especially those with non-severe mental health disorders. Again, a re-engineering of ACT or ICM principles combined with innovative psychotherapies may prove beneficial. Case management approaches used for children with severe emotional disorders may also be useful for some clients (e.g., Focal Point, 1993).
  - People with primary health problems. ACT teams that integrate nursing specialists or nurse practitioners (Worley et al., 1990) may be one approach to investigate.

- Research demonstrations that modify or enhance existing case management approaches in order to improve other outcome domains for homeless people with severe mental illness. In particular, interventions and research are needed to improve employment, social support, and, especially, long-term recovery and wellness.
- Research demonstrations that determine the cost-effectiveness of existing case management services.
- Research demonstrations that adapt, modify, or create new case management approaches in order to enhance cost-effectiveness.
- Research that examines the combined effectiveness of case management and other services and resources, such as housing options.
- Descriptive research or the most common and highly regarded case management approaches in community practice.
- Evaluation research (treatment specification and implementation evaluations) that clarifies the nature of case management services in demonstration projects and in wide spread community practice.
- Evaluation research that identifies client characteristics and services factors affecting client outcome.
- Research that assesses the effectiveness of staff training and other dissemination efforts.
- Research that assess the impact of managed care and other significant policy changes affecting service delivery patterns and exemplary practices.

Table 1
Case Management Models and Approaches for Homeless Clients

Approach/ Model	References	Service Intensity: Direct Services	Service Intensity: Link/Refer Advocacy	Service Intensity: Service Duration	Staff Client Ratios	Service Locations	Staffing Pattern	Staffing Discipline	Special Emphasis/Descriptive Features
Target Population: People with Mental Illness									
Intensive Case Management (ICM)	Roget al., 1987 Wasylenki et al., 1993	Some	Extensive	Ongoing	10:1 or 15:1 to 40: 1	Community	Individual	ICM/Generalist	Emphasis on outreach assisting clients to access needed services and providing advocacy as needed
Assertive Community Treatment (ACT)	Dixon et al., 1995 Lehman et al., 1997 Morse et al., 1992 Morse et al., 1997	Intensive	Some	Ongoing	10:1	Community	Team	Interdisciplinary	Emphasis is on providing intensive treatment and support services *in vivo*, for an ongoing, open-ended period of time. Staffing is intensive, utilizing an inter-disciplinary team that includes psychiatrist and nurse and a shared caseload.
Clinical Case Management	Kline (1993)	Intensive	Some	Ongoing	10:1 to 20:1	Community	Individual	CCM/MH Generalist	Emphasis is placed on individual, therapeutic relationship between primary CCM and client, though attention is also given to resource neds and linkages. Services are provided in community and office-based.
Social Network Case Management (SNCM)	Kline et al. (1991) Bebout (1993)	Some	Some		10:1 to 20:1	In community and office	Individual		Emphasis is placedon increasing the capacity of the clients' social networks to interact and support each client while also performing ICM functions of outreach, and service linkage.

		Service Intensity							
Approach/ Model	**References**	**Direct Services**	**Link/Refer Advocacy**	**Service Duration**	**Staff Client Ratios**	**Service Locations**	**Staffing Pattern**	**Staffing Discipline**	**Special Emphasis/Descriptive Features**
Broker Case Management	Morse et al. (1997)	Minimal	Extensive	Moderate to ongoing	50:1 to 85:1	Office based	Individual	Generalist	Emphasis is placed on assessing, planning, referring and helping clients to access needed services and resources delivered by other providers elsewhere in the community, and monitoring ongoing needs. Contact tends to be office-based and less intensive.
Advocacy	Freddolino & Moxley (1992)	Some	Extensive						Emphasis is upon providing case-specific advocacy to facilitate clients gaining needed resources and services while promoting consumer involvement. Staff are generalist with training in mediation, negotiation, and mental health law. Advocacy services are designed to be ongoing, as needed.
Critical Time Intervention (CTI)	Susser et al. (1997)	Some	Extensive	Time limited – up to 9 months		In community			Key feature is that services are time-limited to a "critical period" during and after the transition from shelters to housing (limited to 9 months). Activities are otherwise similar to ICM, but with a special focus on assisting clients to develop stable, ongoing relationships within their natural and service support systems.

Approach/ Model	References	Service Intensity: Direct Services	Service Intensity: Link/Refer Advocacy	Service Intensity: Service Duration	Service Intensity: Staff Client Ratios	Service Locations	Staffing Pattern	Staffing Discipline	Special Emphasis/Descriptive Features
Target Population: Substance Abusers									
Intensive Case Management	Orwin et al. (1994) Willenbring et al. (1991)	Some	Moderate to Extensive	9 months	30:1				CMs link clients to service, monitor involvement, and assist (ICM) clients in problem-solving and recovery strategies.
ICM	Orwin et al. (1994)	Minimal	Moderate to Extensive	Decreasing but open ended					CMs assess client needs, plan, link with services, monitor.
ICM	Orwin et al., (Willenbring et al., 1991)	Some	Moderate		15:1 to 20:1	In community and office		SA Counselors/ Case Managers	Aggressive outreach, develop trusting relationship, counseling, practical assistance.
Homeless Families									
ICM	Rog et al.	Some	Some	Open-ended	20: 1	Home and Office	Individual	Varied across CMs, counselors, SWs, RNs	Intended as ICM, with frequent open-ended service. In practice an average of 15 contacts and 15 hours direct service per first year.

Table 2
Experimental Studies of Case Management Approaches for Homeless People

Primary Reference	Client Group	Comparison/ Design	n	Study period	Main Findings
Hampton et al. (1992 - cited in Mueser et al., 1998)	Homeless SMI/homeless risk	ACT vs. standard CM	165	12 mos.	One ACT site improved stable housing. One ACT (with implementation problems) vs Standard CM non-significant
Herinckx et al. (1997)	SMI (31% homeless)	ACT vs. usual care	174	up to 870 days	ACT produced greater engagement and better retention into treatment
Hurlburt et al. (1996)	SMI	Factorial: Section 8 Subsidy (yes, no) by case management (traditional vs. ICM)	361	24 mos.	Main effect for Section 8. CM non-significant
Korr & Joseph (1995)	SMI (State Hospital discharged)	Assertive CM vs. control	114	6 mos.	ACM produced better housing status
Lehman et al. (1997)	SMI	ACT vs. usual community services	152	12 mos.	ACT: reduced inpatient and ER use, increased community housing, reduced psych symptoms, (Time effects: family contact, life satisfaction)
Morse et al. (1992) (1993)	SMI	ACT vs. CMHC Clinic vs. Drop-in center	178	12 mos.	ACT produced more client contacts,, higher utilization of needed resources, higher client satisfaction, and less homelessness(Time effects included: decreased symptoms; increased income, self-esteem, interpersonal adjustment)

Primary Reference	Client Group	Comparison/ Design	n	Study veriod	Main Findings
Morse et al. (1997) (1998)	SMI	ACT vs. ACT plus Community Workers vs. Broker CM	165	18 mos.	ACT and ACT/CW: Greater service contacts, higher access and utilization of needed resources, reduced symptoms, higher client satisfaction. ACT: more stable housing
Shern et al. (1996) (cited in Mueser et al., 1998)	SMI Homeless	ICM plus Psychosocial Rehab. vs. Standard CM	168	24 mos.	ICM/PR produced better housing and symptom outcomes
Soloman & Draine (1995)	Homeless, released from jail	ACT vs. Forensic CM vs. Standard CM	117	1 year	No differences
Susser et al. (1997)	SMI Homeless	Critical Time Intervention (CTI) vs. usual services	96	18 mos.	CTI reduced homelessness

Table 3
Non-Experimental Outcome Studies of Case Management Approaches for Homeless People

Primary Reference	Client Group	Comparison/ Design	n	Study Period	Main Findings
Barrow et al. (1996)	Homeless women SMI	Pre-post ICM	185	12 mos. and 24 mos.	**One Year:** 5 1% housed, 42% in shelters **Two Year:** 61% housed, 39% homeless. CM Retention: 16% still active, 30% active until housed, 11% referred elsewhere, 43% Dropped out/inactive MH Treatment Retention. 7 1% some MH services
Blankertz & Cnaan (1994);	Homeless dually diagnosed	Quasi-Experimental: CM/Residential	176		Experimental had lower dropout rate (19% vs. 47%), and, among those who completed 60 days, higher
Blankertz & White (1990)		Program vs. 12-step residential			Successful discharge discharge rate (29% vs. 8%)
Drake et al. (1997)	Homeless dually diagnosed	Quasi-Experimental: ICM (Clinical CM and Social Network CM) vs Standard CM	217	18 mos.	ICM improved housing stability and marginal improvement of substance abuse
First et al. (1990)	SMI: Homeless at risk of homelessness	Post-only ICM	88	up to 27 months	63.3% placed in housing
Meisler et al. (1997)	Homeless dually diagnosed	Pre-post (retrospective review) ACT/Integrated Treatment	114	12 to 48 months	Improvements: treatment retention, housing stability, community tenure. No or minimal effects: Substance abuse

Primary Reference	Client Group	Comparison/ Design	n	Study Period	Main Findings
Orwin et al. (1994)					
a. Boston..	Homeless Substance Abusers (Post detox)	Quasi-Experimental[1] Intensive Casemanagement vs Customary aftercare	491	?	CM effective for improving housing permanence and housing independence; Equivocal improvement on abstinence, employment
b. Louisville	Homeless Substance Abuse (Post detox)	ICM vs. Standard CM	179	?	No reliable effects
c. Minneapolis	Homeless Substance Abusers	ICM vs. intermediate CM (45: 1 ratio) vs. Usual Care	260	?	Intermediate CM tended to produce more effective substance abuse results and employment, though minimal and equivocal
Rife et al. (1991)	Homeless	ICM	176	32 mos.	56.8% clients placed in housing; 30% remained engaged in ICM and housing 6 months or greater. For those retained in housing and ICM, improvements in some quality of life domains: general well being, living situation, leisure activities, finances, safety, health.

[1] This report include sites with some randomized, experimental procedures but results are cited here from a multi-site, quasi-experimental analysis

Primary Reference	Client Group	Comparison/ Design	n	Study Period	Main Findings
Wasylenki; et al. (1993)	Homeless SMI	ACT: Pre-post	59	9 mos.	Increased residential stability, social adjustment, and network size, vocational functioning; decreased symptoms.

Table 4
Service and Client Factors Related to Case Management Outcomes
Service Factors (Mediators)

Study	Outcome Variable	Service Factor (Mediator)	Study Design
Morse et al. (1994)	Stable housing	Supportive Services Housing Service Contracts Entitlement Service Contracts MH Service contacts	Experimental/ Multivariate Analysis
	Client satisfaction	Supportive services MH services Overall service contacts	
Dixon et al. (1994)	Receipt of Section 8 certificate	Representative Payee services (negative relationship)	Experimental/ Bivariate Categorical
Barrow et al.	Retention in CM services Stable housing	Staff client interaction Continuing CM services	Pre-post/ categorical
Herinckx et al.	Length of retention In treatment	ACT services	Experimental/ Multivariate

Client Characteristics (Moderators)

Study	Outcome Variable	Service Factor (Mediator)	Study Design
Dixon et al. (1994)	Receipt of Section 8 certificate	Schizophrenia (negative relationship) Psychotic symptoms (negative relationship)	Experimental/ Bivariate
Barrow et al. (1996)	Retention in CM services	Psychotic symptoms (negative)	
Morse et al. (1994)	Stable housing	Women (positive) Caucasian (Positive)	Experimental/ Mulitvariate
Rife et al.	Retention in CM services	Frequency of CM contact	Pre-post/ Multivariate
Herinckx (1997)	Length of retention in treatment	Number of nights homeless (negative relationship)	Experimental/ multivariate analysis
Hurlburt et al. (1996)	Housing stability	Gender (female) Time homeless (negative relationship) Alcohol problems (negative) Drug problems (negative)	Experimental/ multivariate analysis
Rife et al. (1991)	Retention in CM services and in housing	Independent living skills Age Substance abuse (negative) Times homeless (negative) Number of hospitalizations (negative)	Pre-post/ Multivariate Analysis

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Balancing Act: Clinical Practices That Respond to the Needs of Homeless People

by
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Abstract

This paper describes special adaptations to clinical practice necessary for addressing the most common health problems of homeless individuals and families. A case is made for the integration of primary care, mental health and substance abuse services as the preferred approach to care for this population, based on the complexity of multiple interrelated health problems that are seen. These problems are examined in a section on the epidemiology of health problems common to people without homes. Homeless people face numerous barriers to access which can be overcome by adaptations to the structure of the delivery system, including extensive outreach, mobile sites and flexibility in policies and procedures. The nature of the homeless condition also calls for special adaptations to clinical practice in the areas of intake and assessment, clinical preventive services, diagnosis, follow-up to assure continuity of care, referrals to specialty care and linkages to other services. Specific adaptations for treatment of physical and mental illnesses are presented, with discussion of primary care, treatment services for substance use disorders, treatment services for serious and persistent mental illnesses, and special services for homeless people with dual diagnoses. The paper concludes with comments on how to address the threats that challenge successful continuation of the unique approach to homeless health care that has evolved, including: inadequate funding to fully implement the integrated approach to homeless health care; impact of market-driven managed care; lack of funding for accessible and appropriate substance abuse treatment; limited cost and outcome data; the disconnect between research and practice; and the scarcity of skilled practitioners willing to serve this population. increased demand for services, decreased capacity and limited resources, the effects of Medicaid managed care, and the need for more qualified practitioners in this field.

Lessons for Practitioners, Policy Makers, and Researchers

After more than a decade of practice, there is considerable agreement as to what constitutes state of the art clinical services for homeless people. Based on research demonstration programs sponsored by public and private funding sources, and experience accumulated by front line workers in the many health care programs across the country, nine general principles have emerged as lessons for practitioners involved in providing care for homeless people:

- The importance of *outreach* to engage clients in treatment.
- Respect for *the individuality of each person.*
- Cultivation of *trust and rapport* between service provider and client.
- *Flexibility* in service provision, including location and hours of service, as well as flexibility in treatment approaches.

- The need to *attend to the basic survival needs* of homeless people and to recognize that until those needs are met, health care may not be an individual's priority.
- The importance of *integrated service provision* and *case management* to coordinate the needed services.
- *Clinical expertise* to address complex clinical problems, including access to specialized care.
- Need for a range of *housing* options, including programs combining housing with services.
- A *longitudinal perspective* that ensures continuing care until the person's life situation is stabilized.

Introduction

Physical and mental illnesses are implicated as both causes and consequences of homelessness for many individuals. While the shortage of safe, decent, and affordable housing is the most fundamental cause of homelessness, untreated physical and/or mental health problems create vulnerabilities that can lead to loss of income and home. At the same time, those who experience homelessness are subject to conditions that can result in deterioration of health or exacerbate existing chronic or acute illnesses, leading to rates of illness and injury from two to six times higher than for people who are housed (Wright, 1990). Homelessness also severely complicates the delivery of health services (Institute of Medicine, 1988). Without access to appropriate health care, acute and chronic health problems may go untreated, creating medical complications in multiple co-occurring conditions and ultimately impeding the individual's ability to overcome homelessness. Failing to provide homeless people with health care of a standard that is available to other people, even when they need elaborate or expensive treatments, constitutes a form of discrimination that should be unacceptable in a democratic society (Bangsberg et al., 1997).

A strong commitment by homeless health care practitioners to respond directly to these complex multiple health care needs of homeless people has resulted in the evolution of an integrated approach to providing clinical services. Primary health care, mental health services and substance abuse treatment need to be made available either from one organization's comprehensive service system, or if this is not feasible, through linkages with other agencies.

The purpose of this paper is to describe current clinical practice within an integrated system of primary care, mental health and substance abuse services for people without homes. Whenever possible, research has been used to support the discussion. A significant amount of research is available to describe the health problems of homeless people. However, less is found in the research literature related to efficacy of specific clinical practices with this population. Experience in the field and descriptive accounts by practitioners are the basis for many of the special adaptations to clinical practices recommended here for addressing the most common health problems of homeless individuals and families. The discussion is presented in the following sections:

- Outcomes: What do we want our clinical interventions to accomplish?
- Epidemiology: What are the health probiems of homeless people?
- System adaptations designed to overcome access barriers.
- **Adapting clinical practices tb the homeless condition.**
- Specific adaptations for treatment of physical and mental illnesses (descriptions of treatment approaches within each of the three specific areas of interest: primary health care, substance abuse treatment and mental health services, with special consideration for dealing with people who are dually diagnosed).

Outcomes: What Do We Want Our Clinical Interventions To Accomplish?

Although there is a major movement to quantify actual outcomes of health care interventions, providers of health care to homeless people have had to adapt their own notions of successful outcome to the realities of the homeless existence. A working group on homeless health outcomes was convened in 1996 by the Health Care for the Homeless (HCH) Branch of the Division of Special Populations/Bureau of Primary Health Care (U.S. Department of Health and Human Services, 1996). This group identified

seven systems-level outcomes and seven client-level outcomes that are goals for federally-funded HCH projects. The seven system-level outcomes are interrelated in that HCH projects "provide ***access*** for homeless people to a ***range of comprehensive services.*** They offer ***continuity*** of ***care*** within an ***integrated system*** to help ***contain costs*** and ***prevent*** new or recurring problems. Ideally, ***client involvement*** is evident in every step of this process." The seven client-level outcomes are related, but can be measured independently of one another. These include: ***improved health status; improved level of functioning; improved quality of life; involvement in treatment; disease self-management; client choice;*** and ***client satisfaction.***

However, the group also noted that "because homeless people are a heterogeneous group with multiple and complex needs, numerous personal and societal factors outside the clinicians' control may impact the final outcomes for individual patients. Also, their mobility often makes it difficult to track homeless people for follow-up measures" (U.S. Department of Health and Human Services, 1996, p.ii).

A central question in this discussion is determining what qualifies as a "successful outcome". Health care practitioners working with homeless people are concerned with improving health status, level of functioning and quality of life. Obviously, the most significant change affecting all of these would be acquiring permanent housing. Although this is certainly a recommended goal for health programs, usually undertaken within the framework of case management services, it is not an outcome that can be used to measure the effectiveness of clinical care. This is particularly true given the lack of resources for appropriate affordable housing in most communities, over which the health care practitioner has little control.

The nature of homelessness and the health conditions that accompany it also complicate the determination of "successful outcome." Homeless people, particularly those with addictions and/or mental illness, go through various stages of change as they move towards the desirable improvements in health status, functioning and quality of life. These stages include: precontemplation; contemplation; action; maintenance; and relapse (Prochaska, DiClemente & Norcross, 1992). This is not a linear process and each individual changes at his or her own rate. Chronic conditions-especially substance abuse and mental illness-are subject to regressions and relapse. This should be expected and needs to be built into program planning, as well as into outcome evaluation methodologies. For example, while recognizing that the incremental steps may occur at different points and may sometimes go backwards, a "hierarchy of objectives" can be constructed for homeless people who are mentally ill, beginning with the most basic to the most sophisticated as follows (Breakey, Susser & Timms, 1992):

- Accepts sandwich from outreach worker
- Maintains eye contact with outreach worker
- Accepts clean clothing
- Accepts housing/shelter assistance
- Permits interview with clinician
- Accepts medication
- Spontaneously attends to personal hygiene
- If dangerous, is brought to emergency facility
- Attends clinic regularly
- Manifests reduction in symptoms
- Improvement in self-care ability
- Adjusts satisfactorily to sheltered living program
- Participates in social activities

- Maintains mutually satisfactory relationship
- Transfers from homeless program to generic program
- Participates in vocational rehabilitation program
- Able to live independently
- Sustains competitive employment

Homeless health care practitioners are often limited to measuring change in small increments such as these. New strategies to assess these incremental outcomes are needed, such as the Service Continuum matrix being developed by the HCH Network, a program of the Seattle/King County Department of Public Health, to track clients in their progress towards stability and independence. This assessment matrix is based on incremental change in the areas of relationship, financial resources, health/treatment, social support network and residential status in stages ranging from the initial approach through companionship, partnership and mutuality to stability and independence (HCH Network, 1998).

Other significant work has been initiated to develop appropriate outcome measurements for the homeless health care setting. As a follow-up to the working group on homeless health care outcomes mentioned above, 20 HCH projects were provided federal funding to develop outcomes studies in a variety of areas. It is hoped that the study results and lessons learned will encourage further work in this area by homeless health care projects (U.S. Department of Health and Human Services, 1998b).

Epidemiology: What Are the Health Problems of Homeless People?

As a consequence of the poor nutrition, lack of adequate hygiene, exposure to violence and to the elements, increased contact with communicable diseases, and fatigue that accompany the conditions of homelessness, people without homes suffer from ill health at much higher rates than people living in stable housing. Several studies have found that one-third to one-half of homeless adults have some form of physical illness (Bassuk & Rosenberg ,1988; Burt, 1989; Gelberg & Linn, 1989; Morse & Calsyn, 1986; Roth & Bean, 1986). At least half of homeless children have a physical illness (Wood et al., 1990) and they are twice as likely as housed children to have such illnesses (Wright & Weber, 1987). This lack of health takes its toll by preventing many homeless people from exiting homelessness. For example, one-quarter of homeless adults reported that their poor health prevented them from working or going to school (Robertson & Cousineau, 1986). Even more seriously, rates of mortality are three to four times higher in the homeless population than they are in the general population (Alstrom, Lindelius & Salum, 1975; Hanzlick & Parrish, 1993; Hibbs et al., 1994; Morbidity and Mortality Weekly Report, 1991 and 1992; Wright & Weber, 1987).

The most common physical illnesses among homeless persons include upper respiratory tract infections, trauma, female genitourinary problems, hypertension, skin and ear disorders, gastrointestinal diseases, peripheral vascular disease, musculoskeletal problems, dental problems, and vision problems (Wright & Weber, 1987; Reuler et al., 1986; Miller & Lin, 1988; Wood et al., 1990). Inadequate immunization, while not a physical illness, reflects the lack of preventive health care in this population (Alperstein et al., 1988; Wood et al., 1990; Miller & Lin, 1988). However, the two health conditions most likely to trap people in a state of chronic homelessness are substance abuse disorders and mental illness.

Health problems in these three domains-physical illness, mental illness and substance abuse disorders-are intimately related. For example, surveys of the health status of homeless people demonstrate repeatedly that the single most common disorder is substance abuse. This in turn contributes to a wide range of other health problems resulting from self-neglect and poor hygiene,

nutritional deficiencies, trauma, exposure, accidents, victimization, toxic effects of ingested substances (e.g., hepatic cirrhosis due to alcohol) and infections (e.g., bacterial endocarditis, hepatitis and HIV infection due to IV drug use). Studies also demonstrate the poor general health status of severely mentally ill homeless people. They are more prone to neglect personal hygiene and their basic health care needs, and to have poor nutrition. Seriously mentally ill homeless people have been found to be at higher risk for tuberculosis (Sakai et al., 1998) and HIV infections (Susser et al., 1993).

Another example of how many of these problems overlap is in the area of impairment of physical function. Despite their young age (mean age in the mid 30's), half of homeless adults state that they are limited in performing vigorous physical activities (Gelberg, Linn & Mayer-Oakes, 1990). Further, many are limited in moderate physical activities (21 percent), walking several blocks (28 percent), bending, lifting, or stooping (28 percent), type or amount of work (43 percent), or all types of work (29 percent). Functional disability might be due to any acute or chronic physical illness. Just as likely, this impairment might be the result of mental illness. In fact, it is difficult to tease out the differential effects of these two aspects of illness, since they are both multifaceted and both influence one another. For example, if a homeless person experiences physical impairment, this might be due to cardiopulmonary disease, or to the vegetative symptoms of severe depression.

The remainder of this section will address the epidemiology of health problems of people who are homeless. Although there is overlap among the different problems, they will be divided for the sake of clarity into the following categories: acute illnesses; chronic physical conditions; communicable diseases; dental problems; substance abuse disorders; chronic mental illness; and violence. Because of special issues related to gender and age, sections are also included on: women's health; health of children and teens; and health of the elderly.

Acute Illnesses

About two-thirds of the problems homeless people present to primary health care sites are acute in nature (Wright, 1990). Some of these maladies, especially minor respiratory infections, could easily be self-treated by people in homes, with over-the-counter medications, appropriate nutrition, bedrest and a little bit of medical advice-all of which are inaccessible to those without homes. The three most common acute illnesses that afflict homeless people (Wright, 1990) are usually a direct consequence of the homeless condition:

- respiratory infections (ranging from colds to influenza, pneumonia and pleurisy)
- trauma (lacerations, wounds, sprains, contusions, fractures, burns, etc.)
- minor skin ailments (including sunburn, contact dermatitis, psoriasis, corns and calluses)

Exposure to the elements and crowded shelter conditions increases the risk of contracting respiratory infections and the risk of complications. Most of the trauma is directly related to life on the streets. And dermatological problems are frequently due to exposure to the elements, shelter conditions, lack of hygiene facilities, and inappropriate footwear, among other factors. Other acute problems that can also be traced to the homeless condition include infestations (such as lice or scabies), nutritional deficiencies, and acute gastrointestinal disorders.

Chronic Physical Conditions

The other third of the physical health problems of homeless people are chronic problems, such as hypertension, diabetes, gastrointestinal problems, neurological disorders, chronic obstructive pulmonary

disease, arthritis and other musculoskeletal problems (Wright, 1990). Many of these illnesses are also common among the housed population, but are made worse by the stress and exposure of homelessness as well as by the lack of access to ongoing treatment. Studies comparing housed and homeless populations have shown that people without homes are more likely to suffer from a chronic health problem (Wright, 1990).

One chronic physical disorder considered to be classically characteristic of the homeless condition is peripheral vascular disease (Scanlan and Brickner, 1990)—venous or arterial deficiencies in the extremities, including such disorders as varicose veins, phlebitis, thrombosis, swollen ankles, cellulitis of the extremities and gangrene. This is primarily due to people being on their feet all day, the lack of opportunities to elevate feet and legs, and often having to sleep in a sitting-up position.

Communicable Diseases

Communicable diseases are of particular concern for two reasons: the potential for rapid spread among people living in crowded shelters or unsanitary conditions; and the health risk to the general public. About one out of every five HCH clients has an infectious or communicable disease (Wright, 1990). Most of these disorders are relatively minor, such as lice or scabies infestations, other skin diseases, etc. However, serious respiratory infections were found in almost four percent, sexually-transmitted disease (STD) in about three percent, and active tuberculosis (TB) infection in about one percent (Wright, 1990). Contagious diseases, such as tuberculosis (Brickner et al., 1985; Wright et al., 1987; Zolopa et al., 1994) and HIV infection (Torres et al., 1990; Zolopa et al., 1994), are more common among homeless people than in the general population.

Tuberculosis

Five factors contribute to a heightened risk for TB among homeless persons (National Health Care for the Homeless Council, 1994):

1. Insufficient access to preventive services and health care, including lack of outreach, case management or other enabling services which would improve the likelihood of 'receiving effective care.
2. Prevalence and incidence of tuberculosis among other homeless persons, increasing possibility of exposure.
3. Crowding and insufficient ventilation in shelter environments.
4. Increased prevalence of other health conditions which suppress the immune system, such as HIV infection, poor nutrition, untreated diabetes, chronic obstructive pulmonary disease, alcoholism, drug abuse and psychological stress.
5. Incomplete drug therapy, due to difficulties of compliance in a homeless environment, which leads to development of drug resistant bacteria.

As a result of this increased risk, the prevalence of TB infection among homeless adults ranges from 32 percent in San Francisco (Zolopa et al., 1994) to 43 percent in New York (McAdam et al., 1990). The rate of active TB among men in a New York shelter clinic was 6 percent (Zolopa et al., 1994). The rate of positive TB skin tests has been found to be related to duration of homelessness (Zolopa et al., 1994; Gelberg et al., 1997), living in crowded shelters or single-room occupancy hotels (SROs) (McAdam, 1990; Zolopa et al., 1994; Gelberg et al., 1997), area of the city (Gelberg et al., 1997), and injection drug use (Zolopa et al., 1994). The general public is also at risk. A homeless person with undiagnosed pulmonary TB who frequented a neighborhood bar infected 42 percent of the regular customers of that

bar (Kline et al., 1995). TB is more difficult to treat in a person who is homeless because of the difficulty of screening, following, and maintaining treatment, and because many have multidrug-resistant organisms (Bernardo, 1985; Brudney and Dobkin, 1991).

HIV/AIDS

The prevalence of HIV infection among the homeless population is also higher than in the housed population. Studies reveal an HIV infection rate of 9 percent among San Francisco's homeless adults (Zolopa et al., 1994), 1.3 percent among African American homeless women in Los Angeles (Nyamathi, 1992), 19 percent among homeless psychiatric patients in a New York City men's shelter (Susser, Valencia and Conover, 1993), 62 percent among homeless men who visited a New York City shelter clinic (Torres et al., 1990), and 5 percent among homeless youth in a New York City shelter clinic (Stricof et al., 1991). Recent research (Smereck and Hockman, 1998) has also shown that rates are higher for homeless people living on the street (19 percent of population studied) than those in other living situations such as shelters (11.2 percent of those studied). Rates also differed by gender and race, with exceptionally high HIV+ rates for on-the-street homeless Hispanic males (29 percent) and females (32 percent) and for on-the-street homeless black females (38 percent).

Another recent study (Somlai et al., 1998) found that different factors were associated with HIV risk levels among homeless men and women. In men, high-risk patterns were associated with negative attitudes toward condom use, low levels of intention to use condoms, high perceived risk of AIDS, and low perceived self-efficacy for avoiding risk. Women at high risk of HIV infection had greater life dissatisfaction; were less optimistic and held more fatalistic views about the future; held more negative condom attitudes; perceived themselves to be at risk; and frequently used alcohol, marijuana, and crack cocaine.

Hepatitis

Viral hepatitis has become a major concern to clinicians providing care to homeless persons. The hepatitis C virus (HCV) is now the most common chronic blood-borne infection in the United States (CDC, 1998). Although the incidence of HCV infection is declining in the general population, its prevalence remains high in particular subpopulations, especially those involved in high risk behavior of intravenous drug use and unprotected sex. There currently is no significant body of research on HCV specific to the homeless population, but homeless health care clinicians have been seeing a rapid increase in the number of chronic cases, in part because of increased screening. According to these clinicians, the incidence of HCV infection is higher in health care settings serving a larger proportion of injecting-drug users or HIV-infected individuals (HCH Clinicians' Network, 1999). "Since HCV-infected persons can remain asymptomatic for 20-30 years, many are unaware of their condition, complicating infection control and prevention of ultimately life-threatening sequelae." (HCH Clinicians' Network, 1999)

Due to the high prevalence of intravenous drug use and unprotected sex, homeless youth and adults are at also at great risk for hepatitis B. Little has been published on rates of hepatitis B positivity within homeless populations, but the limited literature notes that homeless adolescents are at high risk (Busen and Beech, 1997; Morey and Friedman, 1993; Wang et al., 1991). Experience suggests that all homeless children, youth, and probably most adults should be immunized against hepatitis B and high-risk persons should be tested for hepatitis B and C infection.

People experiencing homelessness are also at risk for hepatitis A, due to overcrowding in shelters as well as eating out of garbage cans, both of which heighten the risk of fecal-oral spread of this disease. In fact, an outbreak of hepatitis A was found in a shelter in Vienna (Kern et al., 1986).

Dental Problems

One of the more overt identifiers of poverty in the United States is poor dental health (Gelberg, Linn & Rosenberg, 1988) and it is one of the major health problems reported by homeless individuals (Mowbray et al., 1986). Ten percent of homeless clinic patients have been found to have poor dental health, a rate thirty-one times that found in the general population (Wright and Weber, 1987). Homeless persons living in the community are one-third as likely as domiciled adults to have obtained dental care in the past year, and consequently are twice as likely to have gross dental decay (57 percent versus 23 percent) (Gelberg, Linn & Rosenberg, 1988). More than half of homeless persons have grossly decayed teeth (Gelberg, Linn & Rosenberg, 1988).

Given this high rate of dental disease, dental care should be an integral part of any health care services package developed for homeless people. Unfortunately, dental care is not always given the significance it deserves within the general health care arena. Some may even think dental care for people who are homeless is a luxury. Yet the impact of dental disease and lost teeth goes beyond the general health implications of infection and pain. Nutrition is affected because people without teeth are severely limited in what they can eat, resulting in fatigue and additional health problems. There is also an important link between the condition of the mouth and teeth and an individual's self-esteem, with the resulting impact on their emotional health and social interactions. This in turn functionally affects their ability to obtain employment. As a formerly edentulous client at one HCH dental clinic commented after getting a full set of dentures, "It's hard to get a job if you can't smile" (McMurray-Avila, 1997).

Substance Abuse Disorders

Epidemiological research consistently demonstrates, and service providers can confirm, the major impact of substance use disorders in homeless populations. Based on clinicians' reports, Wright (1990) estimated that of people seeking primary health care from HCH programs, 38 percent were alcohol abusers and 13 percent abused other drugs. Surveys of homeless people in general suggest higher rates: the Baltimore Homeless Study (Breakey et al., 1989) produced estimates of rates for alcohol use disorders of 67 percent and 26 percent for men and women respectively and rates of 29 percent and 11 percent for men and women for other drug use disorders. Robertson et al.(1997) found lifetime rates of alcohol use disorders of 71 percent in men and 63 percent in women in Alameda County, California. Rates for other drug use disorders were 53 percent and 51 percent. An examination of

> The intoxicants used by homeless people vary from place to place and time to time, following the trends in the wider society. Thus, as the cocaine abuse epidemic increased through the 1980s and 1990s, the amount of cocaine use and abuse in the homeless population increased also. However, in nearly every report, alcohol is still the principal drug of abuse in most places. The drugs of greatest concern in homeless people, from a public health standpoint, are alcohol, heroin and cocaine. Alcohol abuse and dependence are associated with a wide range of health complications involving the liver, the nervous system and the heart. This is in addition to the social deterioration, loss of economic productivity, vulnerability to accidents and victimization that are common outcomes. Heroin dependence, in addition to its social, legal and economic effects on the person, in most cases involves intravenous administration, with the hazards of infections such as bacterial endocarditis, hepatitis and HIV disease which have a major impact on an individual's health and pose major challenges for health care services. Cocaine, when it is administered intravenously, poses similar risks, in addition to the social and mental consequences of its use.

numerous studies to date (Koegel, Burnam & Baumohl, 1996) concluded that about half of homeless people studied have had a diagnosable substance abuse disorder at some point in their lives, with a history of alcohol abuse occurring in almost half of single adults who are homeless, and a history of drug abuse in approximately one-third.

Chronic Mental Illness

In the mid-1980s there were several well-designed prevalence studies using standardized diagnostic methods to determine rates of mental illness in homeless populations of major American cities (Institute of Medicine, 1988; Fischer and Breakey, 1991). Research indicates that prevalence rates of specific psychiatric disorders vary in different subgroups of homeless people and from place to place, but a broad consensus emerged that of homeless people residing in shelters, about one third had significant mental illnesses (Koegel, Burnam & Farr, 1988; Breakey et al., 1989; Susser, Struening & Conover, 1989; Smith, North & Spitznagel, 1992, 1993).

Data from the Baltimore Homeless Study (Breakey et al., 1989) are typical: approximately 35 percent of men and 48 percent of women were found to have a major mental illness. Schizophrenia was diagnosed in 9 percent of men and 16 percent of women, and major mood disorders in 17 percent of men and 25 percent of women. Note that these mentally ill people varied in their degree of disability, as do mentally ill people in general. If criteria of extensive histories of inpatient admissions and significant functional impairment are applied, the number who are "severely and persistently" mentally ill is many fewer. It is this group who present the greatest needs for treatment and rehabilitation. They were estimated to represent between 20 and 25 percent of homeless people by Koegel, Burnam & Baumohl (1996). In the Baltimore sample, they comprised 17 percent of men and 24 percent of women (Breakey et al., 1989).

Violence

Violence in the lives of homeless persons is a major factor for understanding critical pathways from childhood and adulthood into homelessness (Bassuk, Melnick and Browne, 1998; Kipke et al., 1997; Link et al,, 1995; North, Smith and Spitznagel, 1994; Toro et al., 1995). Such violence experienced during childhood and adolescence often continues once individuals become homeless as a result of their lack of protection and personal security. These experiences lead to both acute and chronic health conditions (Gelberg, Linn and Mayer-Oakes, 1990) and potentially affect trust building and subsequent adherence with preventive and ongoing health care (Goodman et al., 1997).

Women's Health

Health services for homeless women are severely lacking (Institute of Medicine, 1988), and yet pregnancy and recent births are risk factors for becoming homeless (Weitzman, 1989). Ninety-five percent of homeless women are sexually active (Nyamathi, 1993), and yet 72 percent do not use birth control (Gelberg & Linn, 1985). Less than 10 percent use condoms, despite lifestyles that place them at great risk for HIV/AIDS and other sexually transmitted diseases (Gelberg & Linn, 1985; Shuler et al., 1995; Brickner et al., 1990). This is evidenced by the fact that 60 percent of homeless family planning clinic users had a history of a sexually transmitted disease (STD), and 28 percent had a history of pelvic inflammatory disease (PID) (Shuler et al., 1995). In addition, more than one-fifth have not had a Pap smear in the past five years (Gelberg & Linn, 1985) compared to less than 9 percent of women in the general population (Hayward et al., 1988). This is alarming given that 23 percent of homeless family planning clinic users had an abnormal Pap smear (Shuler, 1991).

If the homeless condition is unhealthy for people in general, clearly it is even more dangerous for a pregnant woman. Homelessness brings high risks for complications during pregnancy due to lack of prenatal care, poor nutrition, stress and exposure to violence. Normal physiological changes of pregnancy often become pathological, signs of potential complications go unnoticed or unattended, and the minor discomforts of pregnancy are exacerbated by the homeless environment (Killion, 1995). These complications become even more pronounced when the woman is a substance abuser, is mentally ill or is HIV+. Based on studies of women's obstetrical history, 74 percent have had children (Burnam & Koegel, 1989; Shuler et al., 1995) and 54 percent are currently at risk for unintended pregnancy (Shuler et al., 1995). Homeless women are more likely to be pregnant (11 percent of homeless women age 20 and over, and 24 percent of 16- to 19-year-old homeless youth) than their poor but housed peers (five percent) (Chavkin et al., 1987). In addition, they are more likely to receive inadequate prenatal care than poor but housed women (56 percent versus 15 percent) (Chavkin et al., 1987).

It follows that homeless women are more likely than impoverished housed women to have poor birth outcomes (Paterson and Roderick, 1990; Shuler et al., 1995; Weitzman, 1989; Wright and Weber, 1987), with one study showing a difference in low birth weight newborns of 16 percent for homeless mothers versus seven percent for non-homeless mothers (Chavkin et al., 1987). In New York City, infant mortality was highest among homeless women (24.9 per 1,000 live births) as compared to poor housed women (16.6 per 1,000 live births), and non-poor housed women (12.0 per 1,000 live births) (Chavkin et al., 1987). In Great Britain, while homeless women had higher rates of premature births (11 percent vs. seven percent of the general population), their rates of infant mortality were the same as those of housed women (Paterson & Roderick, 1990).

Homelessness puts women at risk for trauma due to violence, often echoing abuse suffered earlier in life. Physical and sexual abuse in family and other interpersonal relationships have been identified as both a cause and a consequence of homelessness in the lives of women (Hagen, 1987; Stoner, 1983). In one study of homeless and poor housed women, 67 percent reported severe physical violence by a childhood caretaker, 43 percent reported childhood sexual molestation, and 63 percent reported severe violence by a male partner (Browne & Bassuk, 1997). Women on the streets are often victims of assault, both physical and sexual. Those who are mentally ill or under the influence of drugs or alcohol are even more vulnerable to attack, and less likely or able to seek help afterwards (Burroughs et al., 1990). Unfortunately, even being in a shelter does not always protect women from violence, especially in large public shelters that also house men. And homeless women who are in relationships are just as likely as housed women to be battered by their partner, becoming victims of domestic violence without the benefit of the "domestic" dwelling (Burroughs et al., 1990).

Health of Children and Youth

Homeless children are more likely to suffer from acute health problems, than from chronic conditions. The most common illnesses in children seen by HCH projects are, in approximate order of frequency: minor upper respiratory infections; minor skin infections; ear infections; gastrointestinal problems; trauma; eye disorders; and lice infestations (Wright, 1990). As might be expected in families that move frequently, homeless children are often behind in their immunizations (Wood, 1992). And without easy access to health care services, chronic illnesses such as anemia, asthma and recurrent otitis media often go undiagnosed and untreated. Poverty has been seen to have a significant impact upon children's health, achievement, and behavior (Brooks-Gunn and Duncan, 1997). The effects of homelessness on normal childhood development have been documented to include academic difficulty (due to missing school) (Eddins, 1993) and behavior problems (Wood, 1992), as well as growth delay (Fierman et al, 1991),

developmental delay, anxiety, depression and learning difficulties (Aber et al., 1997; Bassuk, Rubin & Lauriat, 1986; Eddins, 1993).

Homelessness among adolescents is more frequent than is generally realized (Ringwalt et al., 1998). Homeless youth, sometimes known as runaways, throwaways or simply "street kids," suffer from illnesses directly related to a lifestyle on the streets that is characterized by violence and deprivation (Kennedy et al., 1990; Robertson, 1996). Street youth have often been victims of physical and sexual abuse and family chaos, and have been found to have a greater number of psychological and physical problems than the general adolescent population (Sherman, 1992). Many engage in "survival sex," exchanging sexual favors for food, clothing or shelter, making them vulnerable to sexually-transmitted diseases, including HIV, as well as unintended pregnancies (Rew, 1996). Health problems most commonly seen by clinics serving this population include (in approximate order of frequency): violent and traumatic injury; substance abuse; sexually-transmitted diseases, including hepatitis and HIV/AIDS; psychiatric disturbances; skin infestations; ignored pregnancies; "unwell" babies; and common chronic illnesses that have been exacerbated by the lack of simple care (Kennedy et al., 1990).

A study of homeless and poor housed youths found that approximately 32 percent had a current mental disorder accompanied by impairment in function, but use of mental health services was low (Buckner and Bassuk, 1997). Psychiatric disorders are likely to be ignored, covered up or denied by adolescents. Their frequent past histories of abuse and neglect, their involvement in antisocial lifestyles and neglect of their education have grave implications for their personality development and maturation into adulthood.

Health of the Elderly

Relatively few homeless people over age 65 are seen in health care sites serving homeless people-only 2.7 percent in 1996 (U.S. Department of Health and Human Services, 1998a). This could be due either to early mortality or to the additional benefits and assistance available once a person reaches 65 (allowing for access to income, housing and health care). Although their numbers are few, "the aged homeless are of special concern because of their vulnerability to victimization while on the streets and in shelters, their frailty due to poor physical health, and the reluctance of community senior centers to accept them as participants" (Ladner, 1992). As would be expected, many of their health problems are chronic conditions associated with aging, such as COPD, PVD, hypertension and heart disease (Blakeney, 1991; Gelberg, Linn & Mayer-Oakes, 1990; O'Connell, Summerfield and Kellogg, 1990). The majority suffer from alcoholism, but mental illness is somewhat less common than in the general homeless population (Blakeney, 1991).

System Adaptations Designed To Overcome Access Barriers

Compounding the increased risk for illness or injury, there is evidence that homeless people encounter major obstacles to obtaining needed medical and psychiatric services. The majority of homeless adults state that they did not obtain needed medical care in the previous year (Gelberg and Linn, 1988; Robertson and Cousineau, 1986). Even among those with a chronic medical condition, half had not seen a doctor within the previous year (Robertson, Ropers and. Boyer, 1985). Organizations providing services to homeless people have described numerous difficulties in accessing substance abuse treatment for their clients (Williams, 1992).

Since the mid-1980's, significant advances have been made in the development of effective delivery systems for health services to people who are homeless. The support of several agencies of the U.S. Department of Health and Human Services-often through programs authorized by the Stewart B.

McKinney Homeless Assistance Act of 1987—has been instrumental in these advances. The Bureau of Primary Health Care's Health Care for the Homeless (HCH) program has assisted more than 130 communities in providing comprehensive health services to people who are homeless, with a special focus on developing systems that directly address the barriers to access homeless people face.

Some of these barriers to access are related to external factors such as lack of transportation (Robertson & Cousineau, 1986). Others are internal, for example, denial of existence of a health problem, lack of awareness of available services, or active avoidance due to fear or distrust of large institutions. Because an exhibition of toughness is necessary in order to survive on the streets, homeless persons may at times deny that they have health problems in an attempt to maintain a sense of their own endurance. People with substance abuse disorders or mental illness may deny having a problem or be unaware of the severity of it.

Even when aware of their problem and of available services, many homeless people are distrustful of any offers of help due to previous negative experiences with the health care and social services systems. They may be too embarrassed to have medical professionals see them in a condition of poor personal hygiene. Or they may avoid seeking health care because of the fear of having their meager financial resources taken away to pay for the services they receive, or fear of authority figures (Stark, 1992), including Immigration and Naturalization authorities, child protective service workers (by runaway teenagers and homeless women with children), and police (by drug abusers or ex-convicts) (Jahiel, 1992).

Service Delivery Locations

In order to overcome these barriers, health care projects serving homeless people have developed adaptations related to locations of service delivery, with options ranging from mobile to fixed-site services. Mobile approaches-both street outreach and use of mobile units-respond especially well to the barriers mentioned above, finding and engaging people who would otherwise not receive health services. Fixed-site locations include: shelter-based services; community health center or hospital-based clinics with special accommodations for homeless people; and free-standing HCH facilities such as clinics, respite units, drop-in centers or residential programs. Current federally-funded HCH projects tend to use more than one approach, frequently combining street outreach with fixed-site locations in shelters or free-standing clinics (Cousineau et al., 1995).

Scheduling Of Services

Another significant obstacle to access relates to times when services are offered. Mainstream services depend on scheduled appointments, which are often hard for homeless people to keep, due to competing priorities for survival, such as finding day labor, a free meal or a shelter bed for the night (Gelberg, Gallagher, Andersen & Koegel, 1997). People who are homeless also lack access to telephones to make appointments or change them if necessary. For this reason, scheduling of services needs to coincide with the most convenient times for the population being targeted, and should not conflict with those times when homeless people are normally searching for a meal or shelter. Many HCH projects set aside certain times for walk-in clinics, while other times are designated for scheduled follow-up appointments with clients who have an established history of care. Outreach schedules need to be even more flexible, often taking place during early morning or evening hours, depending on the population and the setting (McMurray-Avila, 1997).

Financial Barriers

Lack of financial resources or health insurance and lack of documentation constitute additional access barriers that affect how services need to be structured and delivered. One-fifth of homeless adults who had not obtained needed medical care stated that this was due to inability to pay for medical services (Cohen, Teresi & Holmes, 1988; Robertson & Cousineau, 1986). Only one-sixth (Bassuk, Rubin & Lauriat, 1984; Farr, Koegel & Burnam, 1986; Robertson, Ropers & Boyer, 1985) to one-third (Fischer, Shapiro & Breakey, 1986; Miller & Lin, 1988) of people who are homeless have any form of health insurance, and most have no cash resources at all (Koegel & Gelberg, 1992). One decade after most of these studies were performed, HCH projects still report that over 70 percent of the clients they see have no financial resources for health care (U.S. Department of Health and Human Services, 1998a). Homeless people frequently lack identification or other documentation to prove indigent status in order to qualify for free or reduced services in mainstream health care settings. They often have had their identification documents lost or stolen, or are living in the streets and shelters of the U.S. without legal documentation.

Health care programs for homeless people must therefore tap into every available funding source to eliminate this access barrier. Public funds, through Medicaid and other funding streams, have supported health care for poor and homeless people. As public programs exert pressure to conform to models first developed for managed care in the private sector, effective HCH projects must continue to give priority to responding to the special needs and realities of their clients. At the same time they must strive to address the increased needs for detailed intake, authorization and billing procedures, despite the drain on resources of staff and time. These conflicting priorities may be a source of considerable stress to clinicians and to program administrators. Strict adherence to a business mentality will create frustration for staff and alienation for clients.

Cultural Competence

Access to services is also affected by language and cultural barriers and by attitudes of providers of care. While a positive, open attitude of being culturally sensitive is necessary, it only becomes cultural competence when it is put into practice. Practicing cultural competence involves a combination of *attitude, knowledge* and *skills* (CASSP). An *attitude-of* respect is essential when working with people who are homeless, as well as maintaining an acceptance of cultural differences among people. People from all cultural backgrounds become homeless, so practitioners need to be willing to work with clients of different ethnic minority groups and cultures. *Knowledge* of the history, traditions, values, and family systems of these cultures is important, especially an understanding of the effects of particular cultures on the help-seeking behaviors of people who are homeless, as well as the specific health beliefs and healing practices of the cultures involved.

In addition to the obvious *skill* of language competency, skill is also needed to adjust clinical practice to accommodate certain health beliefs and healing practices of different cultures. Cultural beliefs affect attitudes toward disease and health, as well as offering explanations for causes of ill health, including mental illness and substance abuse. What may be labeled "non-compliance" by a health care provider could in reality be due to cultural differences in interpreting the diagnosis and/or treatment.

Dealing With Disruptive Behavior

An additional barrier to access is created when homeless people with histories of disruptive behavior are actually barred from services. Homeless health care providers continually have to assess the nature of disruptive behavior-is the person acting out due to a mental illness beyond his or her control, or is the

behavior intentional and meant to do harm? Again a delicate balance must be maintained between flexibility-particularly with regard to examining and changing rules or policies that may be inappropriate for the population in question-and the safety of the client, other clients and the staff. What may sometimes be labeled a shortcoming of the client in terms of being "non-compliant" may actually be a shortcoming of the system of services-non-compliance with the approaches needed to effectively serve the clients.

Multidisciplinary Teams

One final adaptation to service delivery that health care providers must make when working with homeless people relates back to the concept of integrated services discussed in the introduction. Most mainstream health care organizations are primarily single-focused. They either provide medical care, mental health services or substance abuse treatment. Few are organized to deal with the multiple issues that are part of being homeless. When people are treated only for the "presenting problem," the underlying cause of that problem may not be addressed. Clinical interventions with homeless people are most effective when carried out by multidisciplinary teams (Burness Gleicher et al., 1990). The practice of clinicians from different disciplines working together offers more chance of arriving at appropriate diagnosis and treatment conclusions.

Health Services for Homeless Youths

Providers of health care must be aware of all of these potential barriers, making adaptations as necessary and paying special attention to the characteristics of the population they are serving. Designing health services for homeless youths provides a good example of this. Adolescents who are homeless and apart from their families present significant problems for health care because of the difficulty in engaging them, but also because of their frequent reluctance to acknowledge their need. Their status as minors, issues of consent and confidentiality and their distrust of adults provide additional barriers to care (Robertson, 1996) Clinicians working with this group should be well-versed in the usual health needs of adolescents, but particularly prepared to deal with the physical and emotional effects of violence, common and exotic sexually transmitted diseases, pregnancy and mental illness. Kennedy et al. (1990) describe a number of principles in delivery of health care to "street kids." These' include outreach to places where adolescents congregate; immediacy, the ability to respond without delay, because a teenager may not wait or come back again, having once expressed willingness to accept treatment; networking, to provide the needed linkages into a range of helping services; and sanctuary, in terms of privacy and protection. Services should be available in youth shelters, but also on the street, through outreach, because many homeless adolescents do not use shelters (New York State Council on Children and Families, 1984; Robertson, 1996). Health promotion, disease prevention and harm reduction strategies focused on this group are essential.

Adapting Clinical Practices to the Homeless Condition

Based on the broad scope of health problems described above, it is clear that a full array of services must be made available and accessible for people who are homeless. Otherwise, the care can easily revert into "Band-Aid medicine" and miss underlying or co-occurring conditions. The following discussion covers elements of health care encounters common to medical, mental health or substance abuse services, including: intake and assessment; clinical preventive services; diagnosis; referrals for specialty and inpatient care; linkages to non-health services; and follow-up to ensure continuity of care. It is important

to remember that the elements may not necessarily occur in this order, or be provided in a typical clinical setting.

Intake and Assessment Procedures

A system that features multiple points of entry is termed the "no wrong door" approach. In such a system, a homeless person is offered the opportunity to link with all needed services through the initial contact-whether through a medical or dental program, street outreach, or any point in the continuum of substance abuse or mental health services. To identify needed services, an adequate assessment of health and social problems is necessary, including housing status and access to basic needs (food, clothing, etc.).

In addition to the standard clinical history questions, the intake procedure should pay special attention to the client's living situation, including questions related to sleeping location, sources of food, support systems (friends or family), history of mental illness, use of alcohol or street drugs, exposure to violence or abuse, cause of homelessness, and plans for getting out of the homeless situation (Usatine et al., 1994). Answers to these questions will help determine the appropriate course of action, regardless of whether the initial encounter involves medical or dental services, mental health or substance abuse problems. Providers of care to homeless people also need to be alert for any possible underlying conditions that could affect the diagnosis, proposed treatment or eventual outcome of each client's case. It is important to note, however, that the need for a comprehensive assessment must always be weighed against the possibility of alienating or intimidating the person being assessed.

Clinical Preventive Services

Prevention activities fall into several categories:

- Screenings for acute and chronic physical conditions, communicable diseases, mental illness and substance abuse disorders;
- *Well-child exams;*
- *Immunizations* (for adults and children);
- *Special services for women,* including family planning and perinatal care;
- *Health education/health promotion* including self-care information for patients with particular conditions (ranging from diabetes to addictions) and encouraging changes in behavior that will improve or maintain health or prevent disease.

Screening. Without overwhelming clients with probing questions unrelated to the stated purpose of their visit, screening for both physical and mental chronic conditions should be included whenever possible, even in acute care visits. Practitioners working with homeless people constantly have to balance the importance of preventive activities (whether screening or promoting behavior change) with the mental or emotional state of their clients, as well as sensitivity to their past experiences with the "system." In order to engage homeless people in ongoing care it is necessary to avoid alienating them and to focus on establishing trust (Cousineau et al., 1995). However, screening procedures are welcomed by many homeless people (Long et al., 1998) and should be a part of each clinical encounter within a clinical program. Some health care programs for homeless for people have also performed screenings in shelters, soup kitchens and other locations, to identify potentially treatable conditions in people who otherwise might not get clinical care.

Blood pressure screening for hypertension is routine with any physical exam. Homeless people should also be offered TB skin testing (CDC, 1995), while recognizing the likelihood of false negatives with people who are HIV+ (Morrow et al., 1997); routine testing for STDs, including HIV/AIDS; breast, cervical, skin, prostate and colon examinations; screening for glaucoma; and testing for cholesterol levels (Weinreb, 1992). In addition to screening for physical illness, primary care providers also need to be alert for signs of substance abuse and mental illness (Usatine et al., 1994). The CAGE is a simple but effective screening tool for alcoholism (Ewing, 1984). Health care providers must also be trained in routine screening of patients for victimization histories, as well as in the recognition of the physical and mental symptoms and signs of violence among their patients (e.g., injuries and post traumatic stress disorder) (Harris & Landis, 1997; Lam & Rosenheck, 1998; Moy & Sanchez, 1992; North & Smith, 1992; Padgett & Struening, 1992).

Well-Child Exams. Like any other children, homeless children require regular examinations and immunizations. Working with homeless families who have children raises additional screening issues. According to Wood, "Homeless families often cite benign acute problems as the reason for a clinic visit. Each encounter, however, should include a history of preventive health care, developmental problems, school problems, medical problems and past child abuse" (Wood, 1992). Because homeless families experience many problems that could lead to child abuse-including extreme family stress, exposure of the child to multiple caretakers, family violence, and drug or alcohol abuse-clinicians should screen for child abuse (neglect, physical and sexual) in the history and physical examination of every child (Wood, 1992).

All homeless children should receive a PPD skin test for TB annually. Homeless children who are African American should receive a sickle cell screening test. And children with a history of pica or anemia should be screened for lead exposure (Wood, 1992).

Immunizations. Immunizations to prevent diphtheria, tetanus, influenza, pneumococcal pneumonia and hepatitis A and B should be made available to all homeless adults (Weinreb, 1992). Rubella vaccination should be offered to homeless women of childbearing age who are not pregnant and who are antibody negative, and who have no other contraindications for vaccination (Weinreb, 1992). Homeless children should receive the HIB (Haemophilus Influenza B), DPT (Diptheria, Pertussis, Tetanus), OPV (Oral Polio Vaccine), and MMR (Measles, Mumps and Rubella) vaccines according to the routine guidelines of the American Academy of Pediatrics Committee on Infectious Disease (Wood, 1992).

Women's Health. The importance of preventive care for homeless women (gynecological exams, family planning and perinatal care) is made obvious by the research cited above. McNally and Wood (1992) recommend a comprehensive approach to providing perinatal care and family planning for homeless women, with special emphasis on awareness of potential complications, screening for alcohol/drug use, HIV/AIDS and other STDs, and use of multidisciplinary teams to include outreach and case management, as well as clinical care (McNally & Wood, 1992).

Health Education/Health Promotion. Health education and health promotion to prevent communicable diseases is especially vital in the homeless population, given the increased risk factors, yet the characteristics and lack of resources of homeless people present an unusual challenge to health educators. Many homeless people are preoccupied with their current difficulties and by temperament are not future-oriented. They may find it difficult to make a short term sacrifice for a long term benefit. It is clearly unrealistic to expect people who are homeless to make changes in behavior based only on the knowledge that it's "bad for their health." For example, an over-reliance on distribution of printed materials would

not be effective with this population. However, provision of resources (such as condoms, bleach kits or syringes) will facilitate the changes of behavior necessary to prevent HIV/AIDS or other STDs.

Self-help approaches, such as those used in mental health self-help agencies (Segal et al., 1998) or12-step programs, are one way to reach people and provide ongoing support for behavior changes. Activities that involve one-to-one personal interaction or group interaction, such as support groups, can be successful, given the isolation many homeless people feel and the need for meaningful human contact (Tsemberis, 1996). The use of "peer educators" in drug abuse prevention with homeless youth (Fors & Jarvis, 1995) and "peer health advisors" to improve compliance with initial clinic visits for homeless adults newly tested positive for TB or HIV (Peterson et al., 1993) are examples of successful and innovative health education approaches that involve the target population directly.

Another avenue to health promotion is through education of other service providers. For example, teaching shelter and meal providers about preparation of healthy meals will probably have more impact on the nutrition of homeless people than giving them brochures on the important food groups. Surveillance of health and safety conditions in shelters and other service sites will help avoid potential accidents and injuries, as well as preventing communicable diseases, such as tuberculosis (Mayo et al., 1996). Health care or shelter staff who work with families also need to be aware of potential child abuse and neglect, armed with strategies from education to incident reporting.

Diagnosis

In the practice of diagnosis, three specific accommodations will be mentioned here related to: 1) the clinical exam; 2) recognizing multiple diagnoses; and 3) availability of diagnostic tools such as laboratory testing and radiology.

Clinical Exam. Medical care providers need to be especially sensitive to issues of hygiene when involved in physical exams with people who are homeless. Although some clients, particularly those with severe mental illness, may be oblivious to their unwashed condition, many are quite embarrassed. A high tolerance and understanding on the part of the provider, combined with, availability of shower facilities (as well as clean socks and other clothing), wili go a long way towards developing an environment in which homeless people can feel comfortable and welcome. This issue continues to stand as a major barrier for homeless people attempting to receive care in mainstream settings.

During the clinical exam, the provider will need to be alert for those conditions which commonly occur as a result of homelessness-upper respiratory tract infections, trauma, skin disorders, musculoskeletal problems and dental disease—regardless of what was presented as the chief complaint. In addition, providers should be on the look-out for common chronic conditions such as hypertension, gastrointestinal and neurological problems, peripheral vascular disease and obstetric/gynecologic conditions (Usatine et al., 1994). Because homeless people frequently have lost glasses or had them broken or stolen, vision should also be checked. Serious vision problems have been reported by nearly one-quarter of people who are homeless (Gelberg & Linn, 1989).

Evaluating Psychiatric Symptoms Requires Sensitivity To Each Person's Special Situation. There may be a risk of either over-diagnosing or under-diagnosing treatable conditions. For example, suspiciousness in a homeless person does not necessarily indicate paranoia, but may be an understandable consequence of living on the streets. Conversely, low mood and disturbed sleep should not readily be dismissed as normal reactions to bad circumstances; they may be symptoms of a treatable depressive illness.

Recognizing Multiple Diagnoses. Primary care practitioners need to pay special attention to identifying multiple diagnoses, avoiding isolated diagnoses that may miss co-occurring or underlying issues. This is true whether the co-occurring diagnoses are all physical in nature or combine physical, mental health and/or substance abuse diagnoses.

Availability of Diagnostic Tools. Accurate diagnosis often depends on the availability of laboratory testing and radiology. Making these services easily accessible is essential when working with homeless people. In some cases this may include providing transportation to a site where the testing can be performed or x-rays taken.

Follow-Up to Assure Continuity of Care

Successful outcome when working with homeless people depends on more than just accurate diagnosis and quality treatment. Frequently, success hinges on the client's ability to follow through with the recommended treatment. Care providers face numerous obstacles in supporting this ability and establishing continuity of care. In addition to barriers already listed, additional complicating factors include:

Competing Needs and Priorities. People who are homeless may place a greater priority on fulfilling their basic needs for food, shelter, hygiene, and income than on obtaining needed health services or following through with a prescribed treatment plan (Ball & Havassy, 1984; Gelberg & Linn, 1988; Gelberg, Gallagher, Andersen & Koegel, 1997; Robertson & Cousineau, 1986; Sacks, Phillips & Cappelletty, 1987). Keeping follow-up appointments necessary for continuous, comprehensive care is also difficult for homeless people due to their competing needs and different time orientation (Koegel & Gelberg, 1992). Although we typically think of homeless people as having an inordinate amount of time on their hands, often they must deal with the varied schedules and locations of several service facilities to ensure that all their needs are met (Koegel & Gelberg, 1992).

Mobility. While many homeless persons are long-term residents of their communities, others are quite mobile within or between cities or states in their search for subsistence resources. This mobility makes continuity of care difficult (Brickner et al., 1984; Koegel & Gelberg, 1992).

Difficulty Keeping and Storing Medication/Food. The conditions of street life affect compliance with medical care. There is usually a lack of proper sanitation (Baxter & Hopper, 198 1); lack of a stable place to keep medications safe, intact, and refrigerated (Brickner et al., 1984; Wright & Weber, 1987); and an inability to obtain the proper food for a medically indicated diet to deal with conditions such as diabetes mellitus or hypertension (Brickner et al., 1984; Wright & Weber, 1985).

Discharge Planning. Homeless people who have been hospitalized are often discharged directly from the hospital to the streets with inadequate discharge planning to assure conditions for safe recuperation. Even homeless mothers are discharged to the streets with their newborn infants soon after childbirth. Readmission of homeless patients to hospitals is not uncommon (Stark, 1992).

Attitudes of Health Care Providers. People who are homeless may sense from the medical profession a reluctance to treat them due to their poor hygiene or mental illness, or because of assumptions that they come to hospitals for shelter and not for a medical problem (Baxter & Hopper, 1981). Being treated with a lack of respect does not encourage follow-up care or compliance with care.

Respite Care. One of the most valuable activities for promoting continuity of care is the availability of respite care facilities for homeless persons who are not considered sick enough to be hospitalized, but are too sick to stay on the streets. Shelters and streets are often the sites to which homeless patients are discharged from hospitals (Goetcheus et al., 1990; Stark, 1992). Since shelters are usually open only at night, where do ill homeless persons go for rest, nutrition and simple basic care? Convalescent facilities are needed so that homeless persons, after being provided medical, surgical or obstetrical care are not discharged from outpatient settings or hospitals to the streets when their recuperation requires running water, a bed, refrigeration, or proper nutrition (Stark, 1992). Respite care ensures that homeless persons receive care that most others, with homes and families, receive routinely (Goetcheus et al., 1990).

Referrals for Specially Care and Inpatient Care. Although the focus here has mostly been on primary care and the importance of early intervention, the realities of homelessness often result in illnesses or injuries being left untreated, resulting in numerous complications requiring more specialized attention. Homeless people need easy access to specialty care and hospitalization to deal with these situations. Homeless health care providers work hard to establish relationships with public and private health care institutions to obtain this access. However, providers in those institutions who are not familiar with the homeless population may need support, advice or training from homeless health care providers. In some cases, client advocates from a homeless health care project may need to accompany clients when they are referred to those institutions, to assure appropriate care.

Linkages to Other Services. The comprehensive assessment mentioned earlier provides the foundation for determining what linkages are needed. Establishment of referral relationships with other service providers, and a system of case management to coordinate those services, help assure the effectiveness of care given for physical or mental health problems. Given the negative impact that homelessness has on health and health care outcomes, clearly the most significant difference between treating homeless people and the general population is the need to include elimination of homeless conditions as part of any treatment plan. For this reason, linkages to other services-including transitional or permanent housing-is an essential element of care. (The sections below on services for substance abuse and mental illness will deal with this in more detail.)

Specific Adaptations for Treatment of Physical and Mental Illnesses

In the sections that follow, primary care (medical and dental), treatment for substance use disorders, treatment of serious and persistent mental illnesses and treatment of patients with co-existing mental illness and substance use disorders (the "dually diagnosed") will be considered in turn.

Primary Care Services

Clinical protocols for primary care treatment of specific physical illnesses or injuries are frequently the same for homeless people as for the general population. Variations from standard protocol are most often related to improving the possibility of compliance with treatment by taking into consideration complications of the patient's living situation or co-occurring diagnoses, including multiple physical illnesses, substance abuse or mental illness.

Medications

One of the most common changes in treatment is found in prescribing practices that are adjusted to accommodate the homeless environment. For example, medications that can be given in larger doses

over a shorter period of time may be more effective (e.g., injections vs. oral medications). People without homes usually have to carry their belongings with them at all times and supplies of medication that must be taken over a long period of time may be lost or stolen. Another alternative is to consider giving the patient just enough medication to last until the next scheduled visit. The promise of receiving medications at a future visit may be an incentive for the patient to return. When possible, once-daily dosing is best (Usatine et al., 1994). Medical and dental providers also need to be sensitive to possible substance abuse issues when prescribing medications. Collaboration with substance abuse staff is essential in order to avoid prescribing narcotics or other medications inappropriately, while still assuring adequate pain management.

The importance of compliance with medication regimens for TB in order to prevent development of multi-drug resistance has resulted in programs of directly-observed therapy (DOT) for clients with active TB and directly-observed preventive therapy (DOPT) for those who have been infected. In both cases, patients are given each dose of medication directly by health care providers, sometimes even if it means finding the patient on the street (Caminero et al., 1996; Chaulk et al., 1995; McAdam et al., 1990; Pablos-Mendez et al., 1997). Incentives have also been used to enhance DOT (Mangura et al., 1997), including monetary incentives (Pilote et al., 1996).

Describing all the possible alternative treatment protocols for every illness or situation would fill up numerous volumes (e.g., see O'Connell & Groth, 1991, for a complete manual of information on common communicable diseases in shelters). Instead we will illustrate some of the problematic situations encountered in treating homeless people by reviewing some of the recommendations clinicians have made for treatment of four common chronic medical conditions and dental health

Hypertension. Fleischman and Famham (1992) state that the difficulty of follow-up in the homeless population renders impractical the traditional recommendation of multiple blood pressure determinations before treatment for hypertension. Beginning treatment with dietary changes is also futile, since food at shelters and in soup lines is high in sodium and fat. Thresholds for starting drug therapy must be individualized, considering diminished compliance, poor follow-up, and compounding life-style variables, such as alcohol abuse. In homeless alcoholics with hypertension, referral for alcohol detoxification/treatment may be more appropriate than medications for hypertension:" Many patients will refuse diuretics because of poor access to bathroom facilities (Pianteri et al., 1990). Proper storage and safe-keeping of pills is an issue, with pills often being lost or stolen. If kept in a pocket, they may be pulverized by the movement of constant walking (Filardo, 1985).

When used, the ideal medication should incorporate the following considerations: once-daily dosing, limited need for laboratory follow-up (i.e., avoid potassium-losing diuretics), and no rebound phenomenon (since poor compliance and lost medications may bring on this complication) (Fleischman & Famham, 1992). An alternative for homeless hypertensives is the clonidine transdermal patch, which delivers a steady therapeutic level of the medication for seven days (Michael & Brammer, 1988; Pianteri et al., 1990; Popli et al., 1986). (See Vicic & Weber (1992) for additional guidelines for treatment of hypertension in homeless people.)

Diabetes. Tight control of diabetes may be a dangerous goal in homeless persons, because of their unstable eating and activity patterns (Usatine et al., 1994). Teaching a homeless person to use insulin requires frequent follow-up appointments and careful monitoring. Most shelters do not provide clean, accessible and safe storage places for insulin, medications, or blood glucose monitoring devices. In addition, possession of syringes or alcohol swabs on the street or in shelters can make homeless people into targets for theft (Scanlan & Brickner, 1990). Thus, in a homeless adult patient with noninsulin-

dependent diabetes, it may be best to avoid insulin therapy by prescribing oral hypoglycemic agents at maximum dosages and tolerate less tight control of serum glucose (Usatine et al., 1994).

Peripheral Vascular Disease. "The most important intervention for peripheral vascular disease is a change in lifestyle. Elevation of legs, at least during sleep, is the key to treatment. A network of shelter referrals for beds (not pews), respite beds, or hotel vouchers may be required if the clinic is to help the homeless client find a place to elevate his or her legs. Bus tokens should be given to limit the need for walking long distances" (Fleischman & Farnham, 1992).

A similar practical approach can be used when addressing any of the orthopedic or podiatric problems of homeless people. More than 10 percent of homeless adults have impaired ability to walk and 60 percent have problems with their feet (Gelberg, Linn & Mayer-Oakes, 1990; Wrenn, 1990). These problems are related to osteoarthritis, common in the general population as well, but also are due to the life conditions that homeless individuals endure. They have to walk throughout the day to obtain their basic needs for shelter, food, and clothing, often in poorly fitting shoes, without socks. Providing well fitting shoes, changes of socks, and a bed to sleep on might seem like small interventions, but can greatly improve a homeless person's ability to function.

Heart Disease. Treatment of heart disease in homeless adults is quite difficult. Homeless persons may need to be admitted more often to the hospital and at a lower clinical threshold than the domiciled population. For example, controlling sodium intake and enforcing bedrest, mainstays of therapy in the domiciled population, are virtually impossible. Hospitalization is often required to achieve adequate diuresis in a controlled environment where electrolytes can be monitored (Fleischman & Famham, 1992).

Dental Health. People who are homeless need access to a full array of dental services:

- prevention-dental hygiene; education; free toothbrushes, toothpaste and floss
- assessment-exams and screening (including screening for oral cancer); x-rays
- emergency care-emergency extractions; treatment of infection
- restorative care-fillings; root canals; crown and bridge work
- prosthetics-dentures and partials
- oral surgery-for more complex cases that require a specialist

Ideally each individual would be engaged in a comprehensive treatment plan to address all of the dental problems that have built up over the years. Unfortunately, the homeless condition is not always conducive to follow-up with such a long-term venture. Dental staff need to have clear criteria for determining the appropriate level of care to be provided. With a person who is clearly transient and planning to move on, a short-term response such as an extraction may be more appropriate than initiating a full treatment plan. If dentures are needed, a determination needs to be made regarding the ability of the client to care for and maintain them. Setting up a complete treatment plan is most realistic for clients who are more likely to be able to follow through, or who have been stabilized in transitional housing or treatment programs.

Particular consideration also needs to be given to working with people with mental disorders and people who are known to be HIV+. Special accommodations may also be necessary to care for children (McMurray-Avila, 1997).

Treatment Services for Substance Use Disorders

A wide variety of options and treatment models can be used to develop a responsive network of substance abuse services for people who are homeless. A substance abuse services continuum should be designed to meet local needs, consistent with available resources and the special needs of homeless people (Schutt & Garrett, 1992). Barriers to accomplishing this are political, such as the NIMBY response ("Not-In-My-Back-Yard"), or due to the limited resources available from public and private funding agencies.

In general, the development of services for homeless addicts has lagged behind the development of primary health care services and services for treating mental illness. To address this lack, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) supported two rounds of community demonstration projects with funding from the Stewart B. McKinney Homeless Assistance Act to identify effective approaches for providing substance abuse treatment to homeless people (Argeriou & McCarty, 1990; Conrad, Hultman & Lyons, 1993). The following general conclusions were drawn regarding necessary and desirable program characteristics (Stahler, 1995):

- Need to develop treatment programs that focus not only on the addiction, but also *address the tangible needs* of people without homes.
- Need to develop *flexible, low-demand interventions* that can accommodate clients who are not initially willing to commit to more extended care.
- Need for *longer-term, continuous interventions* for this population. Aftercare needs to address not only the maintenance of sobriety, but also the tangible needs and social isolation of clients.
- Need to *match clients to appropriate treatment* services based on characteristics such as educational attainment, cultural background, severity of substance use, criminal involvement and level of social isolation.

Although the dynamics, demographics and legal implications of addictions to different substances may vary, the principles of treatment are the same: motivation of the person to stop using the substance, detoxification to support the person through the withdrawal process, and rehabilitation to maintain sobriety through a process of recovery. Homeless persons have particular needs at each of these stages, however it is important to recognize that these are not necessarily linear stages. Engaging a homeless person in the recovery process is a long-term undertaking, marked by numerous relapses and fluid movement in and out of stages.

Motivating the addicted person to recognize his or her need for treatment may be the most difficult. Street outreach workers, police officers, social workers, emergency medical staff and primary health care workers in individual cases have important roles in persuading a homeless individual to seek treatment. *Outreach* is particularly important because of the reluctance of many homeless people to seek treatment on their own behalf. Initiating contact with homeless substance abusers on the street, in shelters, drop-in centers, soup kitchens, etc., provides information about available services and begins the motivation and engagement of the person into the system of services. Effective outreach workers are often formerly homeless substance abusers who understand the situations and dilemmas of homeless people and can provide support and encouragement, drawing on their own experiences. For homeless people the likelihood of relapse, discouragement and fatalism is great for both patient and treatment provider. It is part of the outreach function to instill hope in the addict that recovery is possible. *Sobering-up stations* provide another form of outreach. In these small facilities, a clean sanitary, safe and supportive environment is provided to homeless substance abusers who may not yet be ready to contemplate

detoxification. They are often staffed by individuals who are themselves recovering addicts. For a proportion of the users of the station it provides a first step in a recovery process.

Detoxification is technically the simplest phase of treatment, although not always the most readily available. It requires a setting where the person can go through withdrawal with the necessary support to tolerate the unpleasant and sometimes dangerous withdrawal syndromes. *Medical detoxification* involves prescribing medications to protect the patient from the withdrawal symptoms and complications. It is most commonly done in a residential or inpatient setting, but can be done in an ambulatory program if adequate support can be provided for the patient. *Social model detoxification* avoids use of medications if possible and relies on mutual support, social learning and the 12-step principles of AA/NA. Social model programs are less expensive to run than medical detoxification programs and reported to be equally safe for their clients (Whitfield et al., 1978; Lapham et al., 1996).

Once detoxification has been accomplished on a residential or ambulatory basis, a long process of **rehabilitation** is required. During this period the person needs protection from his or her tendency to relapse, provided through peer and professional support and appropriate supportive living situations. The individual needs opportunities for acquisition of new skills for everyday living, relationships and employment and the establishment of a drug-free lifestyle. This phase of treatment is the most time-consuming, most costly and least likely to be available and accessible for homeless people.

Elements of treatment may include individual or group counseling and education to help clients define their needs, understand their addiction(s) and develop their treatment plan. Case management is particularly valuable for homeless people in recovery to assist them in coordinating and negotiating the often fragmented systems of care that exist. Case managers can help identify resources, acquire medical or dental health care services, etc. Sometimes several elements such as counseling, education, case management, group work, etc. may be combined into an intensive day treatment program for people who have stable arrangements for where they will stay at night.

Although many communities have moved toward outpatient treatment to save costs, people without homes are less likely to benefit from such a program. Treatment and rehabilitation are unlikely to be effective as long as the person lives on the streets or in the general shelter system where the daily pressure to use drugs or drink remains high. A range of appropriate opportunities for ***supportive*** housing must therefore be available (NIAAA, 1991a; NIAAA, 1991b; Wittman & Madden, 1988). Residential recovery programs can be designed for the different stages of recovery, including detoxification, primary treatment or as a half-way house or quarterway house. Recovery houses can be based on a social model design where residents are responsible for running the house or on a therapeutic model with greater staff involvement. For some homeless people in recovery, a group home or adult foster care arrangement may be appropriate. Sober housing-housing that is alcohol/drug-free-is an essential follow-up to the treatment process. Months of hard work in treatment and recovery can be lost if the client must then return to the streets. Sober housing may include supportive services or simply be a transitional stage to independent housing in the community.

Throughout the entire process of recovery, **peer group support** is of great importance, usually provided by groups such as Alcoholics Anonymous or Narcotics Anonymous, that provide both a theoretical model for the process of recovery and the emotional support of other addicts. Groups exist in every city and meetings occur every day of the week.

Total abstinence has traditionally been the goal of substance abuse services, but in many cases, addicts are unwilling or unable to contemplate abstinence. Strategies for **harm reduction** serve to reduce the

risk of complications or other adverse effects until such time as the person is willing and able to enter the recovery process (Marlatt, Somers & Tapert, 1993; Marlatt et al., 1997). Thus *methadone maintenance programs* provide a substitute for heroin on a daily basis, with the aim of enabling the person to avoid drug dealing and other crimes, and also to avoid some of the other health hazards of street drug use. *Needle exchange programs* for IV drug users are effective in reducing the incidence of blood-borne infections such as Hepatitis B or C and HIV, but are not legal in all states. Many programs also make *bleach kits* available to IV drug users so that they can perform a rudimentary sterilization of their syringes and needles.

As a low-demand approach to keeping people safe and alive until they are ready for treatment, *wet housing* allows residents to drink in their room, while *damp housing* does not allow drinking on-site, but does allow for relapses. *Wet shelters,* similarly, provide shelter for alcoholics who can not contemplate abstinence, and thus enable them to avoid some of the dangers of street life while permitting them to continue drinking. Homeless health care providers can make use of all these harm reduction techniques to support and assist those clients who are not yet willing or able to enter a treatment process of detoxification and rehabilitation.

Treatment Services for Serious and Persistent Mental Illnesses

Within the broad scope of mental health, many disorders can be diagnosed by the primary care practitioner (Slavney, 1998) and in many cases treated effectively, with or without the assistance of a therapist or counselor or support group. This is particularly so in relation to the depression and anxiety that are the natural and understandable accompaniments of. life on the streets. Health care projects can also expand their clients' access to therapy by linking with other agencies that offer specialized counseling, including rape crisis services, domestic violence programs, and programs for veterans.

The treatment of *major mental illnesses* in adults requires expertise that in general can only be provided by a team of professionals including a psychiatrist. Illnesses in this category include major affective disorders, including recurrent major depression and bipolar disorder, schizophrenia and related paranoid disorders, severe personality disorders and dementia. Nevertheless in some situations primary care practitioners may find themselves where psychiatric consultation is not available, or a patient is unwilling to accept a referral. There may be no local community mental health centers or they may not be responsive to the needs of homeless people. In this situation the clinician should be able to provide at least basic pharmacological treatment for a mental illness and possibly enlist the assistance of a social worker or other colleagues or agencies to attempt to address some of the person's other needs.

Psychiatric specialists may also be called upon to assist in diagnosing disorders associated with physical illness, although the primary treatment responsibility remains with the general physician (e.g., delirium associated with liver failure) (Slavney, 1998). It is important, therefore, that primary care practitioners have the needed knowledge and skill to make this diagnostic distinction and have access to psychiatric consultation when needed.

Services for homeless people with serious mental illnesses are distinct from psychiatric services for other low-income people in that they have two principal goals: remission of the illness and resolution of the person's homelessness. Services for homeless people are also distinctive in that they must take into account the patients' transience, the hardship of their living circumstances, their distrust of formal service systems, their lack of effective social supports, and their extreme poverty (Fischer, Colson & Susser, 1996).

Essential Elements of a Responsive Service System. The Federal Task Force on Homelessness and Severe Mental Illness, in a 1992 report, *Outcasts on Main Street* (Federal Task Force on Homelessness, 1992), recommended the following essential elements of a system that would be responsive to homeless people with severe mental illness:

- Assertive outreach
- Integrated care management
- Safe Havens
- Housing
- Alcohol and/or other drug abuse treatment
- Health care
- Income support and benefits
- Rehabilitation, vocational training, and employment assistance
- Consumer and family involvement
- Legal protections

In each area, clinicians and other professionals working with homeless people must team together through alliances, cooperative agreements and coalitions to provide the array of services in the form best suited for their local situation, culture and available resources.

Treatment Process. There are four principal stages in providing psychiatric services for homeless people (Breakey and Thompson, 1997):

Engagement. Homeless mentally ill people often do not want the treatment that they badly need. Primary care practitioners, shelter workers and others may have vital roles in gently persuading patients to accept help. Outreach teams are vital. They may either work to motivate the person to come in to a treatment center, or may bring the treatment resources to the homeless person "on the street.". Outreach workers go to shelters and soup kitchens, to the streets and alleys, parks and railroad stations (Susser, Valencia & Goldfinger, 1992). In some cases outreach may be life saving, where individuals risk death or injury through exposure. The process of engagement, however, is often slow and outreach workers must be prepared to devote many hours over many weeks or months on occasion, using much creativity, to establish trust and rapport. Outreach is an ideal staff role for formerly homeless people, whose knowledge of the territory and ability to establish rapport with homeless people is frequently superior to that of most professionals (Van Tosh, 1993).

Basic Service Provision. Shelter, food, income support, clothing, and general health care will be needed in most cases, in addition to whatever psychiatric treatment may be indicated. It is unrealistic to expect homeless people to participate in treatment programs until their basic survival needs have been met. Coordinating the various social and health agencies is frequently a major problem; case management has come to be the major strategy employed. (Billig & Levinson, 1987; Goering & Wasylenki, 1996; Swayze, 1992).

Clinical mental health services needed for homeless people cover the full range of services generally provided by a community mental health center: diagnosis and evaluation, pharmacological and psychotherapeutic treatments, and linkage to inpatient services when needed. Treatment teams need to have the skills necessary to understand and treat some of the most difficult cases they are likely to encounter in clinical practice. Empathic approaches are needed to gain the cooperation of people who may have had bad experiences with treatment or its side-effects in the past, as is respect for the individuality and integrity of each person.

Sophistication in psychopharmacology is essential. Homeless people may be more intolerant of side-effects of medications than many other patients. Drowsiness, neuromuscular abnormalities or diminished alertness may expose a person to increased risk of victimization. A psychiatrist must be careful to avoid such problems for patients while getting maximum therapeutic benefit. Effective medications with potential for hazardous side effects may have to be avoided if patients are not able to have blood tests at regular intervals. Oral medications may be lost, so that long-acting injectable preparations are preferable where feasible. Some medications with street resale value will have to be avoided. In some cases arrangements can be made for shelter staff or others to act as custodians of a person's medications.

Transition and Integration. Community mental health programs understand that their patients with severe and persistent mental illnesses in all probability will require treatment for life. On the other hand, programs for homeless people can not, by definition, provide indefinite care for people. Once a person has been engaged, and basic service needs met, he or she must be moved into the mainstream mental health service system. Homeless health care programs should work at developing collaborative professional relationships and establishing linkages to community mental health programs in their areas. There are many instances where the homeless health care program, with its special expertise, can be of assistance to staff of the mental health center, just as there are instances where the homeless program staff will look to the mental health center for long term support and treatment of their clients. To facilitate transition the therapist in the homeless program may continue to work with the person after they become settled in a home. A special model for this approach has been described "Critical Time Intervention" (Susser et al., 1997).

Transitioning care into the mainstream system may prove extremely difficult or impossible in some cases or situations, creating a dilemma for the homeless program. Either the mainstream system may not be receptive, or the patient may not want to make the transition from a clinical situation he or she feels comfortable with, to one that is unknown. In the latter case, the clinical team must work though this difficulty with the patient explicitly, perhaps emphasizing the fact that other people may need to have access to the benefits he or she has enjoyed. Where the mainstream system is unreceptive, the only solutions are personal bridge-building and political advocacy at whatever level is necessary to compel the system to respond to the needs of all citizens.

Housing Stabilization. Treatment of severe mental illness is difficult or impossible until the person has some measure of stability in his or her housing. Initially, some type of emergency shelter must be found until resources are obtained to provide a transitional housing arrangement and, in due course, more permanent housing. Many individuals with severe psychiatric disabilities need much support in coping with even the simple tasks of everyday living, so supervision and case management support will be needed. Some emergency shelters are able to provide this level of support. Supervised group homes may be of value for some clients, but many are solitary individuals who prefer to be on their own. Single room occupancy (SRO) hotels may be ideal for such people, provided that they meet acceptable standards and provide needed support services. Safe ***Havens*** provide safe environments and basic needs with low demand on adherence to rules or participation in treatment (Federal Task Force, 1992). The Department of Housing and Urban Development's Section 8 housing subsidies have been demonstrated to increase the likelihood that mentally ill formerly homeless people will remain housed (Hough et al., 1997). Another HUD program, Shelter Plus Care, provides housing subsidies linked to treatment and case management.

Service Integration. The treatment process described above requires that patients have access to a full range of treatment, rehabilitative and support services, including needs assessment, diagnosis and

treatment planning, medication management, counseling and supportive therapy, hospitalization and inpatient care, 24-hour crisis-response services, rehabilitation and social skills training, income support, housing and case management. Categorical federal and other governmental funding, as well as the structure of human service organizations at the local level, have long been the source of service fragmentation which interferes with the smooth and coordinated provision of this complex array of services. A series of recent initiatives have therefore focused on the provision of comprehensive services. Beginning in the early 1990s, the Center for Mental Health Services (Substance Abuse and Mental Health Services Administration) funded the Projects for Assistance in Transition from Homelessness (PATH) Program, which has been successful in providing outreach and case management to homeless mentally ill individuals. To test a variety of services integration strategies, the Center for Mental Health Services subsequently awarded ACCESS (Access to Community Care and Effective Services and Supports) grants to nine states. These strategies range from an innovative voucher system to co-location of services, cross-training of staff, and the use of interagency, multidisciplinary treatment (Calloway & Morrisey, 1998; Randolph et al., 1997; Rosenheck et al., 1998).

At the clinical level, the use of interdisciplinary teams to provide coordinated care is best exemplified by the Assertive Community Treatment (ACT) model, which has been extensively evaluated and found effective for domiciled individuals with serious and persistent mental illnesses (Bums and Santos, 1995; Olfson, 1990; Primm, 1996). This approach has also been found effective for work with homeless people. Mobile teams consisting of clinicians, case managers and advocates, accessible to patients 24 hours per day and 7 days per week provide long term care and are prepared to work with the person in whatever is the most appropriate setting (Dixon et al.,1997; Lehman et al., 1997)

The National Institute for Mental Health and the Center for Mental Health Services sponsored a series of research demonstration projects in five cities in the 1990s. This series of experiments tested a variety of strategies for case management, transition out of shelters, rehabilitation and housing integration, and demonstrated that with appropriate methods, such as those listed above, 80 percent of seriously mentally ill homeless people can be assisted to remain satisfactorily housed in the community (Shem et al., 1997; Thompson and Breakey, 1997).

Special Services for Homeless People with Dual Diagnoses

People who suffer both from a major mental illness and a substance use disorder pose major challenges to developing services that will successfully address both types of disorder. Their treatment is particularly problematic because of the historic separation between addiction and mental health services, which extends as far as the federal agencies concerned. Bringing together resources and treatment philosophies in the service of a particular patient has proved difficult, but the current professional opinion is that integrated treatment and rehabilitation approaches are most effective and model treatment programs provide substance abuse and mental illness treatment simultaneously (Minkoff & Drake, 1991).

In homeless persons, the prevalence of substance use disorders in mentally ill persons is at least as high as in those without mental illnesses. Estimates are fairly consistent that between 10 percent and 25 percent of homeless people have dual diagnoses (Breakey et al., 1989, Koegel & Burnam,1988; Tessler & Dennis, 1989).

The Center for Mental Health Services and the Center for Substance Abuse Treatment sponsored a Collaborative Demonstration Program at 16 sites for services for dually diagnosed homeless people. The report of this program defines five critical client characteristics that influence program design:

- Disaffiliation;
- Multiple, complex needs;
- Impoverished environments;
- Effects of illness and addiction; and
- Low motivation for change/low self-esteem.

Major interventions employed by the 19 programs were similar to those that have been employed for other homeless subgroups: outreach, case management, detoxification, day treatment, residential treatment and system-wide coordination.

The initiative clearly established the importance of collaboration between professionals in the substance abuse and mental illness fields to provide integrated services for this particularly vulnerable group who constitute a significant segment of the homeless population (Winarski & Dubus, 1996). Ideally treatment for substance abuse and mental illness should be provided simultaneously in the same facility. Where this is not possible, close referral agreements should be established so that the maximum level of coordination can be attained.

Conclusion

Despite the tremendous amount of knowledge and experience that has been gained over the past decade in adapting clinical practice to the needs of homeless people, there is still much to be learned, as well as numerous threats that challenge the successful continuation of this work. Recommendations to address research and policy that will strengthen our knowledge and diminish the threats follow:

Continue to Support Increased Funding for Integrated Health Programs

Advances have been made in primary care, mental health and substance abuse services for homeless people, only to be set back by the inability to maintain effective models. Demonstration projects need the option of ongoing funding, if the program proves to be successful. Funding is also needed to expand into areas now recognized as vital for improving and maintaining health, such as dental services, respite care during convalescence, and integration of housing into mental health and substance abuse programs. This is especially relevant in an environment of increasing need and decreased capacity to meet that need (O'Connell, Lozier and Gingles, 1997).

Work For Universal Health Care Coverage to Eliminate the Negative Impact of Market Influences on Delivery of Health Care

The rush by many health care organizations to stay afloat by increasing Medicaid revenue has resulted in loss of access to services for uninsured homeless people. Even for those who do have insurance, conversion of Medicaid to a managed care system has made access more problematic. It is interesting to note in the discussion of clinical treatment above that the recommendations frequently include a lower threshold for initiating treatment or hospitalization, necessity of frequent follow-up visits (sometimes daily), use of alternative medications which may be more expensive (e.g., once-daily dosing), divergence from strict protocols, flexibility in service location and easy access to a wide range of integrated services, including specialty care. In other words, the kinds of adaptations to clinical care needed by homeless people are in many cases the very practices that managed care discourages. Wunsch (1998) summarizes the challenges of involving homeless people in managed care:

- The social circumstances of homeless people are often not compatible with the tightly controlled access to health care that characterizes managed care.
- The health status of homeless people is markedly inferior to that of traditional managed care enrollees, and is characterized by complex, interrelated conditions, including non-medical factors not usually addressed by managed care entities (MCEs).

Develop a Federally-Funded Substance Abuse Program Targeted to Homeless People

As a society, we continue to deny the vast extent of the pathology and social dislocation attributable to alcohol and drugs (Wilhite, 1992). The impact of substance abuse in causing and perpetuating homelessness cannot be adequately addressed without significant additional resources. Existing community resources are not sufficient-and often not appropriate-to meet the needs of homeless people with substance abuse disorders, especially those with co-occurring mental illness.

Develop Effective Methodologies to Collect and Analyze Cost and Outcome Data.

Data on health care utilization, cost and outcomes have not been collected and analyzed for homeless people as a group, undermining the ability of states to effectively serve them through managed care arrangements (Wunsch, 1998). There is a consensus in the field that more information is needed on costs of caring for homeless people, as well as which practices result in the best outcomes for which types of people who are homeless. The BPHC initiative on outcomes mentioned earlier is one potential source for developing approaches to measuring outcomes (U.S. Department of Human Services, 1996). Although little has been done in the difficult arena of accurately determining costs of care, there is evidence of the cost of not providing the care that results in expensive hospitalization (Salit et al., 1998).

Improve Dissemination to the Field of Results of Research and Practice

Additional research will not be useful without better strategies for incorporating research findings into actual practice in the field. Health care is a rapidly changing and evolving field, with new technologies, medications and treatment approaches being developed constantly. Not only do new practices need to be tested for relevance with people who are homeless, mechanisms need to be developed to assure that homeless health practitioners receive that information in a format that is useful and practical, including a method to provide feedback and engage in ongoing dialogue with researchers.

Increase Training for Recruitment and Retention of Skilled Practitioners

Committed practitioners who are skilled in working with homeless people and willing to accept the difficulties of the work are scarce. There is a need to continue training for providers already in the field-both to continually improve quality and stay abreast of current practices, as well as to enhance retention by preventing burnout. New practitioners also need to be trained. The reform in medical education toward a more humanistic primary care model will hopefully result in the creation of a cadre of medical providers who are trained to care for vulnerable populations such as people without homes.

More mental health professionals are also needed in health care programs treating homeless persons. Their training should include placement in community-based health programs so that they can learn to work hand-in-hand with generalist physicians in treating the intertwined physical and mental health problems of homeless people. Since a great deal of care is also provided to homeless people in emergency rooms, all medical and surgical trainees in medical school, residency, and fellowship

programs must be trained to develop an appreciation for their patients' housing and poverty status, and victimization history.

Unless they are resolved, all of the above factors-inadequate funding to fully implement the integrated approach to homeless health care, impact of market-driven managed care, lack of funding for accessible and appropriate substance abuse treatment, limited cost and outcome data, the disconnect between research and practice, and the scarcity of skilled practitioners willing to serve this population-threaten the survival of the unique integrated approach to care that has evolved to treat the health of homeless people. Until such time as there is universal health care coverage and adequate housing for all, people experiencing homelessness will need access to a health care system designed specifically to respond to their unique needs.

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Emergency Shelter and Services: Opening a Front Door to the Continuum of Care

by
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Abstract

This paper describes the provision of emergency shelter and services to homeless persons in the United States. Administered by the U.S. Department of Housing and Urban Development, the Emergency Shelter Grant (ESG) Program has been helping States and localities provide facilities and services to shelter homeless people but at the same time to aid in their transition from temporary shelter to permanent homes. In large part, this paper grows out of an evaluation of the ESG Program, conducted in 1993, which provides the best description currently available of emergency shelters and homeless services across the United States.

The paper also describes several variations on the ESG program. Many emergency shelters require that clients participate in case management and services. A recent development is the provision of shelter with more flexible requirements. Safe Havens provide a safe and decent alternative to the streets for homeless persons with severe mental illness who need adjustment time before engaging in treatment and other supportive services. Recent interviews conducted by Abt Associates with a range of other emergency shelter organizations reveal that homeless shelters continue to respond to the needs of homeless people by expanding their programs to include a wider spectrum of services. In addition to describing the types of shelter programs found throughout the United States, this paper describes the populations being served, identifies the effective practices in emergency shelter and services, and comments on the future research needs.

Lessons for Practitioners, Policy Makers, and Researchers

- Shelter providers currently see their mission as opening a front door to the Continuum of Care, so that their clients are started on a path toward stable independent living.[1]
- Today's emergency shelters are much more than "three hots and a cot"-or three meals and a bed. Nor are they a temporary stopgap. Instead, they are sources of a wide range of services for homeless persons.
- This paper grows out of an evaluation of the Emergency Shelter Grant (ESG) Program. The ESG funds may be used for the construction, rehabilitation, or conversion of buildings into homeless shelters, shelter operating expenses and administrative costs, provision of essential services, and homelessness prevention. ESG monies typically make up six to ten percent of shelter budgets.
- Families, which make up approximately one-third of the homeless population nationally, were the most frequently cited population served by the ESG-funded providers.

[1] In many cases,crossing the threshhold into an emergency shelter is one of many entryways that a homeless person may take into the continuum of care.

- The four top sources of the referrals to shelters were social services agencies, clergy, friends, and other shelters.
- The mean length of stay in these emergency shelters was 71 days (the median was 30 days).
- The joint provision of shelter and services has proven to be one of the most useful means of assisting clients.

Introduction

This paper describes the provision of emergency shelter and services to homeless persons in the United States. In general, emergency shelters for the homeless provide indoor space with beds and meals to those who have no other place to stay. Common variations of emergency shelters include the night-only shelter (which requires guests to be elsewhere during the day), the day-only shelter (which provides daytime space, meals, and sanitary facilities but not overnight sleeping space), and 24-hour shelters (which can be used by guests around the clock). Different types of shelters may serve different populations. Shelters also vary greatly in size, from fewer than 10 beds to several hundred beds.

In large part, this paper grows out of an evaluation of the Emergency Shelter Grants (ESG) Program, a Federal program that has been an important factor in expanding the quality and quantity of shelter and services since 1986.[2] The ESG evaluation is a major source of quantitative data collected from a representative national sample of emergency shelter providers in 1992. It provides the best description currently available of emergency shelters and homeless services in the United States.[3] In addition, Abt Associates recently interviewed a number of major homeless services providers to update the ESG evaluation's findings.[4]

Other sources of national data include HUD's 1988 National Survey of Shelters for the Homeless and an earlier examination of related federal support for emergency food and shelter. Apart from these, research on emergency shelters has primarily been descriptive, usually based on a single site; the results are therefore not comparable to a national survey.

Providing Emergency Shelter

Since its inception, the focus of the Emergency Shelter Grants (ESG) program, administered by the U.S. Department of Housing and Urban Development, has been helping States and localities provide facilities and services to meet local needs, to shelter homeless people but at the same time to aid in their transition from temporary shelter to permanent homes. The ESG program was established by Congress through the Homeless Housing Act of 1986, to provide funds for emergency shelters and essential services for the homeless. One year later, it was incorporated into the McKinney Act of 1987 and took its place among an array of programs designed to address the plight of homeless men, women, and children in the United States. It has been a core part of homeless assistance throughout the first decade.

Each year, HUD allocates ESG funding to supplement State, local, and private efforts to improve the number and quality of emergency homeless shelters. The ESG funds may be used for the construction, rehabilitation, or conversion of buildings into homeless shelters, as long as the local agency uses the property as a homeless shelter for a specified time period. ESG grants also may be used for shelter operating expenses and administrative costs.

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2 See Judith D. Feins, Linda B. Fosburg, and Gretchen Locke, *Evaluation of the Emergency Shelter Grants Program* (Washington, DC: U.S. Department of Housing and Urban Development, September 1994).

3 The 1996 National Survey of Homeless Assistance Providers and Clients, conducted by the Census Bureau and sponsored by a dozen Federal agencies under the auspices of the Interagency Council on the Homeless, will provide a more current description. However, its results have not been published yet.

4 These organizations included the Salvation Army, Catholic Charities of America, and the International Union of Gospel Missions.

ESG funds are provided to States, territories,[5] and qualified cities and counties; the States must distribute the funds to local governments or private nonprofit organizations. Local governments must match ESG grants dollar-for-dollar from other sources after the first $100,000. They may administer the grants themselves or distribute the funds to private nonprofit organizations.

Since 1987, ESG funding has helped provide shelter for many homeless persons in need of help.6 A total of $425.9 million in program funding was distributed nationwide through 1994. But ESG monies typically made up 6 to 10 percent of shelter budgets; the shelters this program supported usually had significant other funding sources. Among the most common other funding sources for emergency shelter were HUD's Community Development Block Grant program and two McKinney programs. The Federal Emergency Management Agency (FEMA) continues to administer the Emergency Food and Shelter grants,[7] for which Congress appropriated $1,552.1 million between 1987 and 1998. In addition, the Emergency Community Services program of the Department of Health and Human Services distributed $220.4 million in funding from 1987 to 1995.

Supporting Homeless Services

Apart from assisting in the provision of physical shelter, the ESG program is an important source of funds for essential services for homeless people. Essential services are related social services in areas such as employment, health, drug abuse, and education. Essential services may be provided in a shelter setting, or they may be offered by separate (non-shelter) provider organizations. When they are offered the latter way, linkages must be made between shelter clients and the service providers. An example of a non-shelter service provider is the Larkin Street Youth Center in San Francisco, a drop-in center for youth aged 12 to 23 that operates 12 hours per day but (in 1992) did not operate a night shelter. Its broad range of services includes case management, employment counseling, referral, and a fully equipped medical center.

Among emergency shelters, day-only and 24-hour facilities tended to be the most services-rich. While nearly three-quarters of night-only shelters offered seven or fewer services, almost two-thirds of day shelters and over 40 percent of 24-hour facilities offer between twelve and nineteen services to their clients. ESG funds directly supported a great deal of this service activity.

ESG funding is also used for homelessness prevention: to assist individuals and families at-risk of homelessness in retaining their housing; and to help homeless clients obtain permanent housing. Homelessness prevention is intended to reduce the flow of clients into shelters, as well as aiding those ready to move into more stable living situations. An example of homelessness prevention is the American Red Cross in the San Francisco area. The Bay Area chapter of the American Red Cross coordinates the homelessness prevention allocations for 29 agencies serving the city's homeless. Their coordination of the pool of funds for prevention ensures that the same criteria for receipt of funds are applied across all agencies.

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[5] Beginning October 1, 1998, Indian Tribes are no longer eligible for ESG funds. Instead, they may apply for the new *Native American Housing Block Grant.*

[6] Since 1995, grant amounts under ESG and several other HUD programs for the homeless have been combined into the Homeless Assistance Grants (also administered by HUD).

[7] The early implementation of the federal food and shelter programs is detailed in the U.S. General Accounting Office publication Homelessness: Implementation *of Food and Shelter Programs under the McKinney Act* (Washington, DC, December 1987).

The ESG program evaluation showed substantial allocations to homelessness prevention; in the 12 months leading up to the study, ESG funds had aided almost 35,000 at-risk individuals and families to retain their housing. However, there are other funding sources and other studies on this topic. It will be addressed in another session of this symposium.

What Are the Program Types?

Shelters and Safe Havens

Of all the service providers that received Emergency Shelter Grant funds in 1991, 81.8 percent were shelters, while the remainder were not. The shelters were either day-only facilities (5.6 percent), night-only shelters (9.5 percent), or 24-hour operations (84.9 percent). Of the 24-hour programs, most were open seven days a week.

Among the shelters receiving ESG funding, there were various types of facilities. Approximately 30 percent were dormitory-style shelters, and 47.7 percent were group homes. Smaller numbers of shelters characterized themselves as scattered-single apartments, groups of apartments or apartment buildings, rooms in single-room occupancy (SRO) facilities, or hotels or motels.

Staff sizes for shelter providers are shown in Exhibit 1. Providers operating shelters reported a median of six paid, full-time-equivalent staff and one unpaid (volunteer) staff person working in their organizations. Staffing levels in local government shelters (a mean of 13.5) were similar to those in private nonprofit shelters (a mean of 14.1).

Among non-shelter agencies (providing other services to homeless people), private nonprofits averaged 11.8 full-time staff members while local government agencies averaged just 4.5 staff members. The staffs of these agencies averaged 2.0 unpaid volunteers. Thus, shelter staffs were slightly larger than the staffs of non-shelter service providers, and they had larger numbers of volunteers.

Exhibit 1
Staffing of Shelter and Non-Shelter ESG Provider Agencies

Shelter Staffing	Local Government Shelters	Non-Profit Shelters	All Shelters
Full-Time Equivalent Staff			
Mean	13.5	14.1	14.0
Median	4.6	6.3	6.0
Full-Time Equivalent Volunteers			
Mean	1.6	3.2	3.2
Median	0.6	1.4	1.3
Non-Shelter Staffing			
Full-Time Equivalent Staff			
Mean	4.5	11.8	10.5
Median	2.6	3.8	3.6
Full-Time Equivalent Volunteers			
Mean	0.3	2.4	2.1
Median	0.0	1.0	0.6

The overall median number of beds for all shelters receiving ESG funds in 1992 was 26 beds, and the mean was 50. Exhibit 2 shows that the number of beds varied across the different types of shelters. Night-only shelters tended to be larger, with a median of 3 1.5 beds, while 24-hour shelters had a median of 25 beds. Not surprisingly, day-only shelters had the smallest number of beds, with a median of 10.

Exhibits 3 and 4 show the number of beds in ESG-funded shelters in 1992, compared to the shelter bed capacity estimated in HUD's *1988 National* Survey of *Shelters* for *the Homeless.*[8] The average bed capacity was approximately the same. However, the proportion of ESG-funded shelters with fewer than 25 beds was slightly higher than the proportion of small shelters estimated by HUD (49 percent of ESG-funded shelters compared to 44 percent in HUD's estimates). The total bed capacity of ESG-funded shelters in 1992 was 108,735, with an average nightly total occupancy of 88,279. HUD's 1988 survey estimated an average nightly occupancy of 180,000 in shelters nationwide. Even assuming some modest increase in the number of available beds between 1988 and 1992, a substantial proportion of the nation's shelter capacity was found in ESG-funded shelters.

A recent development in the provision of shelter services targets homeless persons with mental disabilities. Safe Havens, funded initially as a component of HUD's Supportive Housing Program in 1994, had 80 funded projects by 1997 (National Resource Center for Homelessness and Mental Illness, 1997). Safe Havens provide a safe and decent alternative to the streets for homeless persons with severe mental illness who need adjustment time before engaging in treatment and other supportive services. These programs are designed as transitional residences, with no specific time limits and low-demands to participate in mental health or substance abuse treatment programs or to receive other supportive services.9 They generally provide semi-private accommodations with use of a common kitchen, dining rooms, and bathrooms; and basic services plus necessities such as telephones, storage lockers, and mailing address.

In general, Safe Havens deliberately wrap their resources around the needs of the individual, rather than demanding that the individual comply with the requirements of the program. Those served by this program are typically considered too unstable to be served by traditional shelters, or they have been banned from them. As one provider described the approach, "This is a program where you can fall back without falling out of the program" (Fosburg, Locke, Peck, & Finkel, 1997).

Providers of Shelter and Services

Emergency shelter and services for homeless people are provided by a variety of types of organizations, including government agencies and private groups with or without religious affiliation. Providers of all kinds may receive ESG funding to support delivery of these services.[10] However, results from the ESG evaluation indicated that private nonprofit organizations predominated among the agencies actually funded in 1992. Three-quarters of both shelters and non-shelter providers were private nonprofit organizations with no religious affiliation, and an additional 19.8 percent indicated they were nonprofits with a religious affiliation. The remaining 5.4 percent were local government agencies.

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[8] The differences between the data collected for HUD's 1998 survey and those collected for this evaluation of the ESG program are attributable to sampling. HUD's study was designed to assess the characteristics of all shelters nationwide, rather than the subset funded by the ESG program (which does not fund boarding houses, welfare hotels, or SROs).

[9] However, if a person's only impairment is substance abuse, he/she may not be considered eligible to stay in a Safe Haven.

[10] In fact, almost a fifth of the providers receiving ESG funds in FY91 did not operate emergency shelters. The non-shelter providers using ESG funds included health care facilities, counseling agencies, residential treatment facilities, local governments, and a variety of other entities.

Of the small number of local government shelters, 78.0 percent were 24-hour shelters with day programs, 15.5 percent were day-only shelters, and 6.5 percent were night-only facilities. Among the private, nonprofit shelters, 69.4 percent of those with religious affiliations and 89.6 percent of those without religious affiliations were 24-hour facilities.

Most ESG-funded providers were well-established agencies. Just under half of the providers had been operating for eleven years or more (and a few, such as the American Red Cross, the Salvation Army, and the St. Vincent DePaul Society, have over a century of experience). About a third had begun operations between five and ten years before the study was conducted.

The distribution of ESG-funded providers by census region of the country is shown in Exhibit 5. Some 22.4 percent of the providers were located in the Northeast, 33.2 percent were in the South, 24.7 percent in the Midwest and 19.7 percent in the West. The proportion of shelters in each region was roughly the same. Over 60 percent of the local government shelters were located in the East or South regions of the country.

Joint Provision of Shelter and Services

Emergency shelters are not just temporary stopgaps; instead, they are sources of a much wider range of services for homeless persons. Once in a shelter, what specific essential services are clients offered? The ESG program evaluation gathered data on the range of activities of ESG-funded service providers and found that they offered and/or coordinated a considerable variety of services to the homeless. Few, if any, of the shelters fit the conventional image of a bare-bones, dormitory-style, night-only shelter. They were not "three hots and a cot." Instead, they were delivering a surprisingly wide range of services on-site.

Exhibit 2
Number of Shelter Beds

Responses	Day Shelters Number	Day Shelters Percent	Night Shelters Number	Night Shelters Percent	24-Hour Number	24-Hour Percent	All Shelters Number	All Shelters Percent
Number of Beds								
Mean.	81.0	--	75.4	--	47.8	--	49.9	--
Median	10.0	--	31.5	--	25.0	--	26.0	--
Distribution								
10 beds or less	12	47.3%	6	3.2%	156	9.1%	228	10.5%
11-20 beds	0	0.0%	26	13.9%	527	30.8%	619	28.5%
21-30 beds	4	17.2%	54	28.8%	283	16.5%	369	17.0%
31-50 beds	0	0.0%	28	15.1%	374	21.8%	442	20.4%
51-100 beds	0	0.0%	38	20.5%	247	14.4%	327	15.1%
Over 100 beds	8	35.5%	35	18.5%	128	7.4%	184	8.5%
TOTAL	24	100.0%	187	100.0%	1716	100.0%	2169	100.0%

Exhibit 3
Shelters, Shelter Bed Capacity, and Average Daily Occupancy:
HUD's National Estimates compared to 1992 ESG-funded Shelters

Shelters	HUD 1998	1992 ESG-Funded Shelters	1992 ESG-Funded Shelters as a percent of 1988 HUD National Estimates
Number of Shelters	5,400	2,477	45.9%
Total Bed Capacity	275,000	108,735	39.5%
Average Occupancy Per Night	180,000	88,276	49.0%

Sources: 1988 data from HUD's ***1988 National Survey*** *of* ***Shelters*** *for* ***the Homeless;*** 1992 data from Provider Phone Survey of 651 ESG-funded providers.

Exhibit 4
Average Bed Capacity by Size of Shelter

	Percent of Shelters		Average Bed Capacity	
	HUD's 1988 National Survey	1992 ESG-Funded Shelters	HUD's 1988 National Survey	1992 ESG-Funded Shelters
Small (25 or less)	44%	49%	15	15
Medium (26 to 50)	32%	29%	36	37
Large (Over 50)	24%	24%	133	137
	100%	100%	Average: 50	Average: 50

Sources: 1988 data from HUD's ***1988 National Survey*** *of* ***Shelters for the Homeless;*** 1992 data from Provider Phone *Survey* o 65'1 ESG-funded providers.

Exhibit 5
Characteristics of ESG-Funded Providers in FY 91 By Region

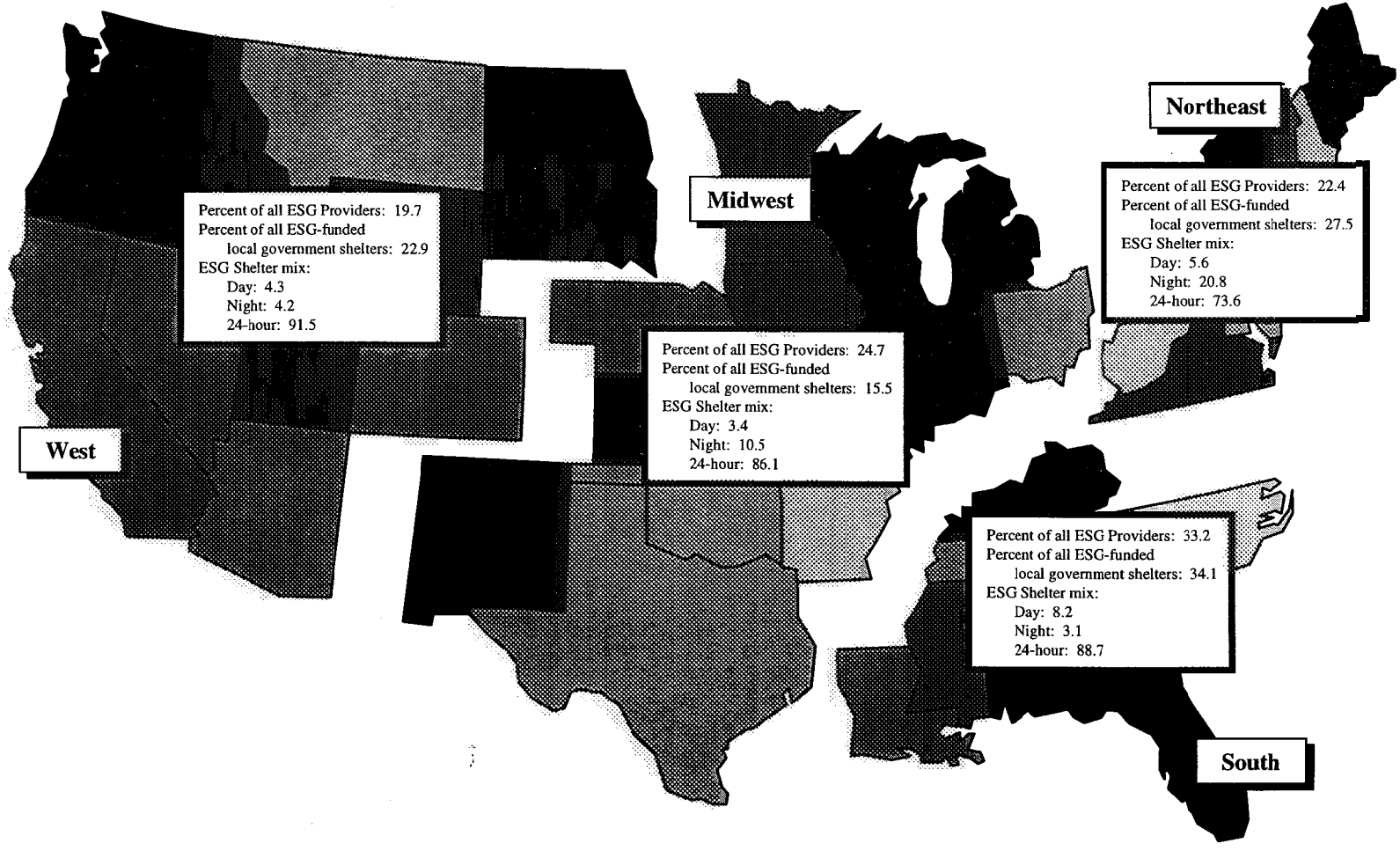

Exhibit 6
Characteristics of ESG-Funded Shelters, by Shelter Type

Responses	Day Shelters Number	Day Shelters Percent	Night Shelters Number	Night Shelters Percent	24-Hour Number	24-Hour Percent	All Shelters Number	All Shelters Percent
Shelters reporting that they operate:								
Temporary Shelters	8	11.1%	136	67.8	873	50.5%	1018	50.6%
Short Term (90 Days or less)	0	0%	119	59.3	1436	83.0%	1555	77.3%
Long-Term, Transient	6	7.2%	57	28.3	869	50.2%	932	46.4%
No Time Limits for Client with Special Needs	20	23.8%	53	26.6	521	30.1%	**594**	**29.5%**

Exhibit 7 summarizes the services coordinated by all providers and indicates whether the services were funded by ESG, whether the service was provided on-site (rather than at another facility), and whether the service or activity was required for all clients.[11] A factor analysis of the list of services revealed that they were offered and/or coordinated by the providers in four clusters:

- core services (sometimes called "concrete services");[12]
- assistance services (including clothing);
- skills development services; and
- intervention/treatment services.

In the category of core services, almost 90 percent of all providers offered bed space,[13] while nearly 80 percent offered breakfast and dinner, and just under 70 percent offered lunch. But a full 93.1 percent of the providers indicated that they also directly offered other services to their homeless or near-homeless clients. These essential services fell into the three groups: assistance services; skills development services; and intervention/treatment services.

The most common assistance services (offered by 90 percent or more of the providers) were help in obtaining benefits and finding permanent housing. Also quite common were assistance in daily living skills, transportation, support groups, and job referrals. Nutritional counseling, childcare and clothing were other forms of assistance offered by a substantial proportion of the providers.

Shown on the'second page of Exhibit 7 are five skills-development services that were commonly offered, including assistance in GED preparation, vocational counseling, and job training. The fourth cluster, intervention and treatment services, included substance abuse counseling, psychological counseling, and medical care. Detoxification and other forms of drug treatment were the least frequently offered services in the entire list of essential services, but they were still offered by nearly a quarter of the providers.

[11] The list of services in the survey did not include "case management."

[12] Core services are typically considered operating costs and are allowable operating costs under the ESG program regulations.

[13] Recall that some providers are not shelters, and that some shelters are day-only operations that may not offer bed space.

Exhibit 7
Services Offered by ESG-Funded Providers, FY 91

Responses	Percent Offering Service	Percent Providing Service On-Site
Core Services		
Bed Space	89.2%	85.8%
Breakfast	79.3%	88.7%
Lunch	69.3%	85.4%
Dinner	***79.6%***	***87.9%***
Essential Services (beyond referrals)		
Assistance in obtaining benefits	94.2%	91.0%
Assistance obtaining permanent housing	92.2%	91.8%
Assistance with daily living skills	86.2%	87.9%
Transportation	79.1%	95.9%
Support groups	78.6%	82.7%
Nutritional counseling	50.1%	90.1%
Job referrals	69.8%	87.6%
Child care	42.2%	67.3%
Clothing	81.7%	77.6%
Assistance in GED preparation	47.9%	69.9%

Exhibit *7 (Continued)*
Services Offered by ESG-Funded Providers, FY 91

Responses	Percent Offering Service	Percent Providing Service On-Site
Essential Services (beyond referrals) (Continued)		
Other basic skills (e.g. budgeting)	**32.0%**	**60.9%**
Vocational counseling	**50.6%**	**65.8%**
Job training	**28.1%**	**56.2%**
English as a second language classes	**20.3%**	**38.9%**
Substance abuse counseling	**53.4%**	**65.6%**
Psychological counseling	**45.5%**	**60.6%**
Medical care	**44.2%**	**56.3%**
Detoxification/other drug treatment	**22.5%**	**13.2%**
Legal Assistance	**39.6%**	**47.9%**

Recent interviews conducted by Abt Associates with a range of emergency shelter organizations reveal that homeless shelters continue to respond to the needs of the homeless by expanding their programs to include a wider spectrum of services. Shelter providers now see their mission as opening a front door to the Continuum of Care, so that their clients are started on a path toward stable independent living. Consequently, their emphasis is increasingly in the following directions:

Transitional housing services are a component of all the recently interviewed shelter organizations. Transitional housing offers a supported, temporary place of residence before the client finds a more permanent housing situation. This topic is covered in the paper that follows.

Another service many emergency shelters are providing to their clients is skills development programs, which have increased in number and scope since the McKinney Act. Several place an emphasis on domestic preparedness (housekeeping and budgeting) and issues around adulthood and parenting.

Education and employment training are at the forefront of services for the International Union of Gospel Missions (IUGM). Fifty of their shelters have computerized education programs, some of which include an "employment readiness" component. This component is implemented by Worknet, a nonprofit organization working with missions on employment education programs and helping them to establish job training. Due to the lack of affordable housing, the Union Missions find it difficult to find permanent housing situations for clients; as a result, they have placed a greater emphasis on success in job training and placement as well as follow-up after the client has left the emergency shelter. More than 300 employers are connected to this training and job placement program and provide both temporary and permanent employment opportunities. Other shelter organizations, such as the Salvation Army, provide job training in conjunction with local community or county needs. Some of the Salvation Army missions also provide transportation to jobs and to GED classes.

Many emergency shelters have expanded their child care or child services, to assist families-especially single mothers-in maintaining or seeking employment. These programs range from offering daycare services at shelters to helping keep homeless children in their original schools by providing transportation from shelters to school and back. Other shelter providers, such as Catholic Charities of America, have had to decrease childcare services due to a decrease in funding.

Shelters are also doing follow-up work with clients. For example, approximately four years ago, Union Missions began a performance measurement program used by case managers, in which they set goals for clients and themselves. By setting target numbers for achievement in such areas as education, employment and housing, case managers are' better able to assist the clients with progressing toward more independent living and track them. In addition, it gives Union Missions a record of work with each client and a way to measure the overall rate of success.

Other programs offered by emergency shelters that are the result of expanded services in the last decade include rehabilitation, conflict resolution, violence prevention, GED courses, youth programs, and assistance for women and children with HIV/AIDS.

The Role of Case Management

The term "case management" refers to the functions required to pull together and provide linkage to the network of supportive services providers who can meet the various needs of homeless persons. The importance of a case manager derives from the understanding that it is extremely difficult for anyone, let

alone a homeless person, to negotiate the complex and diffuse supportive services systems that have grown up due to multiple funding sources and different organization objectives. The most frequently identified functions of a case manager are assessment of services needs, development of a services plan, linkage to services, monitoring of services provision, maximizing compliance, and client advocacy.

Over eighty percent of the shelters surveyed in the ESG evaluation offered and even required case management of their clients as a condition of remaining in the shelter or program. Another indication of the trend toward requiring homeless clients to cooperate with the case management process is the fact that case worker assessment was a method used by 82.4 percent of all ESG-funded providers to identify service needs. The role of case managers can vary from place to place. In some instances, they serve as the primary provider of all services for the homeless client. In other instances, their role is confined to coordinating the delivery of needed services.

Who Is Served?

Range of Populations

Nationwide, over half the homeless population is made up of single men. Families make up the next largest segment (about a third of the total). The evaluation of the Emergency Shelter Grants program indicates that service providers vary considerably in the populations they serve. Shelter providers serve different clients from non-shelter providers, and different types of shelters (day-only, night-only, or 24-hour) served different homeless populations, as summarized in Exhibit 8.

The proportion of non-shelter providers indicating that they worked with a particular population was generally higher than the proportion of shelters reporting working with the same population. This implies that the populations served by non-shelter service providers are more diverse, while shelters may have facilities and programs designed for more narrowly targeted groups. The two exceptions to this observation were that the night-only shelters were slightly more likely to serve single men, and that the day-only shelters were significantly more likely to serve single youth.

Exhibit 8
Population Served by Shelter and Non-Shelter ESG Providers

Responses	Day-only Shelters	Night-only Shelters	24-Hour Shelters	All Shelters	All Non-Shelters
Percent serving:					
Single men	65.6%	83.0%	38.4%	44.9%	78.5%
Single women	80.9%	81.9%	78.4%	75.7%	88.3%
Single youth	56.4%	18.7%	31.7%	30.7%	33.8%
Families	91.1%	57.7%	86.8%	82.7%	95.4%
Women and children	88.0%	53.3%	82.6%	78.6%	93.6%
Families with no children	62.2%	57.3%	43.0%	44.9%	80.1%

These exceptions are consistent with the remarks of providers during site visits to the State and local agencies that administer federal emergency shelter funding (the ESG grantees) and to the providers they fund in fifteen locations around the country. [14]

Families, which make up approximately one-third of the homeless population nationally, were the most frequently cited population served by the ESG-funded providers. Eighty-five percent of all providers indicated that they served families, including 82.7 percent of shelters and 95.4 percent of non-shelter providers. Among the shelters, almost all of the day-only and 24-hour shelters served families, while only 57.7 percent of the night-only facilities reported that they could accommodate families.

While single men account for more than half the homeless population nationally, they were only served by about half the ESG-funded shelters. However, about three-quarters of the non-shelter service providers reported offering services to single men. Two-thirds of day-only shelters and 83 percent of night-only shelters worked with single men, while only 38.4 percent of 24-hour shelters provided services to this population. In one place, a shelter ran 24-hours for families, but single men could only be there at night.

Single youth (approximately 4 percent of the homeless population nationally) were the least frequently served population across all types of ESG providers when the research was conducted. Only about one-third of both shelter and non-shelter providers offered services to homeless single youth, and a similar proportion of shelters worked with young people.

Providers also reported whether they work with particular subgroups of the homeless, or with families or individuals with particular characteristics or problems. About half of all providers indicated they offered services to battered women and drug-dependent or alcohol-dependent clients. Between 42 and 45 percent reported working with the elderly, veterans, and the physically disabled, while 37 percent offered services to the chronically mentally ill. HIV- positive clients were served by 39 percent of the providers, and mentally retarded individuals received services from 30 percent of ESG-funded agencies. Children and youth were served by only 23 percent of the providers. Recent interviews indicate a growth in the number of families (especially women with children) served over the past decade.. In response, the Salvation Army increased access for women and children to its shelter facilities from 70 to 90 percent.

Prior Residences

If emergency shelters are meant to function as a front door to the Continuum of Care, how do homeless people find their way there? The ESG evaluation is a good source for the population as a whole, although there have also been studies that asked this question about special populations.[15] Some combination of four circumstances (living on the street, living with friends/relatives, private rental housing, and emergency shelters) accounted for a substantial proportion of most providers' clients.[16]

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[14] It is noteworthy that single youth, especially teenage males, are frequently not allowed in night-only or 24-hour shelters. The day shelters are their only alternative. Having to return to the streets at night, they are a very vulnerable special needs group.

[15] See Fosburg, et al. (1997) for a discussion of the Shelter Plus Care program administered by HUD. Eligible program participants targeted by this program are disabled homeless persons (and their families) who have serious mental illness, chronic alcohol or other drug problems, acquired immunodeficiency syndrome (AIDS), or some combination of these disabilities.

[16] Among homelessness prevention providers, a substantial proportion of the client population came from a housing rather than shelter situation; a total of about 40 percent of these clients came from private rental housing, public housing, or an owner-occupied home. An additional 16 percent were living with friends or relatives. This latter group was at the greatest risk of homelessness. Other prevention efforts were directed toward placing shelter residents in permanent housing.

The prior residency of the clients of each type of shelter varied widely, as shown in Exhibit 9. Night-only and day-only shelters tended to draw clients from the streets. The 24-hour shelters drew most of the their clients from a combination of the streets, living with friends and relatives, and private rental housing. Non-shelter service providers tended to draw the highest percentage of their clients (21.7 percent) from private rental housing, suggesting that people at risk of homelessness sought help from the non-shelter service providers first. However, the non-shelter providers were also drawing from the streets (16.5 percent), from people living with friends and relatives (16.6 percent), and from emergency shelters (13.9 percent).

Referral Sources

According to the providers, clients learned about the services they offered from numerous referral sources, as shown in Exhibit 10. The top four sources of referrals-social service agencies, clergy, friends, and other shelters-were a source of clients for virtually all shelters, regardless of type. Other very common sources included citizens, doctors, police and the courts, public housing agencies, parents, and hot-lines. Detoxification and substance abuse treatment facilities, as well as psychiatric programs and treatment centers, were also important referral sources, suggesting ways that some special populations were linked into the shelter system. The numbers of different referral agents reported by the providers and the substantial percentages reported for many of them underscore the strength of the providers' networks and their reputations in the community.

By and large, the sources of client referrals were similar for all types of shelters, with one exception: the day-only shelters were much more likely to have clients referred to the program by their own outreach workers. Only 22.1 percent of all ESG-funded providers reported that they employed outreach workers to help identify people who might benefit from services. Of those who did, 81.5 percent had their outreach staff contact social service providers, and 66.5 percent contacted local police to identify potential clients. Roughly half contacted public housing agencies, detox or substance abuse treatment facilities, and psychiatric facilities.

Exhibit 9
Provider Clients' Prior Places of Residency by Shelter Type

Responses	24-Hour Mean Number	24-Hour Median Percent	All Shelters Mean Number	All Shelters Median Percent
Percent of provider clients coming from...				
Streets	19.1%	10.0%	26.4%	10.0%
Living with friends/relatives	17.7%	10.0%	15.4%	10.0%
Private rental housing	11.7%	5.0%	10.5%	3.5%
Emergency shelters	7.2%	5.0%	8.8%	5.0%
Public housing	4.9%	1.0%	4.3%	0.0%
Jail/prison	5.6%	1.0%	5.3%	1.0%

Exhibit 10
Sources of Client Referrals for ESG-Funded Providers, in FY 91 by Shelter Type

Responses	Day Shelter Number	Day Shelter Percent	Night Shelter Number	Night Shelter Percent
Providers indicating they receive referrals from:				
Social Service agencies	74	100.0%	359	95.4%
Clergy/Churches	74	100.0%	371	100.0%
Friends	74	100.0%	304	94.3%
Other shelters	74	100.0%	334	88.8%
Citizens	64	86.8%	304	94.3%
Doctors/hospitals	62	90.0%	294	92.6%
Police	64	86.8%	367	97.4%
Walk-ins	64	86.8%	322	100.0%
Detox/substance abuse treatment programs	72	97.3%	279	92.2%
Psychiatric programs and treatment centers	57	89.2%	262	82.4%

Exhibit 10 (Continued)
Sources of Client Referrals for ESG-Funded Providers, in FY 91 by Shelter Type

Responses	24-Hour Shelter Number	24-Hour Shelter Percent	All Shelters Number	All Shelters Percent
Providers indicating they receive referrals from:				
Social Service agencies	1897	100.0%	2627	98.9%
Clergy/Churches	1809	95.0%	2547	96.1%
Friends	1788	94.6%	2455	95.0%
Other shelters	1794	95.0%	2484	93.7%
Citizens	1748	92.3%	2404	92.9%
Doctors/hospitals	1726	92.1%	2320	90.4%
Police	1711	90.6%	2370	89.9%
Walk-ins	1609	86.9%	2251	88.3%
Detox/substance abuse treatment programs	1458	80.2%	2028	81.5%
Psychiatric programs and treatment centers	1396	75.1%	1956	76.9%

Estimates of Population Served

In 1992, the ESG program supported organizations that served nearly 4 million individuals and families in a variety of ways, as well as helping prevent loss of housing for some 35,000 households. Almost 28 million days/nights of shelter were provided.[17] Although duplication (multiple counting of an individual or family) is a chronic problem with counting the homeless, the data gathered for the ESG study were closely scrutinized and (based on their consistency with other measures and data sources) appear to have substantial credibility. Overall, the shelters in the ESG study reported an average nightly census of 40 persons over the previous 12 months, or an average of 12,644 shelter days/nights for the year. In the absence of recent systematic data, it is difficult to determine how the number of emergency beds has changed over the past six years.[18] However, one indication of the growth in the number of homeless over the last several years is that the Salvation Army alone provided 6 million emergency bed nights in 1997.

In HUD's 1988 survey of shelters, it appeared there were sometimes mismatches between the type of shelter space available and the type of client needing shelter. HUD's survey findings suggested that spaces were generally available in a jurisdiction's larger homeless shelters, but these facilities generally offered only the "concrete services" of beds and meals. Spaces at smaller facilities that offered more services seemed always to be at a premium.

Shelters in the ESG study reported that, on average, they operated at 78 percent of capacity.[19] Small shelters (those with fewer than 25 beds) reported an average occupancy rate of 72 percent, and medium (25 to 50 beds) and large (more than 50 beds) shelters indicated they operated at 82 percent of capacity, on average. About 5 percent of the shelters reported that their average nightly census exceeded their number of beds: they regularly served more homeless families and individuals than the number for which they had appropriate space.

All the providers interviewed in 1998 indicated their facilities were full to capacity each night. In fact one of them, Catholic Charities of America, reported that emergency services are in such great demand that funding for other programs within the organization has been reduced to accommodate emergency shelter needs. In the ESG study, some 80 percent of providers nationwide indicated that they had turned eligible clients away. The average number of eligible clients turned away in the past 30 days was reported to be 43, with shelter operators reporting an average of 48 turnaways.

What are the reasons clients have been turned away? The ESG evaluation reported the primary reason was that the shelter or program was at capacity. The next three most frequently cited reasons for these providers were security problems (especially in shelters undergoing renovation), an inebriated client, or the wrong type of client.

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17 The shelter providers in these figures were estimated to cover about 40 percent of the shelter bed capacity nationwide and about 50 percent of average nightly occupancy.

18 Again, once they are analyzed. data from the 1996 National Survey of Homeless Assistance Providers and Clients will provide updated figures on shelter capacity.

19 For purposes of analysis, occupancy rate was calculated by dividing the provider's reported bed capacity by the reported average nightly census. Computed occupancy rates that exceeded 150 percent of total bed capacity were excluded from the average figure.

Factors Related to Length of Stay

How long do clients remain in emergency shelters? What factors influence their length of residency? Exhibit 11 presents data from the ESG study on these subjects. Across all the shelters, the mean length of stay was 71 days and the median was 30 days. However, this varied greatly, from a few shelters with mean stays of less than 5 days to a handful reporting average stays over a year. The 24-hour shelters had the longest median stays, at 30 days; the small number of day-only shelters showed great variability in length of stay.[20] But for 95 percent of these agencies, the average duration of residence per client was 9 months or less.

Among the emergency shelters interviewed in 1998, the average length of stay ranged from 10 nights to 9 months. This variation resulted from the different kinds of programs the shelters offered ranging from limited-stay bed use to housing units that could be considered transitional.

In the 1992 survey, shelters reported varying standards on the maximum allowable length of stay (possibly depending on the type of client). About three-quarters of the shelters characterized themselves as short-term shelters, with maximum allowable stays of 90 days or less. Half of the shelters indicated they served as temporary, overnight facilities, while the other half reported they provided long-term, transitional shelter (over 90 days, but with some prescribed limit). Just under 30 percent of the shelters said they served clients with special needs (such as substance abusers) and imposed no limits on length of stay.

A range of factors was identified by shelter providers in the ESG study as influences on length of stay. The three factors most frequently cited by the agencies were:

- the extent of the client's problems;
- the degree of client cooperation; and
- the availability of permanent housing.

[20] No direct data on shelter time limits are available from this study.

Exhibit 11
Client Length of Stay in ESG-Supported Programs, by Shelter Type

Responses	Day Shelter Number	Day Shelter Percent	Night Shelters Number	Night Shelters Percent
Length of stay (in days or nights):				
Mean	310.1	--	37.2	--
Median	10.0	--	16.0	--
Factors influencing length of stay:				
Extent of client problems	56	45.0%	86	41.3%
Availability of permanent housing	30	23.9%	71	34.0%
Cooperation of client	47	37.6%	68	32.4%
Shelter time limit expires	15	12.4%	66	31.6%
Financial stability	35	28.0%	45	21.6%

Exhibit 11 *(Continued)*
Client Length of Stay in ESG-Supported Programs, by Shelter Type

Responses	24-Hour Shelter Number	24-Hour Shelter Percent	All Shelters Number	All Shelters Percent
Length of stay (in days or nights):				
Mean	63.9	--	70.6	--
Median	***30.0***	--	***30.0***	--
Factors influencing length of stay:				
Extent of client problems	791	45.0%	1050	42.4%
Availability of permanent housing	965	23.9%	1171	47.3%
Cooperation of client	882	37.6%	1079	43.6%
Shelter time limit expires	451	12.4%	603	24.3%
Financial stability	394	28.0%	517	20.9%

While the first two factors would affect how soon a client could be ready for transition from the shelter, the third could limit the departure of even the most ready clients. Client financial stability was among the other factors prominently mentioned, as was expiration of the shelter time limit. Although nearly 80 percent of the providers in the study reported turning away eligible clients, availability of services or staffing or funding was not often given as a limiting factor once a homeless person or family was in a shelter.

Effective Practices in Emergency Shelter and Services

In the decade's experience with sheltering homeless individuals and families, a number of practices have proven useful in assisting clients and have been very widely adopted. One of these-the joint provision of shelter and services-is in fact the basis for a number of other practices.

The combining of core services and essential services, described earlier in this paper, occurs in two different ways. One is the on-site provision of services to residents of a shelter by an outside service provider (e.g., a hospital with a clinic on the premises). The other is the offering of services by the same provider that operates the shelter. In either case, many shelter providers have gradually added services, typically on site or nearby, to meet the needs of their clients. Many of the providers surveyed used ESG support to expand existing services and/or to start up new services.

Client Needs Assessment

Client needs assessment is widely considered a critical factor in effective service delivery to homeless people. The assessment process serves a number of purposes, including developing a relationship between the staff member and guest and beginning to establish trust, as well as determining the services (and possible outside referrals) that the individual or family needs in order to regain its independence and residential stability.

Providers used a variety of methods to assess the service needs of their clients, as shown in Exhibit 12. Essentially all providers reported using intake interviews, assessments provided by referral agencies, and clients' own evaluation of their needs as ways of assessing clients' needs. There were practically no differences among the various shelter types, except that the day shelters were significantly more likely to offer/use medical examinations and diagnosis to assess the needs of the clients. Another indication of the trend toward requiring homeless clients to cooperate with the case management process is the fact that case worker assessment was used by 82.4 percent of all ESG-funded providers to identify service needs.

Exhibit 12
Providers' Methods of Identifying Client Service Needs by Shelter Type

Responses	24-Hour Shelter		All Shelters	
	Number	Percent	Number	Percent
Intake interview	1907	100.0%	2656	100.0%
Referral from agency/provider	1858	98.2%	2488	96.6%
Self-referral	1794	95.4%	2469	95.9%
Case worker assessment	1479	80.8%	2030	81.9%
Medical examination/diagnosis	453	26.4%	710	30.3%
Standardized tests	63	3.7%	156	6.8%
Other	64	12.0%	91	12.8%

Shelter Rules and Requirements

Another widespread practice of emergency shelters is the use of rules and requirements to guide and limit clients' behavior while in residence. In the ESG evaluation, querying providers on this topic produced a lengthy list of rules. As shown in Exhibit 13 the most common rules prohibited drinking or drug use (found in 98 percent of the shelter facilities) and forbade weapons possession, stealing, and assault (found in 97 to 98 percent). Ninety-four percent of shelters imposed a curfew on the clients. Other common rules prohibited prostitution and consensual sexual activity. And the rules continue, as shown in the exhibit.

Requirements of participation in certain activities are another common practice, used by shelters to help limit client dependence and end the spell of homelessness. A large proportion of the shelters in the ESG program evaluation had certain requirements that clients had to fulfill, in order to remain in the shelter. The most common requirement reported by shelters in the ESG evaluation was meeting with the caseworker. Overall, 83 percent of the shelters made clients do so, but the proportion was substantially less in day and night-only shelters than in 24-hour ones. Clients also commonly had to actively seek housing (82 percent), enroll and keep their children in school (77 percent), and adhere to a case management plan (75 percent).

Most providers reported that participation in the range of essential services was voluntary rather than required of their clients. However, 30 percent did require clients to take advantage of assistance with daily living skills, and 32 percent required participation in support groups. Most providers offered these additional services on-site, rather than referring clients to other agencies.

Indicators of Effective Coverage of the Homeless

Over time, the State and local agencies that administer federal emergency shelter funding (the ESG grantees) have developed strategies for targeting the unique needs of specific segments of the homeless population. As shown in Exhibit 14, most grantees cite numerous targets for the ESG funding. Nearly all grantees (98.6 percent) indicate that they recognized the needs of homeless families. In keeping with this, most grantees (91.4 percent) have included victims of domestic violence in their strategies. The needs of the chronically mentally ill have been recognized by 72.2 percent of the grantees. The elderly and veterans have been recognized by 52.0 to 56.2 percent of the grantees. Others (homeless youth, migrants, those infected with HIV/AIDS, and substance abusers) have received less recognition in the deliberate development of strategies for addressing the needs of the homeless.

Exhibit 13
Rules for Client Behavior in ESG-Supported Facilities and Programs by Shelter

Responses	24-Hour Shelter		All Shelters	
	Number	Percent	Number	Percent
Rules for Client Behavior				
No drinking/drug use in facility	1880	97.8%	2518	98.2%
No possession of weapons	1807	96.9%	2449	97.7%
Cannot steal from/assault persons	1830	95.9%	2473	96.9%
Curfew	1798	93.8%	2359	94.0%
Certain standards of personal hygiene	1657	86.2%	2210	86.6%
No engaging in prostitution	1604	86.1%	2174	84.9%
Must meet with caseworker	1656	88.3%	2053	83.1%
Client must actively seek housing	1602	83.3%	2043	81.6%
Required chores	1610	83.9%	2000	80.1%
No sexual activity in facility	1429	75.8%	1963	77.7%
Children must enroll in/attend school	1542	87.7%	1758	76.8%
Adherence to case management plan	1526	79.7%	1886	75.2%
No foul language in facility	1458	75.8%	1876	74.9%
No drinking/drug use anywhere	1419	74.1%	1874	73.5%
Limited visitors allowed	1495	79.7%	1814	73.5%

Exhibit 14
Grantee Recognition of Special Needs Groups among the Homeless

Responses	All Grantees Number	Percent
Grantee strategies have recognized the needs of...		
Homeless families	377	98.6%
Victims of domestic violence	349	91.4%
Chronically mentally ill	276	72.2%
Veterans	215	56.2%
Elderly	199	52.0%
Homeless youth	114	29.8%
Migrants	114	29.7%
Substance abusers	81	21.2%
HIV/AIDS	40	10.4%

Exhibit 14 *(Continued)*
Grantee Recognition of Special Needs Groups among the Homeless

Responses	All Grantees Mean
Mean ranking, where 1 is low and 5 is high, of effectiveness of services for.. .	
Victims of domestic violence	4.1
Homeless youth	3.9
Homeless families	3.8
Elderly	3.5
Veterans	3.2
Substance abusers	3.1
Chronically mentally ill	3.1
Migrants	3.0
HIV/AIDS	2.9

Despite the grantees' identification of particular groups of the homeless for development of strategies to meet their needs, their self-rating of effectiveness (on a scale of one to five) in addressing the needs of the special groups varied. Grantees indicated that their strategies were most effective (mean rating of 4.1) for victims of domestic violence. The next highest rating of the grantees was for their strategies to meet the needs of homeless youth (3.9). Given the general lack of services to this special group, as reported by providers, this grantee opinion is viewed as questionable. What is more probable is the reported effectiveness of the services for homeless families (3.8) and the homeless elderly (3.5).

Future Research Needs for Emergency Shelter and Services

The problem of homelessness-and the challenge of helping homeless people to find stable housing and achieve independent living-are not likely to disappear soon from the United States. The current healthy and buoyant economy has not eliminated the need for emergency shelter and services, and some factors are likely to intensify this need in the short term. Among them are increasing price pressures on affordable housing as local markets heat up, reductions in the supply of affordable housing due to public housing demolitions and to prepayments/opt-outs in the private assisted stock,[21] and welfare system changes that will cut significant numbers of families from the TANF program within the next six months. Beyond these factors, substance abuse and mental illness will continue to contribute to loss of permanent housing, as will domestic violence and health emergencies that wipe out people's resources to make rent or mortgage payments. An economic downturn in the future could lead to loss of jobs and housing for families and individuals now living at the margin.

If the need for emergency shelter and services will continue to be felt, then there is also substantial need for related research. One area of need is for an up-to-date picture of the shelter and service agencies and their clients. The National Survey of Homeless Assistance Providers and Clients, conducted by the Census Bureau between October 1995 and November 1996, collected information about the providers of homeless assistance and the characteristics of homeless persons who use their services. Analysis of the data, currently underway, should produce newer estimates of shelter capacity and utilization, as well as current information on the kinds of services being provided in these settings.

Nevertheless, many other aspects of this topic are not currently being studied. Research is needed in these areas:

What are the main strategies being used for *homelessness prevention,* and what has been the impact of these interventions? A thorough study of prevention would include careful investigation of the program types, the criteria for selecting the populations served, and the impacts, to determine the types of circumstances in which specific prevention methods can be effective.

There are *differing needs among different groups in the homeless population.* The needs of families with children-and of unattached youth-are not likely to be the same as those of homeless individuals with chronic mental illness, substance abuse problems, or HIV. On the other hand, there could be significant areas of overlap (especially regarding substance abuse). Careful research on the different subpopulations and their needs, carried out over an extended period, could help improve service targeting and could reveal whether the causes of homelessness are changing over time.

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[21] HUD's 1997 Report to Congress on Worst Case Housing Needs finds that the stock of rental housing affordable to the lowest income families is shrinking, and Congress has eliminated funding for new rental assistance since 1995. Further, worst case needs are increasing fastest among the working poor. See *Rental Housing Assistance--The Crisis Continues (The 1997 Report to Congress on Worst Case Housing Needs)* (Washington, DC: US Department of Housing and Urban Development, April 1998), Executive Summary.

As Burt (1998) has noted in her paper for this symposium, with respect to services, we know considerably less about *what works for homeless families* than we do about assisting the special-needs parts of the homeless population. Clearly, affordable housing-or provision of housing subsidy through public housing or Section 8-appears to be an important factor in stabilizing formerly homeless families.[22] But is it sufficient? What about the role of case management and stabilization services, with or without transitional housing?[23]

More generally, we do not have good data or analyses on the *effectiveness of services designed to move poor families toward economic self-sufficiency*. Despite the welfare system changes that put such a premium on entering the world of work, we have little systematic knowledge of what means are effective in helping single parents make this transition, or of the circumstances in which particular interventions do help. Thus, research needs to be conducted in a variety of settings, including homeless shelters and transitional housing (but also including public housing and other places where there are concentrations of low-income families) to address the challenges these families increasingly face.

The last of these proposed study topics suggests that research on the homeless and research about other parts of the low-income population should be closely linked. Especially in light of the evidence that homelessness is episodic, we need to focus more on why-and when-families and individuals lose their ability to live independently. In the coming winter of welfare cut-offs and continuing shrinkage of the affordable housing stock, this question could become the most urgent one of all.

[22] An analysis challenging the view that expansion of subsidized housing will reduce the number of homeless people can be found in Dirk W. Early, "The Role of Subsidized Housing in Reducing Homelessness: An Empirical Investigation Using Micro-Data" ***Journal of Policy Analysis*** and Management 17:4 (Fall 1998), pp. 687-696.

[23] In studies of the Homeless Families Program, which combined case management and Section 8 housing (and which was sponsored by HUD and the Robert Wood Johnson Foundation), researchers reported that there were encouraging gains in residential stability but that families were still heavily reliant on federal support. The lack of progress in employment suggested questions about how durable the gains in stability would be. See D. Rog and M. Gutman, "The Homeless Families

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Transitional Housing and Services: A Synthesis

by
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Abstract

Despite HUD's endorsement of transitional housing as an essential part of a comprehensive continuum of care, consumers, providers, and advocates have frequently disagreed on its value, on the best ways of linking services to housing, and on appropriate mechanisms and sources for funding transitional housing programs. Critics have emphasized the stigma associated with transitional programs as well as the diversion of resources that might otherwise serve to expand the supply of and access to affordable permanent housing; proponents counter that homeless families and individuals with multiple problems need help with more than housing alone if they are to achieve residential stability. To sort through the conflicting claims about transitional housing requires some consideration of the diversity of the programs thus labeled and what we do and don't know about their impact on homelessness. We begin by clarifying what the concept encompasses; review the evolution of transitional housing; and describe variations in the major approaches developed for homeless families and individuals in terms of differences in target populations, physical structures, service intensity, and other program characteristics that cluster along a continuum with "high demand" service-intensive facilities at one end and "low demand" programs with flexible requirements and optional services at the other. Available research assessing the major models indicates that scattered-site transitional housing programs that convert to permanent housing constitute one effective (and cost effective) approach to helping families and possibly individuals exist from homelessness. Future research should not only test the relative effectiveness of different transitional program models but should compare transitional housing approaches to alternative strategies for ending homelessness for individuals and families.

Lessons for Practitioners, Policy Makers, and Researchers

- Transitional housing is controversial. Critics view it as stigmatizing, de-stabilizing, and a drain on resources better used for permanent housing; proponents view is as the best way to ensure homeless families and individuals get the services that will enable them to attain and sustain self-sufficiency as well as permanent housing.
- Programs vary in numerous ways-including target populations, physical structure, service intensity, admission thresholds, and conditions and duration of tenure. Although there are almost limitless combinations of these dimensions, program characteristics tend to cluster along a continuum, with "high demand" (e.g., congregate, structured, service intensive) programs at one pole and "low demand" (e.g., dispersed, flexible criteria, optional services) at the other.
- Research on transitional housing indicates that adding low demand transitional housing to outreach or drop-in services for homeless individuals improve their likelihood of obtaining permanent housing.
- Transitional programs at the "high demand" end of the continuum usually serve individuals and families with multiple problems. Research suggests that highly structured facilities which double as treatment programs for people with severe mental illness and/or substance abuse problems improve

housing and clinical outcomes for those who remain until they graduate, but they also have extremely high attrition rates. For most who enter them, they are not a route out of homelessness. Providers are encouraged to experiment with alternative approaches for those with multiple problems.

- Research findings show that scattered-site models of transitional housing that "convert" to subsidized permanent housing are a cost effective approach to helping families transition out of homelessness without the stigma and disruption of support networks that facility-based approaches may entail. Some variants of this model also add to the permanent housing stock by restoring deteriorated units. Convertible models have been developed for individuals as well, and providers are encouraged to continue to develop this approach.
- Provider experience underscores the importance of issues of scale, community networks, and "fit" with the fabric of the community-not only to foster community acceptance of transitional housing programs but to enhance safety and stability for residents and neighbors alike.
- Transitional housing can only be effectively implemented in the context of a continuum of resources that includes adequate permanent housing and the supportive community-based services that can prevent returns to homelessness.

Introduction

Rapidly rising homelessness in the late 1970s and early 1980s initially evoked crisis responses from federal and local agencies-responses focused on expanding the capacity for emergency shelter. Only later in the 1980s did the emphasis shift to developing housing and service combinations that would address longer-term needs of the homeless population. Federal support for both transitional and permanent housing has been provided since 1987 with McKinney Act funds; and since 1994, when the U.S. Department of Housing and Urban Development (HUD) began to require that applicants for federal funds create an integrated "continuum of care," transitional housing has been deemed one of the necessary components of a comprehensive response to homelessness (HUD Report to Congress, 1995; Barnard-Columbia Center for Urban Policy, 1996).

Despite HUD's endorsement of transitional housing as an essential part of the continuum of care, consumers, providers, and advocates have frequently disagreed on its value, on the best ways of linking services to housing, and on appropriate mechanisms and sources for funding transitional housing programs. Critics have emphasized the stigma associated with transitional programs as well as the diversion of resources that might otherwise serve to expand the supply of and access to affordable permanent housing; proponents of transitional housing counter that homeless families and individuals with multiple problems need help with more than housing alone if they are to achieve residential stability (HomeBase, 1998).

To sort through the conflicting claims about transitional housing requires some consideration of the diversity of the programs thus labeled and what we do and do not know about their impact on homelessness. We begin by clarifying what the concept encompasses and where the boundaries between transitional housing and related concepts-emergency shelter, residential treatment programs, permanent supportive housing-can most usefully be drawn. We then review the evolution of transitional housing for homeless families and individuals and the major approaches that have been developed for each of these groups. Finally, we examine the relatively limited research literature on the effectiveness of the major models, and conclude with a discussion of unresolved issues requiring further study.

Concepts and Definitions

In the context of a continuum of responses to homelessness, transitional housing occupies an intermediate position. It consists of relatively private accommodations provided on a temporary basis along with intensive services intended to facilitate the transition to permanent housing. The distinctions between transitional housing and other types of temporary and/or service-enriched accommodations for homeless people are not hard and fast: what one locality labels as "transitional" may look a lot like the "shelters" in another setting. Despite this overlap, however, we can clarify core features by examining how transitional housing contrasts with emergency shelter, residential treatment programs, and permanent supportive housing.

Transitional Housing vs. Emergency Shelter

Transitional housing usually differs from emergency shelter in offering smaller facilities, more privacy, and more intensive services with greater expectations for participation. While shelter services address basic needs (food, clothing, a place to sleep), the services in transitional programs almost invariably extend beyond meeting survival needs. They tend to be coordinated by case managers and are geared toward helping residents define goals and achieve greater independence. Finally, transitional housing is almost always time limited, with lengths of stay usually capped somewhere between three months and

two years. Emergency shelter stays, in contrast, tend to be either more limited (e.g., less than thirty days) or, in places where the courts have mandated the provision of shelter, unlimited'.

Transitional Housing vs. Residential Treatment Programs

While it is in the context of widespread homelessness that transitional housing programs have proliferated, transitional accommodations play a role in other types of continua as well. As the locus of mental health care shifted from institutions to community settings, a graduated series of transitional residence programs emerged (Arce et al., 1982) to facilitate ex-patients' adaptation to community living. The substance abuse treatment system, likewise, has produced a continuum that usually begins with detoxification, followed by short-term rehabilitation and long-term residential treatment-all conceived of as transitional steps en route to recovery. As homelessness has increased in the mentally ill and substance abusing populations served by residential treatment programs, they increasingly double as a transitional stage in both rehabilitation or recovery and in the process of exiting from homelessness. There has in fact been little consideration of how these two processes are related, whether the transition out of homelessness entails distinctive service and housing issues, and how these are related to those of recovery and rehabilitation.

Transitional Housing vs. Permanent Supportive Housing

The boundaries between transitional and permanent housing are clearer, although here, too, there are ambiguities. In general, transitional housing is time-limited; permanent housing is not. And, when residents reach the time limits built into transitional housing, they are expected to "graduate" to more independent, "normal" housing settings. Thus transitional housing is a stage in a progression, while permanent housing entails no assumptions about personal growth and development. An additional factor that sometimes distinguishes transitional from permanent housing is tenancy rights. For transitional residents, tenure is usually contingent on participation in services and compliance with program rules, whereas permanent tenants usually hold leases and have full tenancy rights.[2]

Why Transitional Housing? Evolution of Concepts and Practice

During the 1980s, there were major changes in both the population affected by homelessness and in government and community responses. These shifts were reflected in the 1987 Stewart B. McKinney Act, which supported a varied set of housing and service programs to assist an increasingly diverse

[1] Local variations in the availability of both shelter resources and affordable permanent housing influence lengths of stay, as do political and legal factors. In New York City, for example, several court decisions have bearing on how transitional housing has developed. An early law suit against the city by advocates on behalf of homeless men who had been turned away from overflowing shelters led to a court monitored consent decree that guaranteed homeless individuals a right to shelter. This produced a huge expansion of the public emergency shelter system for individuals and precluded imposing time limits. Without viable permanent housing alternatives, many homeless individuals have accumulated long histories of shelter stays spanning years. The system for homeless families has developed very differently. Here advocates responded to the chaos and health hazards posed by sheltering homeless families in congregate facilities and successfully sued to limit the time families can spend at the entry-point to the system, resulting in very brief stays in "emergency assessment units" and assessment shelters. At the same time, the limited availability of permanent housing-either through rehabilitated housing stock or in public housing-has led to the expansion of the "transitional" system and the elaboration of the services it provides. Thus even within a single locale, court decisions produced contrasts in how the line between shelter and transitional housing was drawn and the way services subsequently developed.

[2] There are exceptions on both sides: families and individuals in scattered-site transitional housing programs in Minnesota, for example, hold leases on their apartments; while disabled individuals living in clinically-managed permanent residences in some locales have occupancy agreements that make tenure contingent on remaining in treatment or other conditions not typical of most leases.

homeless population that included growing numbers of homeless women with children and homeless youth, as well as individual adults, many with disabling health, mental health and substance abuse conditions. McKinney funds also spurred growth in the numbers of not-for-profit agencies serving the homeless, as new grassroots organizations, critical of government approaches to homelessness, emerged to develop alternatives that were more responsive to needs of homeless individuals and families as well as the communities affected by homelessness.

In 1992, HUD was charged with coordinating plans and consolidating programs involving homelessness. It's 1994 report, "Priority: Home! The Federal Plan to Break the Cycle of Homelessness" (Interagency Council on the Homeless, 1994), recommended implementing the "continuum of care" concept, intended to bring together all parts of a community interested in addressing homelessness; providing a coordinated system of care for the homeless; building partnerships among localities, states, nonprofits, and the federal government; and encouraging localities to seek long-term solutions.

Development of Transitional Housing for Homeless Families

The increasing numbers of families joining the homeless population in the 1980s quickly overburdened existing emergency facilities in many locales. In New York City, for example, where needs vastly outstripped both emergency and permanent housing resources, homeless families could spend as much as ten days in overcrowded municipal intake centers where the only bed was a chair, the only meal served on paper plates with plastic utensils, infectious and communicable diseases spread rampantly, and fights broke out among clients and staff. Shelters were also overloaded, and as New York continued to lose affordable housing throughout the 1980s, lengths of shelter stays increased.[3]

As homeless families in New York and elsewhere stayed longer in temporary accommodations, providers and families alike recognized that many would benefit from (and others desperately needed) special help and services. The community-based not-for-profit agencies that took an increasing role in sheltering homeless families created facilities that were not only smaller in size and better managed, but also provided more services than shelters operated by government or disaster relief agencies. By incorporating parenting classes, counseling, substance abuse treatment, basic education and job training into the accommodations provided for families, community organizations thus transformed crisis shelter facilities into full-service transitional housing while shifting focus from the systemic problem of not enough permanent housing to the more tractable problems of individual families that could be addressed through services. Many transitional programs began requiring clients to sign contracts stating they will work on personal goals; others mandate classes and workshops; and some contain a research component, assessing each client upon intake and evaluating her progress while in transitional housing. The Continuum of Care encouraged the development of such services and their integration with other resources in each locality.

Development of Transitional Housing for Homeless individuals

Transitional housing for homeless individuals has also been developed by service providers to address unmet needs and to fill gaps in the existing continuum of services. Initially these were often small-scale efforts-for example, renting a few rooms at a YMCA to temporarily accommodate individuals receiving case management services from street outreach or drop-in center programs. When agencies serving homeless individuals with mental illness and substance abuse problems found that providers of

[3] By 1986, shelter stays averaged 13 months; 40.5 percent of the population then residing in shelters had been in a shelter for one year or more; and fourteen percent of all homeless families had been in temporary housing for over two years (Manhattan Borough President's Task Force, p. 25).

permanent housing for people with these disabilities were reluctant to accept homeless clients, they were able to use HUD McKinney monies to develop more service intensive transitional housing programs designed to enhance "housing readiness" by fostering the skills needed to get and keep housing: budgeting and money management; household management skills including shopping, food preparation, nutrition; and, where relevant, self-management of medication and achieving and managing sobriety or recovery. Some programs also offer vocational and employment services. At the same time they build skills, transitional programs also help residents meet stringent entrance criteria used by many providers of permanent supportive housing: a specified period of time clean and sober, compliance with and management of a regime of psychiatric medications, willingness to participate in structured services or activities. In such contexts, transitional housing can provide the requisite credentials for admission to permanent housing.

The Knowledge Base for Transitional Housing Practice and Research

Providers have accumulated considerable experience with transitional housing over the last two decades. Some of this is represented in program descriptions (Fogel, 1997; Lowery, 1992; Proscio, 1998), conference presentations (Lipton, 1993; National Resource Center on Homelessness and Mental Illness 1995; O'Hara 1997; Porterfield 1997), and technical assistance manuals (HomeBase 1998; Sprague 1991; Meister 1993), and taken together, these sources document a rich variety of program approaches and practices. However, description and documentation cannot reconcile the sharply contrasting perspectives on the value of transitional housing as a means to self-sufficiency and stable housing. This requires more systematic examination of the various transitional housing models as well as assessments of their outcomes as compared to other approaches to these goals. These kinds of studies are few in number. The most broadly based reviews of transitional housing have been done as part of the evaluations of HUD's supportive housing programs, which provide an overview of the programs the agency has funded, the populations they serve, and their short-term outcomes (Matulef et al., 1995; More Than Housing 1995; National Resource Center, 1995; 1997). These reviews are complemented by the results of local evaluations -of HUD-funded programs (e.g., Wilder Research Center, 1998).

To assess the effectiveness of transitional housing requires research designs that control for other factors that may influence outcomes while comparing transitional housing programs' to policy-relevant alternatives. Evaluations conducted as part of the McKinney AFDC Transitional Housing Demonstrations supported by the US Department of Health and Human Services (HHS) provide almost the only controlled studies of transitional housing for homeless families (Nathan et al., 1995; Roman and Zhu 1996). For homeless individuals, research demonstration efforts have been supported by the agencies that serve mentally ill and substance abusing populations-CMHS, NIDA, NIAAA, NIMH, VA. While most of these projects have focused on services or permanent housing, a few have included transitional housing models (e.g., Grella, 1993; Rahav et al., 1997; Ware et al., 1992). A small number of studies have focused on outcomes for particular types of transitional housing (Barrow and Soto, 1998) or for individual programs (e.g., Baier et al., 1996; Prabuki et al., 1995). In general, however, the accumulation of experience in providing transitional housing has not been matched by research on its effectiveness. Thus while we offer a synthesis of descriptive writings on transitional housing, our assessments of practices and models that are most effective in helping homeless individuals and families successfully exit from homelessness are necessarily provisional. More definitive evaluation of particular approaches or of transitional housing more generally must await the development of more rigorous outcome research that will complement the elaboration of practice in this area.

Transitional Housing Approaches: Dimensions of Variation

The programs encompassed by the transitional housing label are remarkably diverse. They draw on a range of philosophical and disciplinary traditions, are targeted at different subgroups of the homeless population, utilize a broad array of physical structures, and offer differing configurations and intensities of services, as well as contrasting levels of demand for service participation. Their admission criteria, lengths of stay, and strategies for facilitating moves to permanent housing also differ, and they are embedded in geographical and resource environments with enormous contrasts in available services and housing. These factors do not exhaust the types of variation that characterizes transitional housing, but they define some of the most important dimensions of difference among the programs. We review here how program characteristics are distributed along several of these dimensions and describe some of the more typical program configurations that result.

Target Populations

Transitional housing is aimed at subgroups of the homeless population thought to need special assistance in transitioning to permanent housing. These include homeless families, battered women, youth, mentally ill individuals, persons with substance abuse problems, people living with AIDS or HIV, developmentally disabled and physically disabled persons. Because there is considerable heterogeneity within these categories ("homeless families," for example, may consist of single parent households with children; pregnant women with and without children; couples with or without children; and women whose children are in the foster care system or are living with relatives), as well as overlap among them (mentally ill individuals, for example, may also be members of homeless families, victims of domestic violence, people living with AIDS, or substance abusers), the targeted groups do not neatly coincide with program types. Thus while most transitional housing programs focus their efforts on either homeless families or homeless mentally ill individuals, the form a program takes will be influenced by "secondary" issues the residents are also dealing with. In addition, some programs target their efforts at groups defined by differences in their homeless experiences-"street" homeless or long-term shelter residents. Variations in the target population have significant implications for many other elements of the transitional housing program-including but not limited to its needs for and use of, space, the services provided and those available in the community, the funding available, and the availability of resources for permanent housing.

Type of Physical Structure and Privacy of Living Space

Transitional housing programs run the gamut of available building structures-from former convents, schools, or SROs to multi-unit dwellings and private homes. "Stand alone" transitional programs occupy entire buildings, while "clustered" apartment programs group transitional residents together in a separate wing or floor of a larger structure, and "scattered-site" apartments are dispersed through "regular" apartment buildings or housing projects. Variations in the physical structures have implications for the amount of privacy individuals and families have; the availability of space for on-site programming; and the degree to which transitional tenants are integrated into the building and broader community.

Stand Alone Programs

Stand alone programs include *congregate facilities* and *multi-unit apartment* or single room occupancy (SRO) buildings. Some congregate programs for families have been created by converting SRO buildings, former schools, or convents into housing for pregnant women or small families. These are often older buildings that require significant capital improvements to make them usable by families.

Congregate facilities are also frequently used as residential treatment settings for homeless individuals or families with problems of mental illness and/or substance abuse. In programs for individuals, single or double rooms (or in some cases dormitories) comprise the sleeping areas; there may be offices, storage rooms, reception areas, kitchen and dining rooms, and staffed program space on-site. The congregate setting allows individuals to learn or hone skills for independent living while participating regularly in treatment and rehabilitation services on- or off-site. Transitional residential treatment programs for women with children usually use a rehabilitation treatment design, based on the development of a "community". Child care is the most critical design feature that supports women coming into and staying in a 10-12 month recovery program, and play, study, and day care spaces are designed to meet the needs of children.

Individual apartments in small, medium and large multi-unit apartment buildings constitute an alternative variant of "stand alone" transitional housing. These are the most frequently used accommodations for homeless families in medium to large cities (HUD Report to Congress, 1995: 17). Most of these facilities are owned by not-for-profits and operated through contracts with the local government unit responsible for housing homeless individuals and families. A combination of public and private resources support the building purchase and renovations, including building out office, childcare and services space. Located in communities where homeless people previously lived, most multi-unit residences became vacant because of fire, abandonment by the landlord or disrepair. Rebuilding and turning them into homeless residences aids in the restoration of neighborhoods while providing families who have never held a lease the opportunity to prepare for moving out on their own.

Shared apartments may be created by subdividing larger apartments or by reconstructing small units in a building into larger apartments. In rural communities, shared single family homes may be used to accommodate two to three homeless families. The families are expected to contribute to the upkeep and pay some rent based on a sliding scale. These settings tend to have little space available for program activities, childcare and services, and only limited services are provided on-site. Shared apartment programs may, like congregate settings, occupy entire buildings; or the apartments may be either clustered or scattered within buildings housing non-homeless individuals and families.

Clustered or Scattered-Site Apartments

Clustered or scattered-site apartments differ from stand-alone programs in that they disperse homeless individuals and families through "normal" housing settings. Scattered-site apartments, in particular, are popular with families and may be cost effective for providers. Other than security deposits, costs for minor alterations, and the purchase of furniture and furnishings, the major costs are rent and utilities plus some staff. The apartments are already part of the community, minimizing problems of siting and stigmatizing homeless families. Families requiring limited on-site services make good candidates for scattered-site housing, as services are primarily offered at a central location off-site, although staff may make regular or unscheduled visits to the apartments to monitor activities. For families seeking to be reunited with other family members, this type of "residence" provides both the flexibility families desire and the structure required for monitoring by caseworkers or family court staff.

Scattered or clustered units of transitional housing for individuals are often sited within privately owned apartment buildings, YMCAs, or commercial SROs that also house other transient and/or low-income groups. When the transitional program leases a small number of units, services are typically provided off-site or by mobile teams that visit residents. The scattered rooms or apartments provide a more normal living environment for those who reject living in a "program" setting, but the delivery of services requires greater effort on the part of both the residents and service providers. Some providers are able to

lease a wing or floor of a building, providing a cluster of transitional units within a larger structure. Supportive services-case management, group activities, various clinical services-may be available on site, although some clustered programs use a visiting or off-site service model.

Clustered or scattered apartments shared by two or more individuals also provide "next step" housing for mentally ill or substance abusing individuals who have graduated from congregate facilities but can benefit from continued support. The apartments, which are leased by the provider agency, usually have single or double bedrooms but common living, kitchen and bathroom space. Individuals are expected to attend off-site treatment, rehabilitation or vocational programs. Staff do not live on site but are on-call to provide crisis services. In the most structured programs, case managers visit frequently, even daily, in the first months, to supervise and monitor residents' ability to handle living in an unstaffed setting. Visits taper to perhaps twice monthly over time. Graduates are candidates for either minimally-serviced "graduate housing" or fully independent housing in the broader community.

Services: Location, Type, Intensity and Level of Demand

It is the services provided in conjunction with transitional housing programs that are expected to provide a "bridge to self-sufficiency and permanent housing" (Sprague, 1991). As with every other dimension, there is broad variation in where services are provided (on-site, off-site), the types of services provided (case management, concrete assistance, child care, supportive services, living skills training, employment training and job placement, and medical, mental health and substance abuse treatment), and intensity or level of service participation required (ranging from low barrier, low demand services to high intensity, high demand programs providing specialized treatment services). Whether and how services are "sequenced" also varies.

Location of Services

Location of services on-site or off-site depends on both the physical space available at the site, the availability of the needed services in the local community, and the programs' expectations about residents' ability to access community-based services. Highly structured service-intensive programs using congregate housing settings are most likely to provide services on-site, where participation and compliance can be encouraged and monitored. Safe Havens-type programs using low barrier, low demand approaches may also provide some services on site as a way of minimizing service barriers. However, programs for individuals and families with less extensive service needs often expect residents to access mainstream services in the larger community. This approach also reduces the institutional quality often associated with serviced residences and the stigma associated with "facility''-type living.

Level of Demand

Level of demand refers to the expectations and requirements for service participation that transitional programs impose on residents and the ways in which they enforce these expectations. At the "low demand" end of the continuum, programs for individuals and families operate somewhat differently. Low demand programs for homeless families tend to target those who do not need intensive, specialized programming but who might nonetheless benefit from supportive services, including child care, education and training, and other "soft" services like counseling and life planning and housing relocation assistance, which includes identification of public and private housing resources, preparation for interviewing with landlords or tenant groups, transportation, childcare, understanding the financing and lease arrangements, and help with budgeting, securing household furniture, security deposits and moving expenses.

Low demand transitional programs for individuals, in contrast, are intended to minimize barriers that prevent people from seeking or accepting assistance. They are primarily directed at those who are distrustful of housing and services programs and easily deterred from seeking or accepting assistance—usually mentally ill individuals who cannot or will not comply with the contingencies that accompany most offers of help. These programs for include "Transitional Living Communities" (TLCs), Safe Havens, and a variety of interim accommodations that serve those described as the "hard to reach" homeless (Lipton, 1995; National Resource Center, 1997). Some low demand programs, such as Safe Havens, are exclusively directed at individuals with severe mental illnesses and were developed to "support and assist them in overcoming specific problems that impede access to permanent housing, and develop the integrated supports needed for successful residential tenure" (Interagency Council 1994, p. 3 9) .

Low demand programs for individuals are predicated on the assumption that a supportive, low demand environment with flexible admission criteria and few initial requirements-a low threshold, low barrier approach-is conducive to engaging those who are most estranged from the service system (National Resource Center, 1995; 1997) and will allow staff to build trust and prove their responsiveness before they "contract" with residents for more intensive service involvement. Such programs pose challenges for both staff and residents. Staff may find the flexible, individualized approach is at odds with their training and experience and may have difficulties defining and enforcing rules in ways that are consistent with a low demand philosophy (Erickson & Page, 1997; Proscio, 1998). Residents may find the increase in expectations and requirements over time to be confusing, and the individualized application of rules and expectations may appear unfair or inequitable. Administrators of one low demand transitional residence have noted the "paradox of an effective Safe Haven is that its greatest strength-that of creating a warm, accepting, engaging environment where residents feel respected and safe can also be its downfall-that residents will not want to leave" (White et al., 1997:13). They suggest, however, that "safe havens" foster a sense of possibility and entitlement that residents carry with them into more independent settings. In locales where permanent housing options are limited, inappropriate, inaccessible or unappealing to residents, providers often need to become advocates for the expansion of permanent housing (White et al., 1997).

At the "high demand" end, transitional housing programs for both individuals and families tend to entail specialized treatment and rehabilitation services and.are configured in ways that reflect the special needs of those they are designed to serve. Homeless individuals and families troubled by serious mental health and drug abuse problems,[4] domestic violence[5] or HIV/AIDS are among the subgroups whose needs have spurred the development of specialized "high demand" residences. More recently, welfare reform and increased federal funding for vocational and job training and placement[6] have resulted in the development of specialized transitional housing/employment projects oriented toward moving homeless families off welfare and into work. Unlike specialized programs based on disability, these projects target families with members closer to being "job ready".

[4] Nationwide, it is estimated that 23 percent of homeless families have members with serious mental health and drug abuse problems (Rog et al, 1995).

[5] In 44 percent of cities surveyed by the US Conference of Mayors, domestic violence was identified as a primary cause of homelessness; by some estimates, up to 60 percent have experienced family violence (Waxman & Trupin, 1997).

[6] The Department of Labor budgeted $360 million nationwide in 1999 specifically for welfare to work programs: since welfare reform was enacted in 1996, $3 billion have been earmarked for welfare to work programs. HUD's estimated 1999 budget show an increase of $949 million more for jobs and economic opportunities over the 1998 budget. Initiatives in this category include the community empowerment fund, and $27 million dollars for new welfare to work vouchers (HUD 1999 Budget Summary).

Specialized "high demand" programs are service intensive. They are based on the assumption that homelessness and residential instability are prompted or exacerbated by problems and disabilities such as mental illness, addictions, and serious health conditions. To achieve residential stability and a satisfying quality of life, individuals with these problems need interventions that address their treatment and rehabilitation needs along with their housing needs. A structured environment is viewed as necessary for individuals. with psychiatric disabilities and substance abuse problems to develop the skills needed to avoid relapse and function more independently. Residential treatment programs offer a context for learning and practicing life skills such as managing money, medication, and sobriety, vocational training, job placement, etc. They usually also require that residents engage in clinical treatment, and most also provide services directed at self-management of medications and sobriety-as a means of sustaining clinical gains and to help residents qualify for admission to supportive housing. Residential treatment programs oriented toward rehabilitation and growth encourage residents to meet high expectations and to continuously improve their levels of functioning. Time frames range from three months to two years.

Specialized programs usually involve substantial structure and supervision to inculcate skills and behavior seen as necessary for success in long-term housing, although the particular mix of services offered varies considerably. They tend to impose the most stringent requirements on newly entering residents, whose sobriety, medication compliance, and program attendance are closely monitored through random urine testing, directly observed medication administration, and signed attendance forms for off-site programs. Curfews, participation in group activities, required room clean-ups and other chores may be strictly enforced, with penalties (e.g., restricting off-site travel, requiring an escort) imposed in response to rule infractions. Over time, residents earn greater privileges and independence. When they have demonstrated sustained compliance with program requirements and adequate skills managing money, medication, treatment participation, and household maintenance, they are deemed ready to graduate to more independent settings.

"High demand" programs often do double duty as treatment settings and as preparation for permanent housing. While these two aspects of program mission are usually viewed as mutually reinforcing, they can create conflicting demands and present residents with dilemmas regarding treatment, education, training, work, and permanent housing. The extended duration of residential substance abuse treatment programs, for example, often conflicts with the time it takes to become eligible for permanent housing or with court deadlines for decisions regarding custody of children or time limits on welfare eligibility. In these situations, residents who remain in treatment may forfeit custody of their children or lose an apartment or exceed the time limits on receiving benefits. Additional issues emerge from the "high demand" structure itself, which imposes rules and requirements that many residents fail to adhere to, leading to high rates of attrition and early discharge in the most structured programs. Specialized transitional housing programs need to develop ways of handling these setbacks with clients who return to alcohol or drug use, refuse to take prescribed medication, or engage in other behavior considered detrimental to their safety and the safety of their children. Questions of how to serve those who do not remain in these programs, and the impact of "failure" on subsequent service efforts remain unaddressed and unsolved issues.

Types of Services

Types of services provided in transitional housing programs vary with the populations targeted. Low demand approaches such as the "safe havens" programs for homeless mentally ill individuals initially focus on providing basic services and necessities (e.g., telephones, a mailing address, and a place to securely store belongings) but over time seek to engage residents in goal-oriented services that will address their mental illness and other barriers to housing.

Programs for homeless families usually offer a range of supportive services-job training/placement, child care, substance abuse treatment, mental health services, and instruction in independent living skills-though specific combinations and approaches differ. The service components of these programs have been designed to respond to the emotional distress brought about by dislocation as well as to address longer term or ongoing problems. In addition to parenting classes, budgeting, and small home repair classes, transitional programs increasingly offer training and employment services geared toward preparing adult family members to meet local welfare-to-work requirements or to enter the job market. These services will likely increase with the impact of welfare reform. Housing relocation assistance is also considered a necessary service for success in permanent housing. This assistance includes: identification of public and private housing resources, preparation for interviewing with landlords or tenant groups, transportation, childcare, understanding the financing and lease arrangements, along with budgeting, securing household furniture, security deposits and moving expenses. In urban areas homeless families, notably those with a history of domestic violence, are often relocated away from familiar resources, shopping, family members and friends. Identifying resources in the community for childcare, education and training, medical and other social service needs can be critical for a family's successful transition into a new community.

Twenty-three percent of homeless mothers have been found to have needs that span the areas of "human capital" (education and employment), mental health and substance abuse (Rog et al., 1995). These families and those headed by parents with psychological problems, victims of domestic violence, teenage mothers with no prior independent living experience, as well as individuals with dual problems of mental illness and substance abuse may need more extensive services in transitional residences.

Specialized treatment services are often provided in transitional housing programs designed for individuals and family members with substance abuse problems. Since drug and alcohol abuse have an enormous impact on all family members, programs targeting homeless families may need to address a variety of issues related to substance abuse, and treatment and intensive services can effectively address many of the most serious consequences for infants, older children, and adults. Treatment opportunities make it possible for pregnant substance abusing women to deliver babies without a positive toxicology thereby reducing or eliminating physical problems associated with alcohol and substance abuse. The impact of alcohol and substance abuse on pre-school and older children may necessitate a variety of specialized services, including therapeutic day care and professional staff (family therapists, pediatric social workers) that can recognize and treat children's stress related illnesses and behaviors. Structured service-intensive programs allow adult residents to proceed with recovery gradually gaining more control and independence. Women find that it is possible to be reunited with older children in foster care and with family members from whom they have been estranged. Specialized transitional residences provide a context for the women not only to remain sober and drug free but to learn and practice daily living skills needed for independent living, vocational training, and eventual work. Success in treatment has been shown to directly impact on a resident's ability to remain in permanent housing over time[7]

Across widely differing programs, case managers are the linchpins of the service effort, working with residents to define individualized goals, coordinate resources and services, and monitor progress. In low demand "safe havens" programs for homeless mentally ill individuals, case managers have the task of

[7] In tracking its own program outcomes over time, Women In Need, Inc. has found that among clients who moved into permanent housing, 9.5 percent remained for one year, and approximately 90 percent remained for two years. This is consistent with findings that show that nationwide, 88 percent remained in permanent housing for eighteen months after leaving a transitional residence, showing that the great majority of families who achieve the short-term goal of permanent housing are successful in maintaining housing stability (Rog et al., 1995).

establishing a trusting relationship with persons who may reject service offers and are willing to return to the streets if efforts at service engagement are too aggressive. Even in programs that impose demands for service involvement, however, case managers' effectiveness depends on the relationship established with the homeless individual or family. Regardless of whether programs use team or individual, clinician or broker case management approaches, case managers in most transitional housing programs combine advocacy work, counseling, skill development and service coordination functions.

Service Sequencing

Service sequencing, which specifies the order in which services are offered, is practiced by many programs, but they vary in the order they specify. Low demand programs like Safe Havens usually begin with "low threat" services such as those addressing basic needs and those which entail little risk by consumers. They offer more intensive, potentially threatening services-substance abuse or mental health treatment, educational programs, others that carry the risk of failure-only after consumers are engaged, unless specifically requested at the outset. High demand programs are more likely to require that consumers achieving some substance abuse or mental health treatment goals before they are offered employment training, housing search assistance, or educational programs. There is variation across programs in the flexibility with which these sequencing approaches are used.

Making the Transition: Program Admission, Tenure, and Moving On

Transitional housing programs gear the services they provide to changing both the behavior and life circumstances of those whom they accommodate. Across diverse program contexts, the process of making these changes is described as becoming "housing ready". However, the specific ingredients of housing readiness are contingent on what is required to obtain permanent housing for a given population in a given locale, as well as the program's judgment about what experience and skills will be necessary for maintaining housing, once acquired. Thus there is some variation in how transitional housing programs define and approach housing readiness at various points in the process of moving from homelessness to housing.

Admission

Funding sources and local political priorities have a primary influence on what population groups are targeted for transitional housing services. Programs may be mandated to serve specific segments of the homeless population (literally homeless people living on the streets; long term residents of shelters; people with mental illnesses or substance abuse problems; "multiproblem" families, etc.). However, within a targeted population, thresholds for admission to transitional housing programs are often related to the program's level of demand. "Low demand" settings such as safe havens seek to minimize barriers to entry and impose few requirements. Over time, as residents and staff build relationships of trust, expectations are increased. Motivation is expected to result from rather than precede the service process. Service intensive programs at the "high demand" end of the continuum, in contrast, screen potential residents to identify those who are motivated to make changes in their lives and are thus more likely to comply with the program structure and rules. Those who fail to do so will lose privileges and may be asked to leave the program.

Tenure and Tenancy Rights

Transitional programs vary significantly in the kinds of rights residents have over the terms and duration of tenure. Programs that provide intensive services, particularly those addressing mental illness and/or

substance abuse, usually retain the right to determine not only who enters the program, but how long they stay and when they should leave. These programs often emphasize their "residential treatment" nature, with the provision of housing seen as a factor that facilitates the treatment rather than being the program's primary purpose. In these clinically administered settings, tenure is conditional on participating in services; residents may sign occupancy agreements but do not hold standard leases and do not have the "tenant protections" that are available to renters under local landlord-tenant laws. In some low demand interim or safe havens programs, tenure is less conditional on adherence to strict rules, and the length of stay may be "indefinite" for those who are unable to move to more independent settings. However, here too, it is the transitional housing provider who ultimately determines whether a resident stays or goes. In contrast, in some low demand housing programs-particularly scattered-site housing for families—residents have leases and thus whatever protections are offered under local landlord-tenant law.

The nature of tenancy protections for residents in transitional housing is closely tied to local or state ordinances and the extent to which these support tenancy rights for transitional residents. Ironically, transitional housing providers in some localities with strong legal protections for residents, such as New York City, may seek to limit lengths of stay for transitional housing residents because of the difficulties they face evicting residents who decide to claim their rights as tenants, even when the rent is paid by the program. Thus some programs in New York City restrict stays to 28 days or less or require residents to temporarily leave after 28 days when residents acquire tenancy rights in the premises where they are staying.

While local laws exercise some effect on tenure and tenancy in transitional housing, the duration of stay is strongly related to the availability of permanent housing. Where housing is in short supply or difficult to access because of cost or high admission barriers, residents may need to remain longer in transitional programs in order to locate permanent accommodations, to qualify for admission (e.g., logging clean and sober time or months of medication compliance), and to move through waiting lists. In many locales, transitional housing has become the only or major means through which homeless families can gain access to public housing and other subsidized accommodations. A limited number of vacancies results in longer stays in transitional housing, which becomes a device for titrating the flow of families or individuals to the level that can be absorbed by available housing resources. . .

Moving On: Links from Transitional to Permanent Housing

Within-agency and between-agency referral linkages, co-location approaches, and convertible housing are all efforts to smooth and ensure a viable transition into permanent housing. These approaches have been developed in response to a number of challenges that transitional housing poses for those seeking to end homelessness. Transitional programs sometimes seek to establish informal or formal referral agreements with particular supportive housing providers in order to enhance their residents' access. This can be particularly effective when the same agency operates both the transitional and permanent supportive housing programs, making movement between the two relatively seamless. "Co-location" (also called "combination" housing) of transitional and permanent accommodations within the same building; and "convertible" housing, in which staff and or services are phased out after a transitional period and the housing itself "converts" to permanent are two newer approaches to facilitating transitions to permanent housing.

Combination Housing

Combination Housing consists of transitional and permanent apartments ***"co-located"*** in the same building. Usually these are new construction, owned by a not-for-profit or community development

corporation. The financing is complicated and involves using multiple resources for construction such as tax credits, construction loans, grants; debt service is paid out of contracts for the homeless families, rent and section 8 and other types of housing subsidies. The permanent housing is developed as an out-take for homeless families.

In a number of communities "co-location" (combination) projects provide transitional and permanent housing as next steps for families that have completed substance abuse treatment programs or as a spectrum of options for people who are mentally ill. Some of these also combine units for single individuals and for families within the same building. Co-location approaches assume that movement along a service-housing continuum is facilitated by locating the various programs under one roof (Proscio, 1998). One variant of "co-located" housing is particularly targeted at those who are reluctant to leave a known environment with familiar supports for a more independent setting because it will require severing valued ties and reconstructing a support system from the ground up. This model is also seen as well-suited to those whose progress towards independence may not be linear—e.g., severely mentally ill or MICA individuals. The on-site availability of a less demanding setting permits individuals to weather a period of relapse without being fully dislocated.

Convertible Housing

Convertible Housing offers an alternative way to link transitional and permanent housing. Unlike co-location, which entails the movement of individuals or families within the same building, this approach permits residents to convert the terms of their tenancy from temporary/transitional to permanent. In particular, families with minimal needs for services often find that scattered-site housing is exactly what they need, and they would like it to be permanent. This approach has been successfully implemented in a variety of locales, including Minnesota, Massachusetts, and parts of New York State. Denver offers an example of transitional housing that was successfully converted from McKinney-funded housing for homeless individuals to permanent stable housing by shifting the funding source. Originally funded with McKinney monies a decade ago, the individuals residing in the program had achieved a decade of housing stability and could hardly at this point be considered homeless. Rather than continuing to use McKinney homeless monies for what was clearly stable permanent housing, providers were able to shift the source of funding to regular section 8 certificates, freeing up McKinney monies to develop housing for currently homeless individuals.

A small number of providers are currently experimenting with similar approaches for people with substance abuse problems or severe mental illness. These programs gradually withdraw services and staff as residents' rehabilitation proceeds. "Sober housing" provides for the continuation of services for families while allowing for the gradual withdrawal of services as recovery progresses. Two types of sober housing have evolved: single family homes and apartments. In single family homes, two to five women in recovery take on the responsibility of managing a home. The lease may initially be in the name of the not-for-profit but the goal is eventually for the group of women to take over the lease. An alternative approach involves using rental subsidies to obtain scattered site apartments or an apartment building. The HUD Shelter+Care program pays fair market rents thus making it possible for residents to move into the next stage of housing before moving into permanent housing. Agencies apply for the subsidy which they must match with supportive services.

A small number of agencies have developed convertible housing programs for mentally ill individuals that after a period of time shift from transitional to permanent housing. One impetus for this model comes from a recognition that "graduation" from a supportive transitional residence to an unknown setting where a support system must be constructed anew is a dubious reward for mentally ill and other

vulnerable individuals who have successfully completed transitional housing programs. The convertible model assumes from the start that as residents acquire skills for living more independently, less intensive staff involvement will be required. However, rather than expecting residents to move on to minimally- or un-staffed settings, the program itself reduces staffing and services and converts to long-term "graduate" housing. There are few examples of fully implemented versions of this model. However, experiments in New York and Boston bear watching.

While transitional housing has been developed as a means of addressing the barriers that homeless families and individuals face in their efforts to exit homelessness, several challenges remain to be addressed if transitional housing is to be an effective means of accomplishing this exit. First, transitional programs generally reward those who do well by requiring them to move on. This has been criticized by proponents of "supported housing" (normalized housing with flexible off-site supports) for mental health service consumers as well as by others who note that such moves can be destabilizing, removing valued supports for individuals not easily able to construct new ties and support systems. A second issue is that transitional housing programs can only be effective if adequate permanent housing is available. Many of the residents of these programs have difficulty accessing and supporting fully independent housing. Helping them move on requires adequate permanent housing and available subsidies plus the supports needed to sustain their tenancy. Moreover, an expanded supply of permanent housing and ready availability of flexible supportive services for those who need them might obviate the need for a transitional phase for some individuals who could do well in permanent housing with less extensive preparation. At present, however, competition for limited permanent housing and limited knowledge of how to identify those who most need the special help provided by transitional housing.

Sources and Types of Funding

McKinney funding administered by HUD has been the largest single source of funding for transitional housing programs. A variety of HUD programs-most notably the Transitional Housing component of the Supportive Housing Demonstration Program, but also the Supplemental Assistance for Facilities to Assist the Homeless (SAFAH) program-have supported the development of transitional housing. However, most providers draw on diverse funding streams and cooperative relationships in assembling funding for their projects. In addition to HUD funds, providers of transitional housing receive support from McKinney funds administered by other federal agencies-particularly HHS-through demonstration initiatives; by state-level social service agencies; by city or county-level government; and donations from foundations and private contributors. The Corporation for Supportive Housing has also supported the development of transitional housing models with funding from the Conrad Hilton Foundation. Funding streams affect everything from the scale of the project to the population targeted, the amount and focus of services provided, lengths of stay, and follow-up services. Restrictions on how funds can be used have also been one of the difficulties in implementing convertible approaches, although Denver's success in replacing McKinney funding with Section 8 Certificates illustrates one approach to conversion.

While HUD Supportive Housing funds have been underwriting virtually every type of transitional housing program, one issue of contention is the high proportion of HUD dollars going to support intensive treatment and other services rather than housing. Both providers and advocates have recommended that HHS and state or local mental health and substance abuse (as well as labor and education) agencies take on more of the responsibility for residential treatment and other service intensive efforts, freeing HUD money for housing.

Effectiveness of Major Models

Transition to What? Defining and Measuring Expected Outcomes

Transitional housing programs are designed to assist people in moving from homelessness to stable housing. Additional program goals vary with the subgroups targeted for services, with the way the barriers to stable housing are conceived and approached, and with the operant philosophy about how to overcome those barriers. To assess effectiveness of transitional housing, then, it is necessary to consider outcomes related to the specific barriers a given program is designed to address. In addition to housing outcomes, which reflect central goals in all transitional housing programs, these programs have mainly been designed to have an impact on four domains-services outcomes; behavioral or clinical outcomes; self-sufficiency; and cost effectiveness. Specific measures used to assess transitional housing's effects on these domains may reflect either short-term outcomes assessed at the point individuals or families leave the transitional setting or longer-term program goals that involve stability and self-sufficiency after leaving the program. Although conducting longer term follow-up entails complex logistics and can be expensive, only a long-range view of program effects can test key assumptions underlying transitional housing—e.g., that clinical and life skills services will enable individuals and families to weather the kinds of events and crises that previously resulted in homelessness and thus will contribute to residential stability.

Housing Outcomes

Housing outcomes are central to any assessment of the effectiveness of transitional housing programs. They include short-term measures of housing status at the conclusion of the transitional program, such as whether permanent housing is obtained; length of time required to obtain permanent housing; type and quality of housing; and residents' satisfaction. Longer term housing measures can consist of "snapshots" of housing status (housed/not housed) at a specified follow-up point or may reflect the stability of permanent housing over time-e.g., number of days homeless and number of days housed within a specified follow-up period. Operationalizing the relevant concepts requires clear definition of terms such as "housed" and "homeless", and conventions for categorizing ambiguous conditions (hospitalizations, incarceration in jail or prison, doubled up or living with relatives, etc.), and more complex assessments of residential patterns such as those developed by Hopper and colleagues (1997) and by Hurlburt and colleagues (1997) may be needed to assess whether transitional housing programs have successfully interrupted cyclical patterns of homelessness. It is also important to note that housing stability need not entail remaining in a single "permanent" housing setting. The critical distinction involves remaining housed as opposed to returning to homelessness.

Services Outcomes

Services outcomes include the extent to which a program successfully engages transitional housing residents in the services provided; the amount and range of services utilized by residents; the retention of residents in the program or in particular components; and linkages to community-based services that will be available following the transitional period. Transitional housing programs have been developed on the assumption that the services provided during the transitional period will equip homeless individuals and families to maintain residential stability after they move on. Service involvement is thus a proximal outcome that is expected to contribute to the longer range goals of residential stability and self sufficiency. While all transitional housing programs involve services, the specific service offerings are very different in programs targeting different segment of the homeless population, with corresponding variation in how service outcomes are measured.

Engagement is of particular concern to low demand programs such as Safe Havens that offer low-barrier access to a place to stay as an enticement for clients with psychiatric disabilities to enter the program and establish relationships with staff, seen as prerequisites to providing skill-building, clinical, and housing-focused services. Measures of engagement are not well developed and engagement is often inferred from participation in other services, but more direct indicators of engagement include talking with staff, disclosing information, agreeing to consider/accept more demanding services as well as actual use of those services. To determine how well transitional programs accomplish engagement goals will require development of reliable ways to detect significant changes in these domains.

Service utilization measures focus on how many services an individual or family uses, how frequently, and-for particular types of services-whether they complete the particular service program. In programs that require residents to complete a specific range of services to graduate, rates of graduation also measure service utilization. Where service plans are more individualized, service use must be measured within specific service domains. In interpreting use of services data, however, it is important to be aware that some programs practice service sequencing, i.e., requiring participation and/or completion of certain services (often substance abuse and psychiatric treatment, if relevant) before others---education, job training-are made available. In these situations, low rates of utilization of "higher level" services may be an artifact of the sequencing process.

Retention in transitional housing until "graduation" from services is often a program goal in its own right, but it is also viewed as a means of enhancing housing stability by equipping families and individuals to address problems that might otherwise result in loss of housing. However, relationships between housing outcomes and service retention can be complex and need to be assessed and interpreted cautiously. In localities where eligibility for subsidized permanent housing requires families to spend time in transitional facilities, families that fail to complete skill-building workshops can be discharged and thereby lose access to the major source of affordable permanent housing. In these contexts, analysis of relationships between housing outcomes and retention in services must take into account the likely confounding effect of the discharge policies.

Service linkages usually consist of specific referrals of aftercare arrangements that will ensure ongoing access to supports or treatment once an individual or family has moved to permanent housing. Most transitional programs also provide a period of follow-up case management services to enhance the likelihood that families and individuals will remain connected to community services such as child care, job training or mental health treatment. Measures of service linkage should capture the nature of the links established for various types of services.

Behavioral and Clinical Outcomes

Behavioral and clinical outcomes are often the major focus for transitional housing that doubles as residential treatment. Mental health and addiction treatment services are most likely to serve in this dual capacity. Residential treatment settings usually assume positive treatment outcomes are prerequisites for housing stability. Success is evaluated in terms of clinical outcomes and recovery/rehabilitation goals, as measured by, for example, decrease in psychiatric symptoms, adherence to medication regimens, abstinence or decreased use of drugs and alcohol, amount of time clean and sober, and level of functioning.

Self-Sufficiency

Self-sufficiency is viewed by many administrators and providers as the overarching aim of transitional housing programs, and the one toward which most of the service efforts are addressed. For families and some sub-groups of individuals, attaining self-sufficiency is usually conceptualized as a movement from welfare to work, and measures focus on income and employment. For severely mentally ill individuals, there is less expectation of total self-sufficiency. Measures of income and employment are more often used within this group as indicators of improved levels of functioning, but most are expected to continue to rely on disability benefits, perhaps in combination with part-time employment in supportive employment programs.

Cost Effectiveness

Cost effectiveness refers to the relative costs of achieving different levels of outcome, and thus its measurement is partially dependent on the measures of outcome discussed above. Cost effectiveness studies usually rely on measures of service utilization as reported by residents or documented from MIS systems or program records, in order to assess the service costs associated with successful outcomes—whether these are defined in terms of housing, services, behavioral measures, or self-sufficiency. At least one transitional housing demonstration program has focused on "cost neutrality" in developing innovative transitional housing services-i.e., the new service programs should be no more costly than the system of motels and shelters that was in use before.

Consumer Perspectives

Consumer Perspectives have not figured prominently in most research on transitional housing. Critiques of transitional housing programs coming from organized segments of the consumer population-notably mental health consumers and advocates for "supported housing"-emphasize that transitional housing is stigmatizing and note that graduation disrupts housing stability rather than fostering it. They argue that non-compliance and high attrition from transitional programs reflect strong consumer preferences for de-coupling services needed to consolidate a transition out of homelessness from housing, which should not be contingent on service participation. Research on transitional housing will benefit'from expanding the focus beyond program-defined outcomes to prominently incorporate consumer-defined conceptualizations of outcomes as well. This will not only clarify factors that may contribute to attrition in transitional programs but will also increase the likelihood that efforts to resolve homelessness are responsive to perceived needs.

Relationships Among Outcomes in the Short Run and Over Time

In addition to measuring how well transitional programs meet their self-defined goals, it is critically important to consider how non-housing and housing outcomes are related. As noted above, programs have been developed on the basis of the assumption that housing outcomes are related to other program goals pertaining to service engagement, treatment, and rehabilitation or recovery. Research provides mixed support for this contention, as described below, and thus the relationships among outcome domains warrants closer scrutiny.

What Works? Program Experience and Research Results

In the last two decades, providers have acquired considerable experience in developing and operating transitional housing for homeless families and individuals, and individual agencies have used this experience to inform their own ongoing program development. In addition to these direct renderings of

the experience of providing transitional housing, several programs have been the focus of individual case studies that provide detailed documentation of how transitional housing has been implemented in particular contexts (Hannigan & White, 1990; Lowery 1992; Blankertz et al., 1992; Proscio, 1998). National or local conferences of providers and policy makers and providers' manuals that offer technical assistance to others developing transitional housing have been additional vehicles for communicating lessons learned from doing (Meister, 1993; Sprague, 1991; National Resource Center 1995; 1997). While these accounts are primarily descriptive and focus on issues of process and implementation, both public agencies that administer homeless services and the foundations and corporations that have traditionally provided nonprofits with supplementary resources are increasingly requiring outcome information and using performance indicators in monitoring nonprofit organizations operating transitional housing. Agencies have also implemented innovative program components that enhance their own monitoring and assessment of program outcomes and facilitate more rigorous evaluations.*

Accounts of how specific programs work are complemented by more broadly-based descriptive research on federally funded transitional programs. The largest studies have focused on transitional housing funded under the Supportive Housing Demonstration Program. and its successor, the Supportive Housing Program. In 1990, the General Accounting Office (GAO) reviewed HUD's Transitional Housing Program to determine whether the program was serving the targeted population with a wide range of services, whether it was helping homeless people move to independent living, and what factors influenced successful transitions. The GAO conducted a telephone survey of program directors of 360 (94%) of funded projects and visited 32 of the project sites. The study found that the programs used a variety of facilities, ranging from converted warehouses or hospitals to renovated hotels, apartment buildings and newly constructed buildings. Lengths of stay varied enormously, with maximum duration ranging from one month to 24 months, the limit set by HUD. The programs provided-either directly or by referral-an array of supportive services: case management, housing placement, benefits or entitlements assistance, psychological counseling, job training, medical care, child care, and guidance in life skill, as well as specialized mental health and substance abuse services.

The GAO concluded that the program was reaching its intended targeted population of homeless families and mentally ill individuals; that about 40 percent of the individuals served by transitional programs succeeded in obtaining housing and a source of income upon leaving the program; and that the clients most likely to succeed were those who remained in the program longer and those who used more supportive. services. Families and couples without mental health or substance abuse problems were most likely to succeed, and people whose homelessness was assessed by the GAO investigators as resulting from domestic violence, eviction, or money-related matters were more likely to succeed than those whose homelessness was attributed to mental illness. The GAO report noted that transitional housing programs tended to screen out those with mental illness or substance abuse, except in programs specifically targeted at those groups. While they were not always successful in excluding such persons, the selection process may have screened in the most motivated portion of the population and those most willing to accept the structure and rules of the transitional programs. Follow-up data were not available to assess longer term outcomes.

8 Follow-up programs modeled after alumni groups may be a tool for follow-up evaluations (along with provision of aftercare services, maintaining client contact with community services, promoting client networks). One example of a private resource supporting follow-up evaluations is at Women In Need, Inc. With the support of two private foundations, WIN is beginning a pilot program which brings together alumni from two low demand residences in order to build on the community infrastructure already in place from the high demand shelter, and maintain contacts with former clients while continuing to offer services. Informal alumni groups have developed at several low demand and high demand shelters in the past; this pilot program is intended to formalize the process and make it useful for much-needed evaluations of low demand transitional residences for families.

In 1995, the Final Report on Westat, Inc.'s National Evaluation of the Supportive Housing Demonstration Program (Matulef et al., 1995) updated the GAO findings. The proportion of participants who remained in transitional housing programs until they graduated was 57 percent; another 24 percent withdrew voluntarily, and 19 percent were dismissed. The mean length of stay for project residents was 9 months, with slightly shorter stays for battered women (8 months) and slightly longer for severely mentally ill residents (11 months). Overall, 56 percent of all residents (70% of graduates; 30% of those who withdrew or were dismissed) went on to stable housing-mostly in unsubsidized housing without services. Income and employment both increased. Although follow-up data were. not available, program directors reported that there was great stability in the housing of those who had graduated from their programs. Project sponsors attributed successful outcomes to'several factors: the availability of a safe, secure, private place to live; case management; screening for those who were most motivated to succeed; and a range of specific services. Impediments to success included pre-existing problems like mental illness and substance abuse; and community level factors such as lack of affordable housing and lack of employment or vocational opportunities.

Reports on implementation of state and local-level transitional housing programs offer additional evidence that substantial numbers of families and individuals move on to permanent housing, most express satisfaction with the transitional services and with the new housing they have obtained, and modest gains are reported in income and employment. (See, for example, Wilder Research Center's 1998 report on five years of the SAFAH project in Minnesota.) While both national and local descriptive evaluations of the major federal initiatives offer a general overview of transitional housing and the issues that have emerged in implementing it, few studies of transitional housing programs have attempted more rigorous assessments of the effectiveness of particular types of transitional programs on clearly defined subgroups of the population. Yet in the absence of studies that use experimental or at least comparison group designs, it is impossible to tease out the extent to which the positive outcomes reported in the descriptive studies can be attributed to the transitional housing programs or whether these outcomes are better or worse than the same population would achieve using alternative approaches. For homeless families, in particular, research of this sort has been extremely limited.

Studies conducted as part of the McKinney Transitional Housing Demonstration Projects for AFDC-eligible homeless families are therefore particularly notable, in that they raise and begin to answer some of the key questions about transitional housing as an approach to ending family homelessness as well as about the relative effectiveness of particular models. The AFDC projects were carried out in Massachusetts, New Jersey, and Westchester County in New York State, and were designed to develop service intensive transitional housing alternatives for homeless families. Evaluation reports from these projects describe local implementation of a variety of models of transitional housing for families and compare their costs and their effectiveness to "usual" services-i.e., shelter and hotels-in their locale. The models evaluated differ in a number of ways, with notable contrasts between the different projects. In Massachusetts, for example, all transitional housing programs targeted "multi-problem" homeless families, and all used scattered-site approaches, with three different models that, respectively, provided families with apartments in public housing projects, the private rental market, and newly refurbished subsidized units. All of the public units and a portion of both the private and refurbished "converted" to permanent housing as the families graduated from services. In Westchester County, in contrast, the models examined were all based in single-site facilities-two of them newly constructed as transitional housing for families, the third a notorious welfare hotel that underwent extensive rehabilitation to become a service-intensive transitional facility, although many of the families this program served had been residing there for years before the renovations.

While both of these studies used the existing system of shelters and motels as the comparison condition against which the transitional programs were assessed, their findings on effectiveness diverge. In Massachusetts, the families in transitional housing made greater gains in every area of outcome examined than the shelter/hotel families. The outcome analyses focused on behavioral changes in such areas as paying bills on time, children skipping school, using illegal drugs, or socializing with drug users. In Westchester, where the primary outcomes of interest were service utilization, reducing lengths of stay, and attaining stable housing, the differences between the demonstration sites and others were less striking: the participants in the McKinney programs were offered and used more services, but their lengths of stay in transitional facilities were slightly longer than those of families in non-McKinney programs, and there was no difference in the likelihood of obtaining permanent housing. However, the demonstration project coincided with a major reorganization of services for homeless families throughout the county, and across all types of facilities there were reductions in lengths of stay during the course of the study period. Moreover, the McKinney programs had less access than others to scattered-site Emergency Housing Units (EHUs) which were administered like the single-site programs but used regular apartments which, upon the family's graduation, converted to permanent housing. This option—which closely resembles the demonstration condition in the Massachusetts study-proved a particularly effective-and cost effective-means of transitioning families out of homelessness. The Westchester investigators estimated that up to 61 percent of the families served in the McKinney programs could have been sent directly to EHUs instead, suggesting that the single-site intensive service model may have actually prolonged homelessness for some families. Moreover, analysis of cost data indicated that the longer stays in the demonstration models resulted in higher costs, whereas in Massachusetts the demonstration models actually reduced costs compared to the shelter/hotel alternatives.

The Massachusetts and Westchester studies also had both similar and contrasting findings on service utilization and service satisfaction. On the one hand, in both studies, families in the demonstration sites expressed the greatest satisfaction with their transitional housing experience and with the specific services they received. However, the Massachusetts project found satisfaction unrelated to initially perceived need, while the Westchester study found that those who felt coerced into using services they did not feel they needed were less likely to express satisfaction with them.

The evaluations of the McKinney AFDC projects makes it clear that a variety of'transitional housing models can be used to enhance the services provided to homeless families. They also suggest, however, that even "multiproblem" families can be effectively served in the scattered site convertible models used in different ways in Massachusetts and Westchester County. ..if the local public and private housing resources are available. In Massachusetts, one of the three demonstration models actually refurbished and brought dilapidated housing back into circulation, thus expanding the available supply of units. In Westchester, the demonstration program augmented the stock of transitional units but did not address the county's severe shortage of affordable permanent housing, and limited availability was a major reason that the successful EHU approach was not more widely used. Thus these studies serve as important reminders that in assessing transitional approaches, we must carefully attend to the context in which they are implemented, particularly in terms of the availability of permanent housing stock and mechanisms for making it affordable.

Going beyond the suggestive results from descriptive studies, these demonstration evaluations provide the groundwork for an empirically-grounded knowledge base of policy-relevant research on transitional housing for homeless families. Moreover, they underscore the importance of making the relevant comparisons-not only between differently configured combinations of transitional housing and services, but between transitional housing and alternative approaches to achieving housing stability that do not as a matter of routine subject families to a prolonged transitional limbo.

Research on transitional housing programs for homeless individuals is only slightly more developed than that on families. Few evaluations of low demand programs have been carried out, and most have been descriptive studies with weak study designs and limited follow-up data. A retrospective record study of 160 residents of low demand transitional residence programs in Philadelphia that offered psychosocial rehabilitation services (Blankertz et al., 1992) found that many residents improved their housing status (only 10% returned to the streets) and were linked to mental health services (39% entered treatment), but high rates of missing follow-up data and the absence of control groups make these results difficult to evaluate.

An evaluation of a program in Chicago that "co-located" transitional housing within the same structure as a shelter and permanent housing found that residents of the transitional program did indeed move on to permanent housing and in that sense, the program was a success. However, expectations that most transitional residents would enter the program from the co-located shelter were not borne out. At least in the early phases of the project, referrals to the transitional program from other agencies vastly exceeded the number of "in-house" moves. Similarly, most transitional residents went on to permanent housing elsewhere, with only a small number remaining within the co-located system. The evaluation report suggests that the pressures resulting from scarcity of all kinds of housing ensures that any available resource will be quickly filled, often with those who could do well in more independent settings if they were available. To ensure the units were fully utilized, the program was under pressure to accept these individuals rather than work on persuading more reluctant shelter residents to try the transitional setting (Proscio, 1998).

Another recent study of six "interim housing" programs in New York City (Barrow & Soto, 1996) compared outcomes of individuals entering interim housing operated in conjunction with outreach and drop-in center services with a matched sample drawn from outreach/drop-in programs that provided comparable supportive services but did not offer interim or transitional housing. The interim residents were significantly more likely to be housed three months after exit than the controls, although there were no significant differences in their involvement in service and treatment programs at follow-up. The study also found that within the interim housing group, longer stays and more intensive services were associated with better housing outcomes. These results suggest that low demand transitional programs can enhance the housing prospects for homeless individuals who are among the most estranged from the service system.

In another small group of studies, researchers have looked at the effectiveness of "high demand" transitional housing programs that offer specialized services for individuals with severe mental illness, substance abuse problems or both. These range from retrospective record reviews to experimental studies that randomly assigned subjects to alternative residential settings; and they consider a variety of outcomes, including retention in the program, housing status at exit and/or follow-up, employment and income, and in some studies, clinical outcomes such as changes in psychiatric symptoms and use of drugs and alcohol.

Studies of a transitional residence for severely mentally ill individuals in St. Louis, MO (Murray et al., 1995; Murray et al., 1997; Murray & Baier, 1995) based on a retrospective record review found that 48 percent of 228 individuals who participated in the program over a five and a half year period completed the program as planned-i.e., obtained housing and a source of income, while 18 percent were discharged without "graduating" and 22 percent left "against medical advice". Those who completed the program spent a longer time in residence, participated in more program activities and had a greater number of prior psychiatric hospitalizations. Two studies have been conducted in transitional

Domiciliary Care for Homeless Veterans (DCHV) facilities (Prabuki et al., 199.5; Leda & Rosenheck, 1992). One of these found that program participants showed improvements in clinical status (symptoms of mental illness and substance abuse), social functioning (employment and vocational) and housing status. However, they also noted that these domains of outcome were only weakly related to one another (Leda & Rosenheck, 1992). In the other study, completing the program was associated with improvements in housing, income, and vocational stability, but was not associated with improvements in psychiatric symptoms (Prabuki et al., 1995). Transitional programs thus may not have the same impact on the varied issues that homeless individuals grapple with in their efforts to improve their quality of life.

Retention in high demand programs, particularly those tailored to the needs of substance abusers, is a focus of several reports. In a Los Angeles study that compared a long-term residential program for homeless alcoholics with a briefer version of the program, the experimental group had higher rates of retention, but within both groups, retention in the initial program and housing placements at discharge were associated with race, gender and associated differences in employment histories, economic status, and subsistence patterns while homeless (Grella, 1993). The theme of low retention rates reappears most dramatically in the one controlled, experimentally designed study to assess transitional housing programs for homeless individuals. This study compared two approaches (modified community residence, derived from a mental health services tradition and modified therapeutic community, derived from a substance abuse treatment tradition) to transitional residential treatment for homeless mentally ill chemical abusers in New York City. While the findings showed that for those who completed the program, the modified TC approach was more effective, the most striking result was that only 13 percent of over 600 men who were referred and found eligible in fact completed either program. Moreover, significant attrition occurred even before admission to the programs, with additional attrition in the first sixty days after admission (Rahav et al., 1997).

Descriptive accounts of particular transitional programs and the findings that 40-60 percent of residents of HUD's Transitional Housing Programs move on to permanent housing settings suggest that transitional housing can be effective in helping individuals and families accomplish an exit from homelessness. However, individuals and family members with substance abuse and mental health problems were less successful than other groups. While the limited research on safe havens and other low demand programs for homeless individuals suggests these can be effective alternatives to the streets and drop-in centers for mentally ill and other particularly vulnerable groups, the small number of studies that have examined these programs and the limited duration of follow-up indicate a need for more research in this area. Since low demand programs are often developed to fill gaps in a given agency's continuum of services, evaluations need to avoid confounding the effects of the safe havens component and the more comprehensive service program in which it is embedded.

Research on transitional housing programs that offer specialized services such as mental health or substance abuse treatment to homeless individuals is also extremely limited. Most studies indicate that transitional housing residents improve their housing situations and often experience gains in clinical status as well. However, the weak relationship between clinical and housing outcomes challenges one of the basic premises of transitional housing programs that focus on providing treatment and services for mental illness or substance abuse problems and raises questions about the relevance of using clinical criteria to gauge "readiness" for permanent housing. In addition, existing studies either lack comparison groups or use control conditions that differ in treatment approach but not in housing condition. These studies also usually report only short-term follow-up and/or low follow-up rates. Thus it is difficult to assess whether, in the long run, individuals who go through transitional housing programs achieve more stable and/or independent housing than those who do not. Finally, and perhaps more critically, low rates of retention in transitional residential programs-particularly those for substance abusers and dually

diagnosed mentally ill substance abusers-make it very difficult to determine how widely findings of positive outcomes can be generalized.

As with studies of transitional housing for families, because of limitations of method and design, the research on programs for homeless individuals offers only partial answers to key questions about transitional housing. Thus while studies of low demand programs suggest that adding transitional housing to the services offered in drop-in settings has an impact on housing outcomes, until we have studies that test transitional approaches against permanent housing approaches for comparable populations,9 it will remain unclear whether transitional housing offers a useful way to enhance housing access and stability or primarily serves as a substitute for permanent housing when the latter is inaccessible, undesirable, or in short supply.

Conclusions: Recommendations for Research and Policy

Descriptions of transitional housing programs can be found in annual reports, program brochures, and proposals submitted to funding agencies as well as in conference presentations, case studies written for practice journals or popular media, and technical manuals for those planning similar programs. When these sources are combined with the broad-based descriptive surveys of transitional housing programs undertaken by HUD, smaller descriptive studies of single programs, and research demonstration projects mainly supported by agencies within HHS, transitional housing emerges as an amazingly diverse set of programs directed at a varied population of homeless individuals and families.

Given the diversity encompassed under the umbrella of transitional housing, the limited research on these programs precludes easy generalization. Descriptive surveys of transitional housing programs tell us that a substantial number-usually around half-of the individuals and families that enter these programs go on to permanent housing-and among those who remain in the transitional programs until graduation, a much higher proportion obtain housing. They also confirm that individuals with psychiatric disabilities and/or substance abuse issues have greater difficulty obtaining permanent housing than families without these problems.

Although descriptive accounts of individual programs are plentiful and succeed in conveying many of the variations in target populations and program types, they remain largely outside the published literature. Moreover, they have focused overwhelmingly on three subgroups-homeless families, mentally ill individuals, and substance abusing individuals; they have mainly been carried out in urban and suburban settings; and though they document high proportions of their populations drawn from racial and ethnic minority groups, they tend to shy away from addressing issues of cultural competence. In addition, to the extent that transitional housing programs operated by or primarily staffed with consumers exist, they are notably absent from both the "fugitive" (i.e., unpublished) literature and from published research.

While descriptions of particularly notable or innovative programs sometimes do enter the published literature, well-designed studies of their effectiveness are rare. It is thus noteworthy that in the limited

9 A current SAMHSA initiative is comparing housing outcomes for severely mentally ill individuals in permanent "supported housing" (i.e., affordable permanent housing for mentally ill adults based on principles of consumer choice in housing and services, integration into "normal" housing settings with readily available but optional, flexible, individualized, community-based support services not linked to the housing) versus a variety of clinically managed transitional housing alternatives. Since several-though not all-of the projects in this cooperative agreement are focusing on homeless populations, the findings should begin to answer important questions about the effectiveness of transitional housing for the mentally ill subgroup of homeless individuals.

work on effectiveness of transitional housing for homeless families, there are convergent findings in favor of a scattered site model that eventually converts units from transitional to permanent housing. Moreover, in one variant of this model, dilapidated units are renovated and brought back into use, thus increasing the total stock of permanent housing. This approach has been shown effective even with multi-problem, hard-to-serve families, and thus may be widely generalizable-given availability of subsidies to maintain the affordability of the permanent units. The model not only seems to work; it does so at lower cost than single-site alternatives while also addressing critics' concerns that transitional housing is stigmatizing, disrupts stability by requiring multiple moves, and siphons resources away from permanent housing development.

There is no comparable consistency in the findings from studies of homeless individuals. A similar model of convertible transitional units scattered through a permanent housing settings was one of several included in a study that found that adding transitional housing to drop-in or outreach program services increases movement into permanent housing. However, small sample sizes precluded testing the relative effectiveness of the various models.

Other controlled studies of transitional housing for homeless individuals are few. Moreover, studies of transitional housing for individuals have often focused on residential treatment programs and have been concerned only incidentally with their role as housing. Such studies indicate that attrition is a major issue for "high demand" programs providing intensive substance abuse and/or mental health services, and whatever their merits as treatment programs, they do not offer a route out of homelessness for most who enter them. And, despite the assumption that services addressing underlying clinical issues and skill deficits will enhance housing stability, research support for this is equivocal and raises questions about the relationship between housing outcomes and the clinical and skill-building goals of many transitional residence programs.

To date, then, the research on transitional housing programs offers only a few consistent findings and many major gaps. Thus we conclude with the few recommendations for policy that are suggested by recent research as well as several recommendations for the kinds of studies that are needed to develop more informed approaches to aiding the transition from homelessness to housing.

- **Expanding the supply of affordable housing should be the highest HUD priority.** Inadequate availability of affordable permanent housing limits the effectiveness of all efforts to support the transition from homelessness to housing.

- **Scattered-site transitional housing units that convert to subsidized permanent housing** reduce time families spend homeless, facilitate their transition to permanent housing, and avoid the stigma associated with single site programs, while using case management and community-based services to provide the support needed to maintain housing. Policies facilitating conversion should be supported and providers should be encouraged to experiment with developing convertible models for homeless individuals as well.

- **Research should focus on comparison of transitional housing with non-transitional alternatives:** The most critical need is for studies that compare major variants of transitional housing with alternative approaches to helping people exit from homelessness (see Burt, 1997). Such comparisons can help resolve current controversies over the value of transitional housing and may provide a basis for determining what approaches work best for which subgroups of the homeless population.

- **For homeless families, research should compare transitional housing programs with several major alternatives-short-term** housing assistance (rent arrearages, security deposits, negotiation with landlords), supportive/rehabilitative services, and long-term housing vouchers or certificates, as well as key combinations (transitional housing plus vouchers; supportive services plus vouchers).

- For homeless individuals who need substance abuse and/or psychiatric treatment services, the major questions concern how services addressing clinical and rehabilitation needs should be linked to transitional and long-term housing. The critical comparisons are between transitional housing programs (both low demand, low threshold programs and service-intensive "high demand" transitional housing programs) that refer graduates to permanent supportive or independent housing; transitional housing that converts to permanent supportive housing; direct admission to permanent supportive housing; and service programs providing case management, housing vouchers, and support and assistance in obtaining permanent independent housing and other needed services.

- **Long-term follow-up studies are needed.** We know almost nothing about what kind of service/housing combinations are needed to sustain housing stability over time for the various homeless subgroups. Studies of transitional housing and the alternatives described above should be longitudinal, with follow-up extending at least one year, ideally two, from the point of entry to permanent housing.

- **Consumer perspectives must he brought to bear on research questions, designs, and conceptualization of outcomes.** Consumers' voices have not been heard in most research on transitional housing. Researchers need to go beyond consumer satisfaction surveys and incorporate consumer perspectives and concerns in conceptualizing research questions, designs, and outcomes for transitional housing studies.

- **The importance of context.** Evaluations of transitional housing programs cannot take as given the broader context within which these programs operate. Studies must, for example, take into account how contextual factors like shortages of affordable permanent housing may serve to inflate the importance of transitional housing and services. They must also contend with significant recent changes in that broader context-particularly the array of policies enacted under the rubric of "welfare reform"-that are altering and restricting the terms under which homeless assistance can be provided. As states enact workfare requirements and time limits that make no allowance for the "work" involved in the struggle to exit from homelessness, the once unthinkable disappearance of even minimal social welfare provisions may come to seem as normal and routine as the once unthinkable presence of widespread homelessness already has. Research that focuses on effective strategies for helping families and individuals exit from homelessness must centrally consider the effects of the already advanced erosion of the social contract.

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Reconnecting Homeless Individuals and Families to the Community

by
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Abstract

Homeless people are, by definition, isolated from mainstream society. They lack stable housing, and often lack connections with jobs, families, and communities. This paper summarizes what we know about reconnecting homeless people and individuals into the community and in turn fostering self-sufficiency, including improving their residential stability and employability, and reuniting them with family and friends.

Much has been learned in recent years about how to connect homeless people with stable housing. There have been several major housing initiatives and studies, the majority demonstrating that when homeless people obtain housing with appropriate supports-even those with multiple and severe problems-most stay stably housed. Furthermore, housing is best offered as the first step toward greater reconnection, Much less attention has been placed on testing ways to reconnect homeless people into the job market, with mixed results. The relative success of more comprehensive programs compared to approaches that concentrate only on employment suggests the need for efforts that integrate support services, housing, and job training and development services. Finally, although research continues to show that homeless people have few ties with families and friends, there have been no programs or efforts explicitly designed to improve the social capital of homeless individuals.

In addition to reviewing what is known in each area, this paper discusses the barriers and challenges that continue to challenge efforts to reconnect people back into our communities. The paper concludes with a discussion of the implications of our knowledge for policy, practice, and research.

Lessons for Practitioners, Policy Makers, and Researchers

The literature on reconnecting homeless people to housing, jobs, families, and the community reviewed in this paper provide a number of lessons that can be useful to service-providers, policy-makers, and researchers. The research and practice conducted to date provide some direction for individual housing and social service providers, including the following:

- A coordinated approach to reconnection-the "three-legged stool" of housing, services, and employment-may offer the best prospects for reconnecting people.
- Housing and employment may be best tailored to people's needs and preferences, suggesting that a range of housing and employment opportunities is needed.
- Helping people re-establish ties with family, friends, and the community may be difficult, but providing stable housing and employment opportunities may help renew, or create new ties.

The policy implications from what has been learned so far are:

- Initiatives should emphasize housing first for reconnecting people to society.
- The major challenge to reconnection is replicating housing programs on a broader scale.
- Greater flexibility needs to be built into social and medical programs to encourage rather than deter people from seeking employment.
- Employment and training efforts should be complemented with other programs or initiatives to increase wages or supplement earnings.

Finally, although much has been learned about effectively working with homeless people, many questions remain. Research questions highlighted by the material reviewed in this paper include:

- What combinations of services and housing are most effective, for whom? (For example, what services are essential? When is transitional housing necessary?)
- What options can effectively serve individuals with active substance abuse problems?
- What employment approaches are most effective? (For example, under what conditions can affirmative businesses are self-supporting?)

Introduction

Homelessness is typically more than being without a home (U. S. Department of Housing and Urban Development, 1995). In addition to being without housing, homeless people are often unattached from mainstream society on a number of other dimensions, including employment, health care, and connections with family, friends, and the broader community (Wright, Rubin, & Devine, 1998). This paper summarizes what we know about reconnecting homeless individuals and families into the community, including improving their residential stability and employability, and reuniting them with family and friends so that they can be as independent and self-sufficient as possible.

One of the challenges to reconnecting homeless individuals and families to the community is the extent to which homeless people today are disaffiliated from society. Comparing the characteristics of the "old homeless" who inhabited the Skid Rows of U.S. cities in the 1950s and 1960s to the "new homeless" of today, Peter Rossi notes that "what is striking is that homelessness today is a more severe condition of housing deprivation than in decades past" (Rossi, 1989). In the past, those who were considered homeless were able to find some shelter in flophouses, SROs, or cubicle hotels. By contrast, many of the today's homeless are apt to be found in public places (such as building lobbies or train stations), homeless shelters, or on the street.

Similarly, most of the "old homeless" worked, either full-time or on an intermittent basis, whereas most homeless persons today are not working, have not worked for some time, and "suffer a much more profound degree of economic destitution" (Rossi, 1989). Finally, today's homeless, like homeless persons in years past, lack strong support networks. Most report few ties with family and friends, and thus rarely have anyone to rely on to help out financially or emotionally (Wright et al., 1998).

The literature is replete with perspectives as to "why" disaffiliation and homelessness occur in today's society. In the 1980s, two polar perspectives were offered. One perspective, expounded most strongly by Baum and Burnes (1993), is that people become disaffiliated of their own doing. Personal problems such as mental illness, substance abuse, and legal issues challenge a homeless person's ability to attach, or remain attached, to the rest of society.

Others (see Koegel, Burnam, & Bauhmohl, 1996; U. S. Department of Housing and Urban Development, 1994; Wright et al., 1998) argue that structural changes in the economy and housing market have created more poor people and less low-income housing, making homelessness inevitable for some proportion of the population. According to this view, society abandoned the homeless.

A third view, and probably one that is most broadly accepted, is that "times had grown unforgiving" (Koegel et al., 1996, p. 30). Given the complexities in the overall structural context, people with personal limitations have a difficult time competing for the limited affordable housing and better-paying jobs available. This is especially true for people suffering from chronic disabilities, such as mental illness and HIV/AIDS, and those experiencing problems of substance abuse. Moreover, these risk factors are often bundled together, leading to a further marginalization of this segment of the poverty population (Koegel et al., 1996; Wright et al., 1998).

Efforts to reconnect homeless people with society have been influenced in varying degrees by these different perspectives. Most efforts to date have targeted individuals' needs and limitations, attempting to strengthen their chances of competing successfully in today's job and housing markets. A few efforts have focused on improving more systemic issues, such as increasing the affordability of housing or developing more employment opportunities. More recent approaches, however, have done a little of

both, tackling individual issues while also intervening in the broader system. HUD's concept of the Continuum of Care, for example, suggests that restructuring housing and service systems is needed to meet the needs of homeless persons, especially those suffering from disabilities.

This paper reviews what we know about reconnecting homeless people to housing, jobs, and family and friends. For the first two areas-housing and employment-we review the major programs and efforts that have been tested, followed by a summary of the lessons learned from studies of these efforts, and concluding with a discussion of the barriers and continuing challenges in each area. In the third area—reintegrating homeless people back into families and support systems-little intervention has taken place. Therefore, in this section, we review what is known about the nature of homeless individuals' connections with families, friends, and the community, and what implications this knowledge has for action. ,

Fostering Residential Stability

Introduction

Much has been learned in recent years about how to reconnect homeless persons with housing. In particular, as another paper in this series describes, outreach and engagement efforts are sometimes critical in beginning the reconnection process, especially for individuals who have been homeless for long periods of time and are experiencing severe mental illness and/or chronic substance abuse (e.g., Barrow, Hellman, Lovell, Plapinger, & Struening, 1991). Developing trust through the provision of food and clothing, over long periods of time, often is key to sparking a person's transition from homelessness to housing.

Getting people off the streets and out of shelters, and keeping them in the community requires that various housing options be available to meet their different shelter and support needs. Housing combined with services characterizes many of the interventions that have been developed and tested to improve residential stability, particularly for individuals with specific needs, such as mental health problems or substance abuse issues (Fosburg, Locke, Peck, & Ankel, 1997; Emerson & Twersky, 1996; Federal Task Force on Homelessness and Severe Mental Illness, 1992; Rog, Holupka, & Brito, 1996; U. S. Department of Housing and Urban Development, 1995). The term "supportive housing" is used to broadly define housing designed to help individuals reduce their need for more restrictive services and remain residentially stable, and in turn improve their quality of life and functioning (Newman, 1992).

Supportive housing, also called services-enriched housing (e.g., Friedmutter, 1989) and special needs housing (e.g., Community Information Exchange, 1995), refers to a wide range of housing interventions. For example, supportive housing can be transitional or permanent. Transitional housing is typically congregate housing with considerable services and supports provided on-site where a person can live a predetermined period of time. Permanent supportive housing has no set time limits, and typically includes access to services available in the community. Permanent housing options include single room occupancy (SRO) hotels, multi- and single-family rental housing, scattered-site apartments, and even homeownership. Community differences in the housing stock, together with what funding may be available, often result in differences in the types of supportive housing that are developed. SROs, for example are common in New York City, and can range in size from 30 units to over 500 units.

In supportive housing, housing is combined with access to services and supports to address the needs of homeless individuals so that they may live independently in the community rather than on the street or in

institutional settings such as mental institutions, jails, and hospitals. Supportive housing is generally considered an option for individuals or families who have either lived on the streets or shelters for long periods of time and/or who have needs that may best be served by services that can be accessed through their housing. It is important to note, however, that not all homeless individuals require supportive housing to regain stability. Many, especially those who have experienced short-term homelessness due to a fire, loss of job, or temporary separation from family, may only need assistance in finding housing that is affordable, rather than ongoing services.

There is great variation in what is meant by services within supportive housing. Services may be provided on site or offsite, and may be available for restricted hours or on a 24-hour basis. Supports can be limited to basic security and case management services, or can include a host of health, mental health, and daily living supports. In some instances, the housing case manager facilitates the linkages with the mainstream service system. In other instances, especially when the needs of the residents are specialized and/or the system has gaps in certain service areas, some services may be provided directly on site.

The types and intensity of services and supports are generally influenced by many factors, such as the amount of funds available, staff-to-resident ratios, needs of the population being served (some buildings are targeted to individuals with a specific set of needs-such as individuals with severe and persistent mental illness or individuals with HIV/AIDS; others are open to a broad population of individuals with varying levels of service need), and so forth.

Transitional housing is designed as temporary housing (ranging from 3 months to 24 months or longer) typically with a high intensity of services. It is predicated on the notion that when homeless individuals initially transition into housing, they need a more structured setting with a range of services readily available, including employment readiness and education, mental health, substance abuse, health, and others. However, as the individual or family stabilizes, the concept is that the services will be needed less and the individual will be ready to move into more independent, permanent housing.

Transitional housing is considered a big component of the continuum of housing options (e.g., U. S. Department of Housing and Urban Development, 1994), but it is not a necessary step for all homeless people. Several studies (e.g., Center for Mental Health Services, 1994; Rog & Gutman, 1997) have indicated that some homeless people can move directly from the streets and shelters to various types of permanent housing, including SROs and multi/single family rental housing, and remain stable for considerable periods of time. There may be instances, however, especially with individuals who have been homeless for long periods of time, when transitional and interim housing may be needed as a preliminary step (Fosburg et al., 1997; Barrow & Soto, 1996). In some instances, the housing may be needed as a critical bridge for people who are ready to leave homelessness but do not yet have access to permanent housing.

Interventions

There have been several major supportive housing initiatives over the last ten years or more. Some have been engineered primarily for funding new approaches, others mainly for knowledge-generation purposes, and others with some mix of purposes. A summary is provided below of each of the major initiatives that have been or are currently in operation with the purpose of improving the residential stability of homeless individuals and families.

The largest efforts have been sparked by the support of the federal government through the Stewart B. McKinney Homeless Assistance Act and led by the U.S. Department of Housing and Urban Development

(HUD). HUD has promoted the Continuum of Care approach as a way to shape a comprehensive and coordinated system of housing and services (Center for Mental Health Services, 1997). Since 1994, HUD has included the concept of the continuum of care in its homeless programs. The approach is intended to help communities plan and implement systems of emergency, transitional, and permanent housing resources to assist homeless individuals in moving from homelessness and reconnecting with the community. The components of the system include outreach and assessment, immediate shelter, transitional housing with supportive services, and permanent housing.

In addition to the Emergency Shelter Grant program, HUD's Continuum of Care has three key housing programs: Supportive Housing Program (SHP), Shelter Plus Care (S+C), and Section 8 Moderate Rehabilitation Assistance Single Room Occupancy (SROs). Two of these programs (SHP and S+C) have completed evaluations that offer guidance in implementation as well as preliminary information on outcomes. All three programs provide funding for housing operating expenses, but only SHP provides funding for services. However, the projects funded under these programs encourage and provide access to supportive services (U. S. Department of Housing and Urban Development, 1995).

SHP was created to develop innovative approaches to combining housing and services for individuals and families who are homeless, especially those with special needs (Westat, 1995). The program has four basic components: transitional housing for up to 24 months, permanent housing with support services for homeless permanently disabled persons, supportive services without housing for homeless individuals, and supportive housing that is, or is part of, an innovative project to meet the needs of homeless persons and families (U.S. General Accounting Office, 1994).

Shelter Plus Care (S+C), like the permanent housing component of SHP, provides rental assistance for hard to serve homeless persons with disabilities. Supportive services are funded by outside sources. S+C rental assistance can be tenant-based, sponsor-based, project-based, or SRO-based.

With Section 8 moderate rehabilitation SRO, ten-year rental assistance is provided for homeless persons (not necessarily disabled) to live in moderately rehabilitated SROs. The SRO program covers the full operating expenses of the SRO housing-rehabilitation costs must be secured from other sources but the debt service for rehab financing can be covered.

Housing Opportunities for Persons with AIDS (HOPWA), also administered by HUD but not funded through the McKinney Act, provides funding for housing and services for low-income persons, including homeless individuals, living with HIV/AIDS and their families. HOPWA funds can be used for a wide range of housing, services, and planning and development costs.

Foundations and other entities also have been instrumental in fostering the development of efforts to curb homelessness and to study their outcomes. The Robert Wood Johnson Foundation (RWJF), in particular, has joined forces with HUD on two occasions to demonstrate the relationship between housing and services. Both programs-the Program for the Chronically Mentally 111 (Goldman, Morrissey, & Ridgely, 1994) and the Homeless Families Program (Rog & Gutman, 1997)—examined the implementation and outcomes of Section 8 certificates combined with services for two vulnerable populations-individuals with severe mental illness and families with multiple problems, including long-term instability, domestic violence, alcohol and drug issues, and others.

The growth of supportive housing also has been fostered by other national players, most notably the Corporation for Supportive Housing (CSH), a national nonprofit intermediary established in 1991 with funding from The Pew Charitable Trusts, The Robert Wood Johnson Foundation, and the Ford

Foundation to expand the quantity and quality of supportive housing for special needs populations who are homeless or at risk of becoming homeless. CSH has supported the growth and development of supportive housing across the country, concentrating much of its efforts in ten metropolitan or state regions. CSH has been active in developing both housing and supports, including an employment initiative, Next Step: Jobs.

Research and Evaluation

Of the three major areas addressed in this paper, the area involving efforts to reconnect individuals and families to housing and to keep them stably housed has received the most study. Yet, even in this area, the research has been somewhat limited (Newman, 1992; Rog et al., 1996).

The most rigorously studied interventions include those tested for individuals with severe mental illnesses and individuals with substance abuse problems through the efforts of the federal government (see Table 1). In 1990, the National Institute of Mental Health awarded $16.8 million with funds from the Stewart B. McKinney Homeless Assistance Act to fund five experimentally-designed studies of housing and services (including outreach and case management) for people with severe and persistent mental illness (U. S. Department of Health and Human Services, 1994). Although a range of housing alternatives was tested, most of the housing studied falls under the definition of "supported housing"—independent, permanent housing in the community provided with access to needed services. The Center for Mental Health Services is currently extending this area of research by funding a set of individual studies and a cross-site study examining the effectiveness of supported housing for persons with mental illness in relation to other types of housing models in improving residential stability, independence, quality of life, empowerment, and satisfaction (Center for Mental Health Services, 1997).

Table 1
Major Research Studies and Evaluations on Supportive Housing

Completed

- NIMH "Making a Difference" Studies
- HUD Supportive Housing
- HUD Shelter Plus Care
- RWJ/HUD Program for the Chronically Mentally Ill
- RWJ/HUD Homeless Families Program

In Progress

- CMHS Housing Initiative for Persons with Serious Mental Illness
- Minnesota Supportive Housing Demonstration Program

Also in 1990, the National Institute of Alcohol Abuse and Alcoholism (NIAAA) funded fourteen research demonstrations of interventions for homeless individuals with alcohol and/or other drug problems. All interventions were evaluated according to several primary objectives, including whether

or not they increased the residential stability of the participants. Only a subset of these interventions, however, explicitly included housing programs.

As noted, two of the HUD interventions and others supported by The Robert Wood Johnson Foundation have been accompanied by large-scale evaluations that have provided information on the implementation and outcomes of these initiatives. CSH also has recently published the first year evaluation of the Minnesota Supportive Housing Demonstration Program, a program created by the Minnesota Legislature in 1996 to develop more cost-effective long-term housing solutions for persons with mental illnesses, chemical dependency, and/or HIV/AIDS (Wilder Research Center, 1998).

All of these studies, however, have been descriptive and thus provide only tentative findings on issues of outcome and impact. However, combining the findings across these various evaluations and more rigorous research studies, especially to the extent that they converge, increases their potency and provides clearer direction for policy makers and practitioners.

What Have We Learned About Reconnecting Homeless People to Housing?

Overall, the evidence from this growing body of research and practice indicates that the residential stability of homeless individuals and families can be fostered, largely through providing some combination of housing (or access to housing) and services and supports. Residential stability has been defined and measured in a variety of ways. Most studies have measured stability as accessing community-based housing and living stably (i.e., without moving residences) in that housing for some period of time (generally measured at 12 to 18 months after initially entering the housing).

Reconnecting with housing is often the first step in reconnecting individuals with the community. In fact, as noted below, getting stably housed is increasingly being recognized as a **prerequisite** to other steps in reconnecting with the community-that is, getting back into the job market, getting hooked up with needed services, and reestablishing or initially establishing ties with family and other sources of support. Therefore, identifying interventions that are effective in fostering residential stability is critical to understanding how community reintegration can begin. However, as noted later in this section, despite knowledge of what works, there continue to be significant barriers-structurally as well as those more personally faced by subgroups of homeless individuals-that challenge the ability of these interventions to have widespread effectiveness.

A number of lessons can be drawn from this existing body of knowledge. The specific lessons that have emerged to date, outlined in Table 2, are summarized below.

Table 2
What Have We Learned About Reconnecting Homeless People to Housing?

- Once in housing-generally with supports-the majority stay housed
- Rental subsidies improve residential stability
- Providing housing is often not enough, other assistance can help
- Provide housing first, before tackling other issues
- A range of options may be needed to meet range of needs and preferences

Once in supportive housing, the majority of homeless people-regardless of their disabilities and other needs-stay in housing. Almost without exception, studies have found increased residential stability for people who enter housing. The majority of individuals entering some form of housing-generally those with supports-have remained in stable housing for at least one year. Families as well as those who are mentally ill tend to have the highest stability rates; those with substance abuse problems tend to have among the lowest rates.

In the evaluation of the HUD Supportive Housing Demonstration Program, 56% of the residents in transitional housing entered stable housing (including unsubsidized, subsidized, and privately owned housing) after leaving the program; of those who were considered "graduates" of the program, approximately 70% entered stable housing. Families appeared to have the most success in securing permanent housing of the subgroups studied. Similarly, more than two thirds (69%) of those who received permanent housing remained stably housed for at least a year (U. S. Department of Housing and Urban Development, 1995; Westat, 1995). Moreover, of those who left, nearly half (48%) moved into other stable housing situations.

Similar results to the SHP evaluation were found with evaluations of housing for special needs populations. The recent evaluation of Shelter Plus Care (1997) found that in the reporting grantee sites over half of the residents were housed 6 months or more in both operating years (51% in year 1, 59% in year 2). In the first 12 months of operation of the Minnesota Supportive Housing Demonstration Program, more than two thirds of the 168 individuals who entered the demonstration (most of whom had severe mental illness and/or dual diagnosis) were still in the program at the end of the first 12 months. Housing providers report that roughly 10-20% of the tenants who leave the program do so for positive reasons (e.g., voluntary relocation, receiving a Section 8 certificate, etc.).

In the McKinney supported projects for individuals with severe mental illness sponsored by CMHS (Shern et al., 1997), 78% of the participants in the experimental conditions (all involving some form of independent living coupled with case management and other services) were stably housed in the community at 12-18 months following receipt of housing and services. Similarly, over 85% of the families who received Section 8 housing and services in nine cities were still in permanent housing at an 18 month follow-up (Rog & Gutman, 1997).

In a study of four subtypes of homeless veterans-those with alcohol problems, those with psychiatric impairment, those with multiple problems and those who were considered the "best functioning"-Humphreys and Rosenheck (1998) found a significant increase in residential stability for all groups studied, with those being psychiatrically impaired showing the least improvement.

Access to and receipt of rental subsidies improves residential stability. The affordability (or lack thereof) of housing challenges poor people's abilities to maintain decent housing. Individuals and families with limited incomes have few housing choices. Those who cannot or do not want to live with family and friends are faced with increasing difficulties finding affordable housing in ever tightening housing markets. In turn, high housing costs are one of the most common contributing factors to the loss of housing (Wood, Valdez, Hayashi, & Shen, 1990).

Rental subsidies, such as Section 8 certificates, provide payment for housing that is generally based on some proportion of an individual's income. A Section 8 certificate, for example, allows an individual or family to go into the private housing market and rent an apartment or house from a landlord who agrees to participate. The household pays approximately 30% of its income toward rent, and the federal government subsidizes the remainder.

A number of studies have shown that receipt of rental subsidies improves the housing outcomes of homeless persons (Rog & Gutman, 1997; Shinn et al., 1998; Zlotnick, Robertson, & Lahiff, in press). In a 15 month prospective study of a county-wide probability sample of homeless adults, for example, Zlotnick and colleagues found that economic resources-specifically consistent receipt of entitlement benefits and government subsidized housing-were key variables associated with stable housing (Zlotnick, et al., in press).

As noted earlier, Rog and colleagues found that, in each of the nine cities involved in the Homeless Families Program, over 85% of the participating families successfully maintained housing with Section 8 certificates for at least 18 months. Although all families also received some amount of case management and access to other services, the level of service provision varied greatly across and within each of the nine sites and did not appear to differentially affect housing stability.

Shinn and colleagues also studied the stability of families in New York City who had been homeless and found that at least three years from shelter entry stability was predicted only by receipt of subsidized housing (with an odds ratio of 20.6). Eighty percent of the homeless families who received subsidized housing were stable (in their own apartment without a move for at least 12 months) compared to only 18% of those who did not receive subsidized housing. Families generally did not receive services. The authors conclude that for their cohort, subsidized housing was very clearly both necessary and sufficient for families to be residentially stable (Shinn et al., 1998).

For individuals with mental illness, subsidies are instrumental in getting individuals into independent housing in the community as compared to other treatment-oriented housing options (Hurlburt, Wood, & Hough, 1996; Newman, Reschovsky, Kaneda, & Hendrick, 1994). In The Robert Wood Johnson Foundation Program for the Chronically Mentally Ill (CMI), for example, Newman and colleagues found Section 8 certificates to have positive effects on the housing outcomes for persons with severe mental illness, about a third of whom were previously homeless or living in institutional settings.

Part of the success of subsidies is that they not only allow homeless people to live affordably, but that they also allow them to live in safer, more decent housing. In the CMI evaluation, 'Newman and her associates found that the Section 8 certificates were associated with improved housing affordability and improved physical dwelling conditions. The quality of the physical housing, in turn, is related to other outcomes, especially residential stability (Newman et al., 1994).

The dilemma, as noted below, is that the availability of Section 8 and other subsidies is woefully inadequate to meet the need that exists. A recent report by HUD (1997) indicates that in 1995, the number of very-low income renters (those with incomes below 50 percent of the area median income) with worst case housing needs was at an all-time high of 5.3 million people. These are very low income renters who lack housing assistance and who pay more than half of their income for rent or live in severely substandard housing. Moreover, those households with the lowest incomes (i.e., below 30 percent of the area median income) are most likely to have worst case housing needs (U. S. Department of Housing and Urban Development, 1997). At the same time that need for housing assistance is high, both tenant-based rental assistance and programs to create and rehabilitate affordable housing have declined. HUD (1997) indicates that the stock of rental housing affordable to very low-income families dropped by 9% between 1993 and 1995 (with a 16% drop in the units affordable for extremely low-income renters).

Moreover, no federal funding for new rental assistance or for new incremental rental assistance had been authorized until 1998, when HUD requested 50,000 new Section 8 certificates for families moving from welfare-to-work (U. S. Department of Housing and Urban Development, 1997). An additional 100,000 new Section 8 certificates have also been requested for the FY 2000 budget including 25,000 certificates for Welfare-to-Work participants, 18,000 for homeless persons, and 15,000 for elderly residents (U.S. Department of Housing and Urban Development, 1999).

Provision of housing is often not enough to fully reconnect people into society. Housing is an essential part of the remedy for homelessness, but may not always be sufficient to meet the full spectrum of needs homeless persons have (Buckner, Bassuk, & Zima, 1993). In the five CMHS research projects examining housing and supports for individuals with mental illness, individuals in the comparison groups as well as the experimental groups improved their stability over time, but the greater improvement was for those who received more intensive services than for those who received services as usual (Shern et al., 1997). In the Baltimore study, for example, those who received access to housing and more intensive services spent significantly more time living in the community than those receiving access to housing and regular community services. Similarly, in the New York Critical Time Intervention Program, individuals who received housing and intensive case management spent significantly less time on the streets than those who were only assigned housing and told about possible community services.

Case management, in particular, is highlighted as a key service in housing (Rog et al., 1996; Westat unpublished; Westat, 1995). SHP found that 95% of grantees used case management and that providers believed was key to helping with personal stability (U. S. Department of Housing and Urban Development, 1995; Westat, 1995). Several studies also have shown that case management improves housing stability, particularly for those with serious mental illnesses and dual diagnoses (Morse, 1998) . A variety of models of case management have been used, but most provide some brokering of services inside and outside housing and assistance in daily living, such as money management, assistance in accessing transportation, problem solving, and other areas of assistance that help a person live independently (see Morse, 1998 for a review of models and approaches).

Other housing-related assistance, during the outreach process, the housing search process, and while housed can help homeless persons find and maintain housing in the community. In addition to receiving general case management and subsidies, there are specific areas of assistance that can help a person connect and stay connected to housing. When a homeless person with special needs receives a subsidy such as a Section 8 certificate, for example, it is helpful to have a housing specialist who is sensitive to the individual's situation and limitations. This person can provide individualized attention in processing the application, helping to ensure that the homeless individual follows through with what can be an intimidating and lengthy process (e.g. Dixon, Krauss, Myers, & Lehman, 1994) and serving as a bridge to others in the housing agency. Housing specialists have been reportedly helpful in facilitating the Section 8 process for individuals with severe mental illness (Hurlburt et al., 1997) and families with multiple problems (Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, & Holupka, 1994).

Hiring formerly homeless people as volunteers or paid staff in housing programs also appears to be helpful (Center for Mental Health Services, 1994; Rog et al., 1998). In the CMHS research demonstration efforts studying housing and supports for individuals with severe mental illness, four of the projects used formerly homeless persons with mental illnesses as volunteers or paid staff, as outreach workers, case aides, or respite program staff. In these positions, the individuals were reportedly helpful in locating and engaging clients, serving as role models, and educating other staff members. The researchers noted the positive results and recommended that the programs explore ways to use their

services. Similar success was reported in hiring supportive housing tenants in staff roles in the housing and related employment efforts as part of CSH's Next *Step: Jobs* initiative (Rog et al., 1998).

Assistance in the housing search process, provided either by case managers or specific housing locators, also can be valuable especially when individuals are searching for market housing (Rog et al., 1994). Housing locators can serve as an advocate to landlords, helping to vouch for the individual's or family's ability to pay the rent and that they are linked with supports in the community. In addition, landlords have been found to be more willing to rent to individuals they otherwise may have found too risky but who now have case management support (e.g., Fosburg et al., 1997; Rog, et al., 1994). They view the case manager as back-up support and a person to call upon when crises arise. Finally, transportation to housing prospects as well as day-care, if applicable, can be an invaluable service to allow a person access to a greater range of housing.

Assistance during the transition process also can be critical. Help in obtaining and moving furniture, for example, is often needed at the time of move-in. More emotional support is often needed in the few months after leaving the shelter or streets, a time often reported to be stressful for any tenant but particularly for those who have not lived on their own for some time.

Getting housing first, before tackling other issues, is important to reconnection. Growing research shows that meeting basic needs first is critical to tackling any of the other issues a person or family may have. Wright and colleagues (1998) assert that treatment for alcohol, drug, and mental health issues is rarely effective because it does not address the more fundamental issues of poverty, housing, welfare, and employment. In turn, treatment may be most effective when combined with housing.

Sosin and colleagues have found housing to be a major incentive for remaining in substance abuse treatment for homeless persons with substance abuse problems (Sosin, Bruni, & Reidy, 1995). In a randomized study of substance abuse treatment, clients who received supportive housing and case management were more likely to remain in treatment for at least three months than those who received case management only (78% vs. 42%). In addition, it is also likely that without housing, clients cannot fully focus on recovery when they have concerns about their basic needs. The challenge, however, is to design interventions that can retain homeless individuals long enough to make the treatment work (Wright et al., 1998), which can take over a period of 4 years to achieve high rates of abstinence (Drake, McHugo, & Noordsy, 1993). Some (Burnam et al., 1995) believe that low demand settings have the best prospects of facilitating and maintaining treatment involvement, especially in the first phase of engagement.

Housing may be best tailored to people's needs and preferences; a range of options continues to be warranted. Much of the study of housing for individuals for severe mental illness has focused on their preferences for housing (Rog et al., 1996). Mental health consumers most often prefer to have a choice in their housing and their preference is for independent living. Goldfinger and Schutt (1996) have found, however, that the desire for independent living does not necessarily mean that the individuals do not want staff support; rather, the desire is more commonly related to the desire to live alone and not with others. To date, published findings on the relationship between outcomes and housing preferences indicate that housing choice is related to residential stability (e.g., Srebnik, Livingston, Gordon, & King, 1995.)

Independent, permanent housing in the community is not an immediately viable option for all persons, however, nor is it always one's choice (Hurlburt et al., 1997). Some individuals with severe mental illness, for example, prefer community living. Others, especially individuals who have been living on the streets for extended periods of time, may need to transition into more permanent housing options. The

S+C evaluation found, for example, that both housing and services need to be tailored to the needs and capacity of each household; that is, the appropriate place in the continuum for an individual is determined by the level of independence an individual can live with what level of supervision and services to ensure stability (Fosburg et al., 1997).

One interesting model that has been examined in New York City is interim housing (Barrow & Soto, 1996). This model of housing has been shown to be successfully implemented to meet the needs of groups within the street population in New York City who do not have access to existing housing resources. Interim housing consists of shared apartments and single or double rooms in SRO buildings and YMCAs that provide more privacy, protection, and stability than living in the streets or shelters as well as a means of engaging persons into services and housing. A three month follow-up of residents found that most (62%) went on to some form of long-term transitional or permanent housing at exit and were still there at the follow-up; only one third of a matched control sample who received similar drop in services, but were not provided with case management, was housed in the same time frame.

Barriers to Reconnecting to Housing

Despite the evidence showing increased residential stability for homeless people who enter housing, a number of barriers exist to insuring that all homeless people have access to adequate shelter. These barriers, outlined in Table 3, are described below.

Table 3
Barriers to Housing

- Lack of affordable housing and limited supply of subsidies (e.g., vouchers)
- Community opposition
- Substance abuse

The lack of affordable housing and limited supply of Section 8 subsidies threatens the promise that supportive housing offers. Dolbeare (1996), as well as others (e.g., Wright et al., 1998) makes a convincing argument that unless we grapple with the gaps between housing costs and income, there is no way to effectively eliminate homelessness. The lack of affordable housing and the limited supply of subsidies to compensate for the high rental costs especially for those with the lowest of incomes (U. S. Department of Housing and Urban Development, 1997) makes expansions in supportive housing difficult. Increases in McKinney allocations for these programs over the last decade have helped, but much goes to continue existing housing rather than create new housing. Thus, they are recognized as far from meeting the need that exists.

Various policy changes in public housing promises to further exacerbate the limited housing situation. These policy changes, such as zero tolerance for drug users, allowing local housing authorities to develop their own preferences, and the desire/need to create more "mixed-income" public housing are all likely to reduce the number of units available to poor families with the greatest housing need (Daskal, 1998).

Community opposition to housing programs complicates the housing development process and often stalls efforts to increase the supply of housing needed. Even with funding, supportive housing providers continue to battle community opposition to siting housing, especially for homeless and special needs populations. Although this type of community conflict is not specific to supportive housing, NIMBY-ism

(Not in My Back Yard) and related opposition (e.g., NOOS-Not On Our Street) continue to challenge providers efforts to increase the stock of affordable housing. Efforts at community outreach before and throughout the development process are reportedly critical to trying to avert this type of opposition. Broader efforts at changing public perceptions of the homeless and special needs populations are also called for to deal with the more systemic problems of stigma and prejudice that block these efforts. Finally, more vigorous enforcement of federal Fair Housing laws may be indicated to forge ahead in developing and siting housing.

Substance abuse is a major barrier to gaining residential stability. Substance abuse problems challenge a person's ability to obtain and maintain stable housing. The studies sponsored by the NIAAA provide the most extensive examination of the effectiveness of supportive housing for individuals experiencing substance abuse problems and report limited success in fostering stability (e.g., Burnam et al., 1995; Wright et al., 1998). Other studies have also attested to. the interference of substance abuse in maintaining one's housing. The five CMHS projects all reported clinical observations that substance abuse is a major factor in housing instability. The view is that substance abuse, not mental illness, is the primary cause of housing loss (Center for Mental Health Services, 1994). In the Minnesota Supportive Housing program, the rate of exit was disproportionately high for those who were chemically dependent and not mentally ill (Wilder Research Center, 1998). Similarly, Caton and colleagues (1993), attributed the deterioration in housing successes over time for individuals with mental illness to the concurrent diagnosis of SA for many of the residents.

Reconnecting With the Job Market

Introduction

The vast majority of the homeless are unemployed and extremely poor. In a survey of Chicago homeless, for example, it was found that most respondents had not had any "steady" job for at least four or five years, and that 60% had not worked at any type of job in the last month (Rossi, 1989). A review of sixty homeless studies conducted in the 1980s and the early 1990s found an average unemployment rate of 81% and a median monthly income of only $103 (Shlay & Rossi, 1992). Similarly, less than one-quarter of tenants participating in the federal Shelter Plus Care program were working for pay or as volunteers when they were assessed for the program (U. S. Department of Housing and Urban Development, 1997). Among participants of a federal employment program for the homeless, only 10% had any type of job when they entered the program (U. S. Department of Labor, 1998).

Furthermore, homeless persons today are more isolated from the labor market than those who were considered homeless 30 or 40 years ago. Studies of the homeless in Chicago in the 1960s, for example, found that as many as 28% of the respondents were working full-time, compared to only 3% among current Chicago homeless (Wenzel, 1992).

Although most homeless people are not currently connected to the labor market, it would be a mistake to conclude that most of these people have never worked. In fact, just the opposite appears to be true. Among the more than 45,000 participants in the federal Job Training for the Homeless Demonstration Program, for example, 97% reported that they had held at job at some point in the past. A study of supportive housing tenants from selected buildings involved in CSH's *Next Step:* Jobs employment initiative in three cities found that over three-quarters had been employed at some point in the past, although less than one-third were working at the time they entered supported housing (Hopper et al.,

1997; Rog et al., 1998). Similarly, a study of supportive housing tenants in Minneapolis reported that 94% of the tenants examined had worked in the past (Wilder Research Center, 1998).

Although the vast majority of homeless persons have worked, the types of jobs they have typically held have not provided much income or security (Rossi, 1989). Most of the participants in the U.S. Department of Labor's Job Training for the Homeless Demonstration Program, for example, reported that their most recent job had been as service workers (32%), laborers (28%), or office/clerical workers (10%) (U. S. Department of Labor, 1998). Likewise, employment histories obtained from supportive housing tenants involved in the Corporation for Supportive Housing's employment initiative, *Next Step: Jobs,* (Hopper et al., 1997) and those in the Minnesota Supportive Housing Demonstration program (Wilder Research Center, 1998) showed that tenants generally held part-time, low paying jobs— generally less than $6 an hour-that did not provide health or other benefits. Data from the histories of mothers participating in the Homeless Families Program (Rog et al., 1995) paint the same picture.

Ethnographic studies have been able to provide even more details about the work patterns of homeless people. Wagner, in a study of homeless people in the early 1990s in a Northeastern city, found that, at any given time, approximately 20% of homeless people were working in the "formal economy", typically in such jobs as security guards, waiters or waitresses, cashiers, or housekeepers (Wagner, 1994). Even more people-one-quarter to one-third-were found to have casual jobs, or performed "casual work," such as collecting recyclable bottles and cans, day labor, working at carnivals and fairs, or giving blood. Similar employment histories and work patterns were noted by Snow and Anderson in their ethnographic work with homeless persons in Texas (Snow & Anderson, 1993).

Interventions

Despite the substantial employment problems faced by homeless people, few programs or projects have been developed or evaluated to address this need. Although there's a preponderance of evidence that homeless people face problems finding and keeping jobs, particularly jobs that pay enough to get people into housing, few programs have been developed that explicitly focus on improving the job prospects of homeless people (Johnson & Cnaan, 1995; Whiting, 1994). A substantial number of organizations involved in the federal Supportive Housing Demonstration Program, for instance, reported that the most frequently unmet need of participants in the transitional housing programs was employment-related services, particularly transitional employment or paid internships, job placement, or job training, largely because of difficulties identifying opportunities and programs in their communities (Westat, 1995).
One major exception has been the Job Training for the Homeless Demonstration Program (JTHDP), sponsored and evaluated by the U.S. Department of Labor. This program, begun in 1988 as part of the McKinney Act, was the first comprehensive federal program designed to provide employment and training services for homeless individuals (U. S. Department of Labor, 1998). It began by funding 32 projects across the country, and eventually supported 63 programs, with over 45,000 participants.

Another major, recent employment program is *Next Step: Jobs,* a multi-dimensional, multi-disciplinary initiative begun by the Corporation for Supportive Housing in 1995 with a three-year grant from the Rockefeller Foundation. This program is intended to increase the rate of employment among residents of supportive housing, often formerly homeless and chronically unemployed or under-employed. *Next Step: Jobs* provided grants to 22 organizations in New York City, Chicago, and the San Francisco Bay Area to develop employment programs for supportive housing tenants. Over 3,200 tenants, living in more than 40 supportive housing buildings, were directly targeted by the initiative (with additional tenants in other housing often involved indirectly). A three-year evaluation was designed to provide a

descriptive analysis of Next *Step:* Jobs, concentrating most of the data collection in nine across the three sites.

The *Next Step: Jobs* initiative supported a flexible set of strategies that organizations could tailor to their own resources, circumstances, and tenants' needs. The result was an initiative with three main components:

- Housing based strategies, including: providing pre-vocational and ongoing support activities; hiring tenants in-house; improving linkages to existing training and job programs; and identifying and developing competitive job placements;
- Job creation strategies that supply seed capital and technical assistance for new businesses and special initiatives that create new job opportunities for tenants, such as developing and operating a thrift store, or developing a food services/catering operation;
- System innovation efforts, such as identifying and developing funding streams and mechanisms to integrate employment programs with supportive housing or addressing entitlement regulations that discourage tenants from entering the work force (Hopper et al., 1997; Rog et al., 1999).

What Have We Learned About Reconnecting Homeless People to Employment?

Although less research has been conducted on employment programs than on housing efforts, the work that has been done provides some lessons about efforts to reconnect homeless people to the labor market. These lessons, summarized in Table 4, include:

Table 4
What Have We Learned About Reconnecting Homeless People to the Job Market?

- Need a comprehensive approach, involving housing and services.
- Mixed results on job training and development efforts thus far.
- Job development is inexpensive and useful, but labor intensive.
- Rapid placement and ongoing support may be key.
- Affirmative businesses and in-house jobs offer market alternatives.
- Job turnover is common.
- Even after obtaining jobs, many people remain economically vulnerable.

There is a need for a comprehensive approach towards employment, particularly involving the provision of housing and services prior to or together with any employment effort. Programs designed to employ people who are homeless, or were recently homeless, have used a variety of approaches, including job training, "transitional work programs," and entrepreneurial efforts to create "affirmative enterprises" (Whiting, 1994). A consistent finding from all of these types of efforts is the need to coordinate and combine employment services with other types of services and supports, particularly housing. As aptly summarized by Emerson and Twersky, it is now recognized that efforts to move the homeless into the mainstream must rest on "the three legs of a stool: housing, services, and jobs" (Emerson & Twersky, 1996; Whiting, 1994).

A central finding from the evaluations of the JTHDP programs, for example, is the need to provide a comprehensive set of services in order to break the cycle of homelessness (U. S. Department of Labor, 1998). Core services that need to be available include: case management; assessment and employability development planning; alcohol and other substance abuse assessment and counseling; other support services (e.g., child care, transportation, mental health assessment/counseling, health services); job training services; job development and placement services; post-placement follow-up and support; and housing services. Furthermore, the JTHDP experience suggests that many of these services need to be provided before people are enrolled or participate in employment and training efforts. JTHDP participants were more likely to complete the program if, during the assessment stage, housing and support service needs were identified and addressed. For example, retention rates at 13 weeks were highest for those participants who received housing placements and obtained a job (80%). High retention rates were also reported for those people who received security deposit/rental assistance (76%) and people who received assistance with furnishings/moving (75%).

Similarly, the design of CSH's *Next Step: Jobs* was based on the premise that employment programs in supportive housing need to provide more than training (and housing) to be successful. Projects also must offer a flexible array of services to meet tenants' needs, and to respond appropriately as those needs change. Ethnographic observations and interviews conducted with a number of tenants indicated that those tenants who were able to access a variety of services-such as substance abuse or mental health counseling as well as various employment services-and who had credible "standing offers" of work opportunities, were often the ones who realized the most employment changes (Rog et al., 1998).

Job training and development efforts ***have shown mixed results.*** Since the beginning of the War on Poverty in the 1960s, the United States has implemented a variety of programs to address the problems of unemployment and poverty. These programs have generally included a mix of job search assistance, short-term classroom training, long-term classroom training, and subsidized employment. Unfortunately, most of the job training and development efforts have not had much impact on people who are homeless, in large part because traditional training programs, such as JTPA, have not been accessible to, or focused on the needs of, homeless people Fosburg et al., 1997; Emerson & Twersky, 1996).

In a survey of 55 JTPA programs, for example, over half of the agencies indicated that they had made only modest efforts to recruit homeless persons, and two-thirds said that they did not offer services aimed at addressing the multiple needs of homeless people (reported in Institute for Children and Poverty, 1994). Barriers that homeless people have faced working with traditional employment programs include lack of flexibility, lengthy periods to determine eligibility, and unrealistic limits on funding and duration of services.

Although it is unfortunate that homeless people have not had access to traditional training programs, studies have generally found that most of these programs only have a modest impact, at best, on their participants. A recent assessment of over thirty years of job training programs came to the conclusion that "the results are very discouraging: thirty years of experimentation with job training programs have created a substantial number of programs whose benefits-for individuals in dire need of employment and economic independence -are quite trivial, and are completely inadequate to the task of moving them out of poverty, off of welfare, or into stable employment over the long run" (Grubb, 1995).

Speculating why such poor results have been obtained, Grubb identified a number of possible factors, including: programs that are too small and brief; too much emphasis on short-term results; the poor quality of many programs; lack of follow-up and long-term support; poor matching of people into jobs;

and possible lack of appropriate jobs in the labor market. Grubb's recommendation is to create more comprehensive and coordinated employment-related services. The goal would be to create an education and training "ladder" that people could access at any level, with "vertical" linkages so people could move into a succession of more demanding, better paying jobs, instead of being limited to jobs that are often boring, low-paying, and offer few prospects for advancement.

More recent training and development programs, designed specifically for homeless people, appear to have already taken some of this advice, and have created more comprehensive programs, with mixed results thus far. The JTHDP project, for example, brought together a number of employment and support services, including housing, mental health counseling, and substance abuse treatment, in order to address the multitude of needs faced by participants. In JTHDP, over one-third of the participants were able to obtain a job, and half of those people were still employed 13 weeks after placement. The evaluators concluded that, with the appropriate blend of supports, "a substantial proportion of homeless individuals can secure and retain jobs, and improve their housing condition" (U. S. Department of Labor, 1998).

Another comprehensive program was the Demonstration Employment Project-Training and Housing (DEPTH), also funded by the U. S Department of Labor and combining services concerned with job training and placement with services to locate permanent housing and support services (Toro, Passero Rabideau, Bellavia, et al., 1997). At the core was intensive case management. An evaluation of its outcomes over an 18-month follow-up period did not reveal any changes in job income or other income over time. The absence of results on employment-related outcomes could be in part due to the immaturity of the program and the amount of cases lost to attrition.

In the Heart Project, an employment program for homeless individuals in Oregon, however, 87% of the participants finished the program, and 81% of those who graduated were able to obtain a job (Goetz & Schmiege, 1996). Part of the success of the program was attributed to providing an array of services to participants, including intensive case management, substance abuse and mental health counseling, and stable housing. Furthermore, the program worked closely with local industry to develop job skills needed by local businesses, in this case, construction work. Similarly, in a pilot employment program operated by Homes for the Homeless that integrated intensive forms of skills training and education with a strong network of support services, 75% of the initial participants finished the program, and 60% of those who graduated were able to obtain work (Institute for Children and Poverty, 1994).

The Next *Step: Jobs* employment initiative was designed to provide comprehensive services by weaving employment activities into supportive housing (Rog et al., 1998; 1999). Because the initiative was designed to change the culture of opportunity within supportive housing, the evaluation examined changes in the rate of employment for *all* tenants (not just those receiving some level of direct employment service or intervention) in each of the buildings selected for the evaluation. Using two different measures of employment change, the evaluation found that the rate of employment increased significantly over time in a few buildings, but in most buildings there were no significant changes in employment rates.

Job development is a labor intensive activity, requiring a great deal of time on job search assistance. For a nine-month period, for example, Gervey and Kowal tallied a total of 1255 job leads that were pursued in an employment program for people with mental illness, with 188 resulting in job interviews and 27 resulting in job offers (Gervey & Kowal, 1996). Cook and her associates (1990) also documented the labor intensity of the job developer role. Over 11 months, a part-time job developer made 305 phone calls, sent 45 letters, and made 16 presentations, all of which led to 4 jobs.

Though labor intensive, job search assistance has been noted as one of the least expensive and most successful employment strategies. As alluded to in the HEART Project, the most useful job search and development strategies have been those that involve contacts and links with employers. Even minimal prior contact with an employer can help to establish a relationship between job developers and employers that can have long-term benefits (Kirszner, Baron, & Donegan, 1992).

Supported employment programs have been successfully used in some programs. Although not widely used in employment programs designed for the general homeless population, transitional and supported employment represent the most widespread approaches used with individuals with mental illness, including those who have been formerly homeless. Transitional employment is most commonly found in psychosocial rehabilitation programs (Bond & Boyer, 1988), and has been implemented in a myriad of ways, ranging from sheltered non-paid work to placement in paid positions in integrated community settings. The most common feature across transitional employment approaches has been the limits placed on the amount of time a person can work at a given job (Bond, 1987).

Supported employment is based on a philosophy that individuals with disabilities can perform meaningful work in competitive settings if provided support (e.g., Block, 1992; Drake et al., 1994; Drake, McHugo, Becker, Anthony, & Clark, 1996). The key characteristic of supported employment is that it assists an individual in obtaining and maintaining a job in the regular work force. The support includes assistance in obtaining a job, in training, and in staying on the job (Wehman & Kregel, 1985). The role of job coach is a central feature of supported employment.

Rigorous research on supported employment has been limited but growing. A 1988 review of vocational rehabilitation (Bond & Boyer, 1988) found only three controlled evaluations of supported employment. Since this review, only a few additional studies have been conducted (Blankertz & Robinson, 1995; Bond et al., 1995; Drake et al., 1996). Two key themes emerge from this literature:

- Rapid placement in training and employment programs leads to greater and sustained employment. No evidence that prevocational skills training is required.
- Ongoing support, such as a job coach or other support services, is important in order to help people stay in jobs. What is not clear is the nature of the support needed.

These results are consistent with the findings of some broader, welfare-to-work initiatives. The success of programs which involve mandatory jobs searches for a broad number of people-best exemplified by the Project GAIN program in Riverside, California-indicates that long-term education and training may not be needed to get people employed, although there is some debate about the types of jobs people are able to get in these circumstances (Gueron & Pauly, 1991). The importance of providing long-term, flexible follow-up supports has also been a finding of Project Match, a welfare-to-work program operating in Chicago (Berg, Olson, & Conrad, 1991; Herr, Halpern, & Wagner, 1995).

Faced with problems placing people in "'regular" jobs, more programs are trying to develop their own affirmative businesses and in-house opportunities. In recent years, a number of nonprofit organizations have started to develop business ventures for both disabled and non-disabled populations. According to a recent report from the Roberts Foundation (Emerson & Twersky, 1996), which has supported a number of these ventures in the San Francisco Bay area, nonprofit organizations have started businesses for several reasons:

- Lack of mainstream employment and training programs available to homeless people;
- Difficulty participants experienced obtaining employment in the competitive work force;

- Interest of some organizations to become more self-supporting.

Likewise, the recent national evaluation of the Shelter Plus Care program noted that some programs are considering the development of alternatives to traditional employment, such as affirmative businesses, particularly for tenants with mental illnesses, in order to provide a work environment where they would not be held to the same expectations they would encounter in the regular labor market (Fosburg et al., 1997).

Based on their experience in fostering affirmative businesses, the Roberts Foundation concluded that nonprofit organizations are capable of operating business ventures, but it can be very difficult and challenging. In addition to the normal start-up problems faced by any new business, nonprofit business ventures face unique pressures and challenges. For example, the desire to create a business in order to provide on-the-job training can conflict with the need to maintain a stable, permanent workforce that can ensure quality and meet customer needs (Emerson & Twersky, 1996).

Little research currently exists on affirmative businesses (Emerson & Twersky, 1996). The research that has been conducted has focused mainly on affirmative businesses for people with mental illness. Studies indicate that while cooperatives or affirmative businesses might pay better than sheltered work settings, and come closer to the goal of competitive employment than sheltered work shops or enclaves, competitive work may pay higher wages and provide greater potential for social integration (Clark, 1995). However, affirmative businesses may offer more reasonable accommodations for individuals with mental illnesses than competitive workplaces and thus may be an alternative to private employment for some individuals.

Many of the organizations involved in CSH's employment initiative for supportive housing tenants, Next *Step: Jobs*, also have created internal labor markets in order to offer flexible jobs complementing other site-based employment and support services (Rog et al., 1998). Organizations have offered a variety of job opportunities, from informal, stipend work to transitional employment, to permanent employment within the agency, or within businesses created by the agency. These employment opportunities seem to be particularly useful for buildings serving individuals with severe mental illnesses. One of the unique features of these "in-house" jobs is the ability to make the work atmosphere more inviting, particularly for people who may not have had much success in the past working in mainstream jobs. Along with these opportunities, however, in-house employment also presents some unique challenges. Tenants sometimes have problems. distinguishing between their roles as an employee and as a tenant. This can create conflicts of interest at times, as tenants must balance their work responsibilities against their loyalties and roles as tenants. Tenants who work in-house can also find that they are treated differently by both other tenants and other staff.

Expect and plan for job turnover. One of the most consistent findings in the job development literature, for both the general population as well as with more focused groups, such as the homeless, is that job turnover is likely to be quite high. One study found that of those people who are able to leave welfare by obtaining a job, 60% later return to the welfare rolls (Edin, Harris, & Sandefur, 1997). A follow-up study of job holders in the Massachusetts Employment and Training Program found that 62% of those employed were no longer at their initial jobs 12 to 16 months later (reported in Berg et al., 1991). Reports from Enterprise Job, a program initiated by the Enterprise Foundation in 12 cities across the country, found that of those who found jobs, 31% lost their jobs in one month, and 77% lost their jobs within six months (Berg et al., 1991).

Some of the most detailed job retention studies among welfare recipients have been conducted by Project Match. In one study they found that 61% of those employed lost their first job within six months (Herr et al., 1995). In a second study of Project Match participants, it was found that 46% lost their job within 3 months, 60% in 6 months, and 73% in 12 months (Berg et al., 1991). Examining the reasons why people lost or left their jobs, the researchers found evidence of a social mismatch between the attitudes and behaviors of people living in isolated, urban ghettos and the requirements of many workplaces. In particular, while many entry-level jobs do not require high levels of technical skills, they often demand well-developed interpersonal skills, particularly for the service sector jobs most likely to be available in urban centers.

Employment programs focusing on homeless people have also found high rates of job loss. The JTHDP project found that many people did not stay too long in their initial job placement, with the evaluators speculating that participants may have been too anxious to start a job and thus did not obtain an appropriate match with their skills and interests (U. S. Department of Labor, 1998).

In the evaluation of *Next Step: Jobs, 50%* or more of the tenants in each building examined were employed at some point during the 15-21 month monitoring period although rates at any one point in time were often substantially lower, indicating a substantial degree of job turnover (Rog et al., 1998). Ethnographic observations and interviews conducted with a subset of tenants in three buildings found that some tenants participated in a number of jobs or training and employment programs, thus explaining some of the sporadic work patterns. Furthermore, it was noted that some tenants stopped work due to personal difficulties, such as substance abuse relapse or mental health problems.

Even when people are successful obtaining jobs they are likely to remain economically vulnerable. A corollary of expecting high job turnover rates is to also expect that improvements in employment rates and income levels will not occur quickly, if they occur at all. The evaluation of the Supportive Housing Demonstration program, for instance, found only minimal increases in employment rates among participants of its permanent housing programs, and no meaningful changes in income levels (Westat, 1995). Increases were noted in the employment rates for transitional housing program participants—from 18% to 38% working full or part-time-but only modest improvements were reported in personal income, and concern was expressed in the final evaluation that a majority of graduates remained vulnerable to experiencing homelessness again.

The Job Training for the Homeless Demonstration Program reported a gradual increase in average wages, but only from $5.04 to $6.62 an hour (U. S. Department of Labor, 1998). These hourly wages reflected the predominance of low skill jobs, such as service worker positions (35% of all job placements), laborer (27%), and office/clerical positions (10%). Furthermore, about the same percentage of participants placed in jobs had health insurance after they obtained work (34%) as they did at intake (31%), although the percentage of people with private health insurance did increase from 3% to 13%. Other employment efforts with homeless or formerly homeless people have also noted little, if any, increases in employment rates, and little change in the types of jobs obtained (Rog et al., 1998; Wilder Research Center, 1998).

All of these findings are consistent with the larger body of research on job training programs discussed earlier, which shows that success in obtaining employment, when it occurs, is rarely able to move a person out of poverty, even if the person is able to obtain continuous, full-time employment (Edin et al., 1997; Grubb, 1995; Hardin, 1996). As Hardin urges, this does not mean that employment and training programs should be abandoned. Instead, it means that these efforts need to be complemented by efforts to increase wage levels (such as raising the minimum wage), or expanding the scope of programs like the Earned Income Tax Credit (Hardin, 1996).

Barriers to Work

Homeless people face numerous personal, logistical, and economic obstacles to obtaining employment. As noted above, numerous studies have shown that homeless people have worked in the past, and that most are interested in finding a job. However, numerous obstacles exist that make it difficult for these people to find and/or keep jobs. In the JTHDP program, for instance, case managers and participants identified such problems as (U. S. Department of Labor, 1998):

- Lack of access to transportation (most widely cited issue);
- Lack of education or competitive work skills (cited by almost half of the participants);
- Family-related problems, including lack of day-care;
- Mental illness, physical disabilities, and/or learning disabilities.

The JTHDP program found that active substance abuse was also a major barrier for people completing training and obtaining jobs, although clients in recovery were often highly-motivated and successful (U. S. Department of Labor, 1998; Rog et al., 1998).

Those receiving or entitled to social and medical insurance, such as Social Security Disability Insurance or Supplemental Security Income, also face economic disincentives to work. Based on data collected on income and expenses from a sample of individuals with mental illnesses, it was found that most individuals would need to make at least $5 an hour *plus* health insurance to make it economically viable to give up social and medical insurance. For people working part-time, losses in Social Security, food stamps, and non-cash sources of income would amount to an implicit tax of more than 60% on earned income (Warner & Polak, 1995).

Other obstacles involve the social stigmas and stereotypes associated with homelessness and the disabilities of many homeless people, such as mental illness (Ratcliff, Shillito, & Poppe, 1996). Some JTHDP participants were considered difficult to present to employers, for example, due to strange work histories with large gaps caused by hospitalizations, incarceration, or time spent on the street (U. S. Department of Labor, 1998). Similar concerns have been raised by mental health consumers in explaining gaps in job histories due to periods of mental illness or hospitalization (Freedman & Fesko, 1996). Issues related to physical appearance, both clothes and personal hygiene, can also pose problems when trying to find a job.

As discussed later in this report, various studies have shown that becoming "acculturated" to a homeless lifestyle can create additional impediments to getting off the streets (Grigsby, Baumann, Gregorich, & Roberts-Gray, 1990; Rowe & Wolch, 1990; Snow & Anderson, 1993). With respect to employment, Wenzel found that the length of time spent homeless was significantly and negatively associated with leaving an employment program prematurely (Wenzel, 1992).

The job prospects of homeless people are also affected-if not, to some degree, caused-by changes in labor markets and industries that has disproportionately affected people who are less educated and less skilled (Hardin, 1996). The decline of blue-collar industries and their replacement with service-sector jobs, the globalization of the economy, the rapid pace of technological change, and the relocation of firms outside the boundaries of inner-cities have all erected additional barriers to employment, particularly for less-educated workers (Harrison, Bennet, & Bluestone, 1996; Holzer, 1996; Moss & Tilly, 1995).

Fostering Family/Community Reintegration

Introduction

In the Skid Row studies conducted in the 1950s and 1960s (see, for instance, Bahr, 1973; Bogue, 1963; Blumberg, et al., 1960), the people who were homeless were characterized by three general conditions: poverty; disability (e.g., old age, physical or mental health problem, substance abuse issues); and disaffiliation (La Gory, Ritchey, & Fitzpatrick, 1991; Rossi, 1989) prior to the research that began in the 1980s, homelessness was almost synonymous with disaffiliation.

Those studying the homeless in the 1950s and 1960s "all remarked on the social isolation of the homeless" (Rossi, 1989). Studies found that most of these men-and the homeless population consisted almost entirely of men-were single and had never been married. Kinship ties were tenuous, and few maintained contact with family or kin. Most had no one they considered a good friend, and while there was camaraderie amongst themselves, researchers generally remarked on the superficiality of such ties (Rossi, 1989).

Although more recent studies have shown some differences between the "new" homeless and the "old" homeless of the 1950s and 1960s, such as less access to housing and jobs, research continues to show that homeless people are relatively socially isolated (Rossi, 1989; Shlay & Rossi, 1992). A review of sixty homelessness studies conducted in the 1980s and early 1990s by Shlay and Rossi found that, on average, 36% of the people studied reported having no friends, and 3 1% reported no contact with family members (Shlay & Rossi, 1992). Furthermore, among the homeless, people with severe mental illnesses and/or street disabilities have been found to be among the most isolated (Cohen & Sokolovsky, 1979; Goering et al., 1992; Interagency Council on the Homeless, 1992; Kroll, Carey, Hagedorn, Fire Dog, & Benavides, 1986; Rossi, 1989; Wolch, Rahiman, & Koegel, 1993).

A review of research on homeless families conducted in the early 1990s reported that several research groups had shown that social isolation is even a problem for homeless families (McChesney, 1993). Studies by Bassuk and her colleagues, for example, repeatedly found that homeless mothers have smaller, and more fragmented social networks, and that many experienced major family disruptions when they were children (Bassuk & Rosenberg, 1988; Bassuk, Rubin, & Lauriat, 1986). Similarly, a study comparing homeless mothers to stably-housed poor mothers found that two-thirds of the homeless mothers named only one or no adult supports, compared to one-half of the non-homeless mothers, and that they were more likely to rely on their minor children for support (Wood et al., 1990). In a more recent study, about half (53%) of the homeless mothers reported two or fewer persons to whom they could turn for support, and 14% reported only their children as social supports (Zima, Wells, Benjamin, & Duan, 1996).

The lack of strong ties to family and friends is important because it means few have the social and economic support to move off the streets. Helping homeless people re-establish ties to family and friends, or create new ties, may therefore either prevent homelessness or its reoccurrence.

Family Structure/Background

Most homeless people are single, often never married. Although homeless families represent a new, and growing segment of the homeless population, studies find that the majority of homeless persons are single men. For instance, Rossi's survey of the homeless in Chicago found that less than 10% of the

respondents were ever married, although women were more likely to have been married than men (Rossi, 1989). La Gory and his colleagues found only 7% were married in a sample of the homeless in a major Southern city (La Gory et al., 1991). A national study of over 45,000 participants in an employment initiative for the homeless found that only 10% of the participants were married (U. S. Department of Labor, 1998), and the recent evaluation of the federal Shelter Plus Care program found that 84% of its participants were single individuals (Fosburg et al., 1997). Two recent studies of supportive housing residents, one conducted with tenants from buildings in New York, Chicago, and San Francisco (Hopper et al., 1997; Rog et al., 1998), and the other conducted in Minneapolis (Wilder Research Center, 1998), found that a majority of the tenants were single, and most (51% to 91%) reported never having been married. Indeed, Shlay and Rossi's review of homelessness studies found that, on average, 87% of the respondents were unmarried (Shlay & Rossi, 1992).

Even though most homeless people are not married, many do have children. Marital status may only have a weak relationship to actual family status. For example, a majority (54%) of the respondents in Rossi's Chicago study of homelessness reported having children (Rossi, 1989), while over two-thirds (67%) of the homeless people in a study done by La Gory and his colleagues had children (La Gory et al., 1991). Among the participants of the federal Job Training for the Homeless Demonstration Program, 29% reported having dependent children (U. S. Department of Labor, 1998). Finally, in the buildings examined as part of an evaluation of an employment initiative operated by the Corporation for Supportive Housing, the proportion of tenants who reported having children ranged from a little less than a third to over two-thirds (Rog et al., 1998).

Many homeless people report either having "worn out their welcome" with their family and friends prior to becoming homeless, or never having had much familial support. One interesting question concerning the family and social networks of homeless people is whether their reported lack of ties represents a long-term condition or is a more recent phenomenon. There are at least three arguments that can be made about the family relations of people who are homeless, all three supported by research to some degree (Snow & Anderson, 1993):

- They had ties to families some time in the past, but have worn them out prior to becoming homeless;
- Their family situation was dysfunctional and/or abusive prior to becoming homeless; or
- There was never much family support to begin with.

Poor adults usually exhaust resources and aid provided by family, friends, and social welfare agencies before becoming homeless (Wong & Piliavin, 1997). In an ethnographic study of 80 homeless families, McChesney found that lack of friends and relatives, or the withdrawal of their support, is an important factor in determining which poor families become homeless (McChesney, 1992). Similarly, Shinn and Weitzman note that studies of homeless families seeking shelter in New York find that nearly all have spent some time doubled up before requesting shelter; it appears that many exhausted the resources in their social network (Shinn & Weitzman, 1996). Toro and colleagues (Toro, Goldstein, Rowland, et al., in press), in a longitudinal study of urban homeless adults, further show that the strained family and other support relationships significantly decline overtime.

Based on the length of time people reported being homeless, and the time since they last had a stable income, Rossi suggests that the average length of time families are willing to tolerate or give help is about four years (Rossi, 1989). Furthermore, he speculates that any generosity may be limited by the impoverished conditions that friends and family are often likely to be in, and be limited by personal problems experienced by many people who become homeless—e.g., substance abuse and/or mental health disorders. In turn, however, those among the homeless who have relatively more financial

resources were found to have larger social networks, especially including families, regardless of their mental health issues (Segal, Silverman, & Temkin, 1997). The people who become homeless, unless they have material resources, therefore, often make poor housemates and consequently are more likely to be eased out of a household over time.

There is also support for the argument that many of the people who are on the streets became homeless because they were never associated with stable and supportive familial networks (Nyamathi, Bennet, & Leake, 1997; Reilly, 1993; Snow & Anderson, 1993). Several studies have found that most of the homeless people contacted came either from families that had little economic or emotional support to offer in times of need, or came from no families at all.

Many studies have shown that homeless persons are more likely to have spent time in their youth in a foster care situation and/or to have had other types of adverse childhood experiences, such as physical or sexual abuse (Koegel, Melamid, & Burnam, 1995; Sosin, Colson, & Grossman, 1988; Susser, Lin, Conover, & Struening, 1991; Toro, Bellavia, Daeschler, et al., 1995). Recent data showing that a large proportion of children in foster care in one county were born to parents who had histories of homelessness further suggests an intergenerational cycle between foster care and homelessness (Zlotnick, Kronstadt, & Klee, 1998).

As a consequence of having adverse childhood experiences, many of these people may have little or no family support upon which to draw. For instance, over one-third of the homeless mothers in one study reported being placed either with relatives or in foster care as children compared to only one-fourth of the housed mothers examined (Wood et al., 1990). A study of homeless families from nine major cities found that 15% of the mothers from the participating families had been in foster care (Rog et al., 1995). A comparative study of homeless and housed poor families found that while both homeless and housed low-income mothers experienced high rates of early family disruption, trauma, and loss, only foster care placement and drug use by the respondent's primary female caretaker were significant predictors of homelessness in a multivariate analysis (Bassuk et al., 1997). It is also interesting to note that while homeless mothers have experienced more childhood disruptions than mothers in poor but housed families, they experienced more stable childhoods than women in shelters for single adults (Shinn & Weitzman, 1996).

A study of people who face three distinct problems-homelessness, mental illness, and substance abuse-found that many of these people grew up in families lacking one or both parents (Rahav et al., 1995). Furthermore, even when parents were present, a majority of fathers and a large proportion of mothers as well as siblings were reported to be substance abusers and/or had psychiatric problems. According to the authors, many of these "triply-diagnosed" people were deprived of traditional social development and socialization growing up, and lack the needed support structures and social controls generally provided by families.

Whether its due to straining ties before becoming homeless, coming from a dysfunctional family, or not having any family ties to begin with, taken together all of these findings indicate that many people who are homeless may have few family resources that they can rely upon once they are on the streets. Perhaps even more distressing, the growth in the number of homeless families, and, by extension, children growing up homeless, may presage even more problems in the future. As Blankertz and colleagues note, we may be witnessing an intergenerational transmission of co-morbidity, with second-generation dually-diagnosed individuals revealing substantial social deficits, even when compared to other people with multiple diagnoses (Blankertz, Cnaan, & Freedman, 1993).

Friendship & Social Networks

As noted earlier, studies have consistently shown that homeless people do not have extensive ties to relatives or friends, and that they generally have fewer social ties than the non-homeless (Rossi, 1989; Shlay & Rossi, 1992). However, these same studies show that homeless people are not "totally isolated," as might be inferred from some discussions of disaffiliation among the homeless (La Gory et al., 1991) and none suggest that there is a virtual absence of any ties (Shlay & Rossi, 1992).

Although homeless people typically have some social connections, these ties are not very strong and may not provide much support. The social ties of homeless people have been found to be weaker and less efficacious than the social support obtained by people who are housed (La Gory et al., 1991; Snow & Anderson, 1990). As summarized by Snow and Anderson, social relationships developed between homeless people are "plagued by contradictory characteristics." On the one hand, friendships are often quickly formed, and there is generally an ethos of sharing whatever modest resources are available. Yet at the same time, there is also a chronic distrust of one another, and a fragility and impermanence to these social bonds, perhaps best exemplified by the fact that many people cannot provide the last names of those they consider friends (Rowe & Wolch, 1990; Snow & Anderson, 1993). The reasons for these weak ties may stem more from the precarious conditions under which the bonds are formed than from any personal characteristics. More specifically, the ability to quickly establish and sever weak ties may have important survival value, particularly in the "resource-depleted context" of being homeless (Snow & Anderson, 1993).

Homeless people who have more social ties with other homeless people may have a harder time moving off the streets. Making friends and ties with others living on the streets may act as "a double-edged sword" (Grigsby et al., 1990). In particular, although they may help with survival on the streets, these ties may block efforts to move out of homelessness. Developing coping skills for the street may inadvertently reinforce an. identity of "self-as-homeless" (Rowe & Wolch, 1990) that increases the difficulty of transitioning into housing.

People who become enmeshed in daily street routines and activities with other homeless people often have a hard time exiting from the streets (Snow & Anderson, 1993). Moving off the streets often requires severing ties with other homeless people, an act that is difficult when these individuals are an important, if not the only, part of one's social network. Developing alternative networks, ideally from "reconnection" venues such as job training programs or housing programs, may help in making the transition from the street and from homeless networks. The evaluation of the Job Training for the Homeless Demonstration Program, for example, found that relationships made by the participants through their involvement in the employment program were a critical, and perhaps only, source of support in their search for employment. Most of the individuals lacked family supports, and their peer supports were not always good influences on maintaining employment (U. S. Department of Labor, 1998). Similarly, an evaluation of an employment program for supportive housing tenants found that many tenants who decided to use employment services or obtain a job often experienced changes in their social networks, focusing more on their colleagues at work or on other tenants participating in the employment effort (Rog et al., 1998).

Supporting Social Networks

Because homeless people often lack many social ties, particularly with family and kin, it has been suggested that efforts that would support existing relationships, and promote new ones, might be beneficial, particularly for homeless people with mental illnesses (Interagency Council on the Homeless,

1992; Lehman, Kernan, & DeForge, 1995; Toro et al., in press). Among the strategies proposed include a case management approach that also provides activities to assist people in expanding their networks in healthy ways (Grigsby et al., 1990); drop-in centers as a way to promote the formation of new social networks (Rowe, 1990), and social network therapy (Buchanan, 1995; Drake et al., 1993).

Despite the evidence for the need for integration, no programs have been explicitly developed to help people re-connect with their family and friends, or help establish new ties. This is one area that requires much more work and development (Johnson & Cnaan, 1995). Research that examines whether programs that influence self-esteem, such as supportive housing, indirectly affect the ability and likelihood of formerly homeless people to reconnect to their communities, also needs to be done. In addition, more work needs to be done to explicitly examine the place of families and friendship networks in the process of becoming homeless (Shlay & Rossi, 1992). Understanding how such ties deteriorate under adversity, and what might be done to strengthen them before people become homeless, could be important to homelessness prevention efforts.

Studies are also needed to determine whether some programs, such as supportive housing, create artificial networks that may not be beneficial in the long run. A study of discharged mental health patients, for example, found that many described a support system that was rooted mainly in the mental health system. Patients were able to successfully live in the community, but they did not demonstrate greater community integration (Dewees, Pulice, & McCormick, 1996). Some research in supportive housing, however, (Goering et al., 1992) found that the social networks of tenants was comparable in size to the social networks of people living in other types of community settings but the composition of the networks varied. In particular, staff and co-residents appeared to have replaced, rather than added to, the role of family and friends for supportive housing tenants (Goering et al., 1992). These findings suggest that helping people to establish more functional social networks may be a complicated process.

Conclusion

Homeless people are, by definition, isolated from mainstream society. They lack stable housing, and often lack connections with jobs, families, and communities. The disaffiliation is complicated, with both structural and personal factors contributing to a homeless person's disconnectedness. Likewise, successfully reconnecting homeless individuals and families back into society requires addressing these same structural and personal issues. Efforts at tackling some of these elements often result in no more than a temporary patching of problems (e.g., providing transitional housing with supports) because the other causal factors are still in operation (e.g., the continued lack of affordable permanent housing).

However, if the homelessness cycle can be broken through successful and sustainable reconnection efforts, even for a segment of the homeless population, then there can be an incremental reduction in the population. Research suggests that this type of successful reconnection involves coordinated efforts of getting someone stably housed, back into the competitive job market, and into a network of "positive" support.

The development of supportive housing, in particular, is based upon the premise that some homeless people need more than housing in order to stay residentially stable. Likewise, the experience from various job and training programs designed for homeless people suggests that employment needs to be addressed in conjunction with a number of other issues, particularly housing, if it is to be successful. Calls to assist homeless people by providing all "three legs of a stool-housing, services, and jobs" thus seem to be justified (Emerson & Twersky, 1996).

The best ways to design this stool, however, still need to be determined though they are likely to involve some form of customized approach. What we know about "how" to reintegrate people into communities is limited. If we examine each of the three areas reviewed- housing, then employment, and finally social supports- we realize that there is progressively less information on how to successfully reconnect people to these areas.

Reconnecting to housing has received the most study and efforts in this area have been overwhelmingly successful. Most homeless people who enter supportive housing, even those with multiple and severe problems, stay stably housed for extended periods of time. Housing is best offered as the first step toward greater reconnection, with supports that can assist in the transitioning process and in fostering long term stability. The experiences of employment and training programs, for example, indicate that they are likely to be more successful if social support and housing services are provided ***before*** people become involved in work-related activities.

However, virtually all of the successful housing efforts have involved closing the affordability gaps for a segment of the population, most often targeted to individuals with specific disabilities or needs. These efforts rarely have the chance to affect entire systems or populations of need, but rather constitute "fixes" to the system that are based on insufficient resources (Rog et al., 1994). The feasibility of expanding these efforts on a broad scale is questionable at best, however. Despite the forecasted federal budget surpluses, financial resources for discretionary domestic spending are still limited by the budget caps enacted as part of the 1997 federal budget. Moreover, there has been a general shift in public sentiment away from any sort of "entitlement" programs. Perhaps the best that can be envisioned for the near future is developing and funding comprehensive, albeit time-limited, efforts that can help homeless persons and families become stable and self-sufficient.

Only a few efforts have been tested to explicitly reconnect homeless people into the job market and they have achieved mixed success. Numerous obstacles exist that make it difficult for homeless, or formerly homeless people, to find or keep jobs, even with assistance and support. Some of these obstacles are clearly beyond the control of homeless individuals or programs, such as the changes that have occurred in the labor market and the loss of low-skilled jobs. Others are resource problems, such as lack of transportation or affordable child-care. Finally, some are personal or individual problems, such as lack of education or competitive work skills, family-related problems, mental illnesses, physical disabilities, or substance abuse problems. Resource and personal problems can be addressed, but may be difficult and time-consuming to overcome.

The relative success of more comprehensive employment and service programs suggests the need for more integrated efforts that can offer support services, housing, and job training and development services. However, even when successful obtaining jobs, homeless and formerly homeless people are likely to remain economically vulnerable. Part of the problem is that job turnover is normally quite high, so many people will not be continuously employed once they start work. In addition, the types of jobs homeless or formerly homeless people are likely to obtain normally pay around the minimum wage, are often part-time and/or temporary positions, and rarely provide health insurance or other benefits.

Finally, there is virtually no published literature on how best to improve the social capital of homeless individuals. To date, the attention in this area has focused on documenting the size and strength of family and social relationships when people are homeless, and there have been recent attempts to explore the role of these ties in initially keeping people, particularly families, from becoming homeless. Overall, the research has found that homeless people have few ties with families and friends, often having "used

up" the goodwill of their families. In addition, significant numbers of homeless people came from families that never offered much economic or emotional support, and many came from no families at all. To date, despite this developing body of knowledge, no programs have been explicitly developed to help people improve their social networks.

What are the Policy, Practice, and Research Implications of What We Know?

Policy Implications

Reconnecting homeless people to the community rests, at least initially, on the ability to link them successfully to housing. Much has been learned about how to effectively do this for specific populations of the homeless. How to replicate these efforts on a broader scale is the supreme challenge, given tight budgets and the relative lack of public will to spend the money it would take to meet the need that exists. The dramatic loss of housing during the 1970s and 1980s, coupled with growth in poverty for larger and larger segments of society has created an imbalance that is daunting at best.

In the face of limited resources, therefore, it is important that the resources that are available be used to chip away at the problem with solutions that have staying power. Efforts at developing and restoring low-cost housing, such as SROs, and providing incentives for investors that can help in developing affordable housing are all critical in the fight toward balance.

Enabling people to live in and maintain independent housing over the long run also may take systemic as well as individual action, particularly with respect to returning to the workforce. Although some of the reluctance to enter the job force stems from personal problems, such as mental illness, and from macro-structural changes in the economy-such as declines in blue-collar jobs-other barriers result from disincentives built into social and medical insurance programs. Greater flexibility should be built into these programs to encourage people to try to work. Furthermore, any changes made to these programs also need to be flexible enough to recognize that most people are likely to experience job turnover. It cannot be assumed that once a person finds a job that he or she will stay in that job 'for a long period of time. Programs that cut-off benefits once a person starts to work and that make it difficult to re-obtain them once dropped, will therefore also discourage people from trying to work.

In addition, because most jobs obtained by homeless and formerly homeless people are low-paying and lack benefits and room for advancement, employment and training efforts need to be complemented by efforts to increase wage levels and/or expand the scope of programs like the Earned Income Tax Credit to supplement earnings.

Practice Implications

The research and practice conducted to date provides some direction for individual housing and social service providers. Overall, a coordinated approach to reconnection-the "three-legged stool"-offers the best prospects for getting people stably housed and working. Offering a range of housing options as well as a variety of opportunities for work (e.g., affirmative businesses; in-house employment, etc.) increases the probability of people remaining in housing and furthering their independence in the community.

It is not clear, however, what can be done to encourage or strengthen ties to family, friends, and the broader community. What is important to recognize is that many homeless people are likely to have

already used up much of the "goodwill" that existed in these networks, may never have been able to obtain such support from their networks, or may never have had such networks to begin. Given these circumstances, helping homeless people re-establish ties may be difficult. However, efforts to establish functional social networks, such as in drop-in centers, housing programs, employment programs, and so forth may have greater long-term benefit for individuals. Furthermore, even without specifically trying to achieve it, efforts to stabilize the housing and employment opportunities of people may make it more likely that people will be able to re-establish these networks.

Research Implications

Although current evidence suggests that combinations of support services, housing supports, and employment programs are more effective than any single intervention, research is needed to determine which combinations of services are most effective, and with what types of people. For example, when is transitional housing a necessary step in one's path toward residential stability? What types of support services are essential to provide? What types of employment services are most effective?

It is particularly important to determine what housing services are needed for people with special needs, such as people with mental illnesses, substance abusers, and those with dual or triple-diagnoses. With respect to housing, in particular, identifying options that can effectively serve individuals with active substance abuse is critically needed. With respect to employment, more research is needed on how to develop and operate affirmative businesses, particularly to understand under what conditions these enterprises can be self-supporting (if not income-producing). Actively involving formerly homeless people in the research who have become reconnected may be one useful way to examine many of these issues. It will also be important to determine how well these types of jobs and businesses can prepare people for more mainstream jobs, or if this represents the development of a segregated job market.

No programs have been explicitly designed to improve the social networks of homeless or formerly homeless people. Developing programs and methods to build reliable social support systems for homeless people is therefore an area that needs to be addressed (Johnson & Cnaan, 1995). In addition, research is needed on the effects that existing efforts, particularly programs such as supportive housing, have on social networks. To the extent that programs are able to stabilize a person's life, they may also encourage and facilitate reconnecting with family and friends. Supportive housing programs may also provide a conducive environment for making new friends. At the same time, research should also be done to determine whether these environments create "artificial" networks that are more reliant on staff than on family and friends, and therefore may not be as stable or reliable a source of support.

In sum, over the last decade or so, much has been learned about reconnecting homeless individuals and families back into the community. Some of these lessons have translated into action; others have not. Continued research and programmatic action is needed to add to our knowledge base and provide additional ammunition for action so that homelessness can become a phenomenon of the past, rather than an enduring plight of society.

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What Do We Know About Systems Integration and Homelessness?

by
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Abstract

Comprehensive systems of care to address the needs of homeless individuals have been called for by researchers and policymakers alike. This paper defines and differentiates systems and services integration, and examines specific strategies for each. A brief historical review of integration in other human services fields is provided. Findings from federal initiatives designed to encourage systems integration for people who are homeless are described and examples given. The paper concludes with suggestions for making systems integration work in practice and further recommendations for policy and research.

Lessons for Practitioners, Policy Makers, and Researchers

- **Services integration and systems integration must be pursued simultaneously.** Strategies for client-level (services integration) and administrative-level (systems integration) change must be undertaken at the same time in order for either to be effective.
- **Commitment to change without adequate resources is not enough.** Systems integration efforts can only impact client outcomes if the resources to meet their needs exist. Resources to meet specific needs may need to be increased or existing resources may need to be more efficiently allocated or organized.
- **Three strategies are key** to establishing the basic infrastructure to permit systems integration to occur: (1) having a designated leader responsible for systems integration, (2) getting the key players and decision-makers to the table (and keeping them there); and (3) using a formal strategic planning process.
- Current or former **service recipients need to be involved** at all stages of planning and implementing systems integration.
- Remember that while large-scale systems change may be the goal, **incremental change is often the way in which most systems evolve.** Systems change is a long-term commitment; incremental change is an interim goal, important in its own right.
- **Seek advice from others.** Too often communities ignore the need for an outside expert to identify what is making them stuck and to help them find a way through a difficult issue. Sometimes taking a team of enthusiastic and reluctant community members to visit another community that has already struggled with similar issues can be just what is needed to move beyond an impasse.

The Need for Integration

Nearly everyone writing on homelessness over the past decade or longer has called for comprehensive integrated systems of care to address the multiple and complex needs of people who become homeless (see for example, Wilkins, 1996; Interagency Council on the Homeless, 1994; U.S. Department of Housing and Urban Development, 1993; Federal Task Force on Homelessness and Severe Mental Illness, 1992; Martin, 1990; Levine, Lezak & Goldman, 1986). Many believed that the services that homeless people needed already existed. What was needed, they argued, was to reorganize the categoric and fragmented housing, health, and social welfare services available at the community level so that people's needs could be addressed more holistically and more effectively.

As intensive attention was being paid to the problem of homelessness in the late 1980s, many communities found that some services simply did not exist (e.g., there were service gaps) or the demand for housing, shelter and services far outstripped the supply. Even where services existed, they found that those required by people who were homeless crossed systems – the public housing system, the private housing market, the mental health system, substance abuse system, primary health care system, the welfare or social service system, the criminal justice system, and private religious and other organizations. Each of these systems controlled access to any number of needed services and were often not integrated within a given system, let alone across different systems. Moreover, each system had its special purpose, sources of financing, particular eligibility requirements, geographic catchment area, and modes of operation.

Defining Services and Systems Integration

The goals of integration are to improve access to comprehensive services and continuity of care; to reduce service duplication, inefficiency, and costs; and to establish greater accountability (Randolph et al., 1997; Miller, 1996). Until recently, the terms services and systems integration have been used interchangeably. The lack of specificity between the two terms has lead to a good deal of imprecision and confusion for practitioners, policy makers, and evaluators alike. Over time, they have become increasingly distinct. Kahn and Kamerman (1992) distinguish between ***administrative level strategies*** that are aimed at changing service delivery for a defined population as a whole and ***case-oriented strategies*** designed to change service delivery for individual clients.

The first can be generally thought of as systems integration strategies and the

Figure 1
Strategies for Systems and Services Integration

Systems integration strategies

- Interagency coordinating bodies
- Strategic planning
- Identified systems integration staff
- Pooled or joint funding
- Cross-training
- Co-location of services
- Interagency agreements
- Interagency management information systems (MIS)
- Uniform application and eligibility criteria
- Consolidation of program or agencies
- Provider incentives (e.g., capitation)
- Centralized authority

Services integration strategies

- Case management
- Case conferences
- Individualized service planning
- Assertive community treatment, continuous treatment teams
- "Wrap-around services"
- Flexible funds at the disposal of the front-line worker
- Case monitoring, utilization review, outcome monitoring

second group fall into the services integration arena. The distinction is more than semantic. The strategies for each vary dramatically and so do the methods and measures for evaluating their impact.1 The key strategies of each (see Figure 1) overlap with those listed in every major study of integration regardless of the field in which the initiative originated or target population (c.f., Kahn & Kamerman 1992; Cocozza, Steadman & Dennis 1997; Pitcoff 1998).

In services integration, services are coordinated, but relationships between agencies do not fundamentally change. Systems integration, by contrast, requires changes in the ways in which agencies interact with each other. There are fundamental changes in the ways in which agencies share information, resources, and clients. Such changes are difficult and time-consuming. Communities using similar strategies can vary greatly in the level of systems integration achieved. Konrad (1996) describes systems integration on a continuum ranging from information sharing and communication to cooperation and/or coordination to collaboration to integration.

Rog (1997) makes another useful distinction among three types of systems-level activities that are frequently found in efforts to integrate services and service systems:

- *project fixes*—initiatives which fill an immediate service gap but does not affect the way the overall system relates to the target population;
- system fixes-those that address a systemic problem but usually only on a temporary or time-limited basis (e.g., federal grants or foundation seed money); and
- systems change-reformulations or modifications in the structure of a system that are enduring and far-reaching.

An Historical Perspective

What is often overlooked is that calls for systems integration are far from new (Yessian, 1995; Kahn & Kamerman, 1992; Agranoff, 1991; Yessian, 1991). Although the names change, the underlying concepts do not. Over the past 30 years, efforts to achieve systems integration have been variously called: community integration, comprehensive services, comprehensive planning, coordinated services, systems of care, community support services, and continuum of care-to name a few. In theory, if multiple service agencies were dealing with the same clientele in a case-by-case and uncoordinated fashion, then perhaps gains could be realized and costs reduced if each agency broadened its core service approach to involve coordination with other providers serving the same clients.

This was the impetus for efforts at the local, State, and Federal levels of government to reorganize human services and move them towards an integrated services configuration. Beginning with the Office of Economic Opportunity's War on Poverty in the 1960s, community action agencies created the local-level capacity for case management which could cross system boundaries to link clients to needed services. The Model Cities legislation of 1966 called for demonstrations that would "overcome the local level service fragmentation in education, manpower, housing, health, mental health, public assistance, and poverty" (Kahn & Kamerman, 1992).

In the 1970s, the U.S. Department of Health, Education and Welfare moved to integrate its 500 programs. As a result, hundreds of demonstrations and state or local reorganizations were created through such initiatives as the Service Integration Target of Opportunities (SITO) program (Agranoff & Pattakos,

1 For the purpose of this paper, we will be examining the role of systems integration in addressing homelessness. Services integration in the form of case management is being addressed in a separate paper.

1979); the Partnership Program which created "umbrella" agencies for State and local human service bureaucracies (Yessian 1991); the Integrated Projects Funding System, designed to expedite joint funding from various categorical streams; and the Comprehensive Human Services Planning and Delivery System (CHSPDS) projects for systematic experiments with management reforms. These efforts were documented in publications written or collected by Project SHARE, a clearinghouse HEW created and funded to disseminate the results.[2]

Over the years, more services and systems integration initiatives followed in the fields of education, children's mental health, employment and training, children's and family services, and health. In each, services integration or coordination was championed as one of the basic strategies for promoting system change at the local level. Most of these efforts relied upon voluntary coordination strategies to promote resource sharing, joint planning, and continuity of care among otherwise autonomous service providers. The goal was to foster linkages (formal and informal interorganizational relationships) among the full range of agencies that were needed to create a comprehensive system of services for the target population in communities across the country.

Today, there is a resurgence of systems integration initiatives funded by public and private agencies in a variety of different fields. Federal programs that have systems integration as a key or primary goal, include: the Target Cities demonstration sponsored by the Center for Substance Abuse Treatment, the Departments of Labor and Education's School To Work program, the Healthy Start program sponsored by the Health Resources and Services Administration, the federally-funded Empowerment Zones and Enterprise Communities, and the Children and Adolescent Service System Program sponsored by the Center for Mental Health Services. Private initiatives are even more numerous and include the Annie E. Casey Foundation's seven-year Rebuilding Communities Initiative, the Edna McConnell Clark Foundation's Neighborhood Partners Initiative, and the Ford Foundation's Neighborhood and Family Initiative.

Systems Integration and Homelessness

Most systems integration initiatives had some form of evaluation though it was often unsophisticated, underfunded, and planned after the fact. While many service integration initiatives have noted successful achievement in system-level goals, increased integration does not necessarily benefit the individuals receiving care (Provan, 1997; Talbott, 1995). Research teams which evaluated the Robert Wood Johnson Foundation's Program on Chronic Mental Illness (Goldman, Morrissey & Ridgely, 1994), the Fort Bragg Demonstration of managed mental health services for children and adolescents (Bickman et al., 1997) and others have found little evidence that system-level interventions result in improved client outcomes.

Publication of these results has met with considerable debate. Many people in the research and public policy communities have taken these findings as evidence that the organization of services does not make a difference in service delivery and outcomes. Others believe that this judgement is premature and that it has been our inability to adequately measure the relationship between system changes and client outcomes that is responsible for inconclusive results. Still others believe that there is no reason to expect an overall measurable effect. As we will see, demonstrations that address homelessness offer perhaps the greatest opportunity to assess the extent to which client outcomes are related to systems-level interventions.

2 Project SHARE operated from 1972-1990 and collected over 11,000 documents related to services integration. These materials are now housed at the National Center for Service Integration Information Clearinghouse, c/o National Center for Children in Poverty, 154 Haven Avenue, New York, NY, 10032, phone 212-927-8793.

The literature on homelessness contains findings from four local efforts at systems integration. While these represent single case studies, they offer some insight into the promise and difficulties of systems integration for homeless persons. In Vancouver, B.C., providers from the mental health, alcohol/drug treatment, corrections, social and housing agencies created a "multi-service network" to more effectively serve persons with multiple problems who had been identified as consuming high levels of agency resources over long periods of time. Agencies reported increased communication via regularly scheduled, multi-agency case conferences and the development of a single individualized service plan (Buckley & Bigelow, 1992). This is a good example of services integration rather than system-level integration. A program in New Haven, CT, shows us how a clinical outreach team that is focused on services integration for individual clients can contribute to systems-level change as well (Rowe, Hoge, & Fisk, 1998).

Operating squarely in the arena of system-level integration, the City of St. Louis was among the first communities to formally attempt to stimulate systems integration for homeless services. As a result of a 1985 lawsuit requiring the City to provide shelter and services to help people exit homelessness, the City created a task force to plan a comprehensive system and used purchase of service agreements with local agencies to provide needed services. Johnson and Banerjee (1992) found that the system increased resources and institutionalized a coordinated system of care at the local level. Difficulties cited were the need for a more participatory strategic planning process, more attention to monitoring based on client outcomes, and a tendency toward stable relationships with a limited number of providers making it difficult for new, small, or innovative agencies to participate.

In a more recent example, a city-sponsored Task Force collaborated with a grass roots homeless coalition and a university to respond to homelessness in Long Beach, CA. Using a formal needs assessment process to identify needs and set priorities, conflict arose when the Task Force made its recommendations to the City. Some recommendations were reluctantly implemented and later sabotaged, others were ignored or actively refuted (Dowel1 & Farmer, 1997). What was clear was that City officials and business leaders were not participants in the process of developing the recommendations; they did not own the problem or the solution. The authors argue that the Long Beach experience points to the importance of linking local efforts with regional, state, and federal leadership on such complex issues as homelessness.

Over the past decade, federal agencies and private foundations have undertaken several initiatives designed to encourage localities to use systems integration as a mechanism to assist people who are homeless or at risk of homelessness. Findings from these initiatives are described below.

Baltimore Mental Health Systems (BMHS), **Baltimore's** mental health authority, was founded in 1987 as a condition of the city's receipt of a $2.5 million grant from the Robert Wood Johnson Foundation. The foundation required that a separate entity be created to improve the quality and quantity of mental health services citywide.

To maximize housing opportunities for persons with serious mental illnesses in the city, BMHS, created a housing development and management subsidiary, Community Housing Associates" (CHA). CHA coordinates its housing activities with BMHS to assure that mental health and other support services are available as needed by tenants. CHA also lends its expertise to other organizations seeking to develop housing for disabled persons in the Baltimore area. For example, CHA assisted seven local churches in their development of three group homes.

Through formal partnerships with private investors, the Alliance for the Mentally Ill, and the Enterprise Foundation's Social Investment Corporation, CHA and BMHS have expanded the housing and services options available to persons with serious mental illnesses in Baltimore, many of whom were, or would have become, homeless if not for this project.

HUD/RW JF Program on Chronic Mental Illness

In 1986, the Robert Wood Johnson Foundation funded a five-year demonstration of systems integration for persons with serious mental illness, especially for those who were also homeless, in nine cities (Cohen & Somers, 1990). The U.S. Department of Housing and Urban Development also provided each site with 125 Section 8 housing certificates through the local public housing authority.

Findings from the evaluation of this program suggests that the cities were successful in developing central mental health authorities and that services and housing were expanded, but these changes alone were not sufficient to demonstrably improve the quality of life for individuals with severe mental illnesses (Goldman, Morrissey & Ridgely, 1994). This was largely due to an inadequate resource base for the services that the systems integration strategies were attempting to integrate (Goldman et al., 1992).

While the sites had been given the funds to integrate housing and support systems through a centralized authority, there were inadequate resources to augment already strapped case management services. In addition, the quality of the housing and the neighborhoods available to clients, even with Section 8 certificates, also contributed to the difficulty in producing improved client outcomes (Newman, 1994).

The NIMH/CMHS McKinney Demonstrations

Section 612 of the McKinney Homeless Assistance Act provided the authorization for two rounds of increasingly systems-change oriented demonstrations for homeless persons with serious mental illnesses. The orientation to systems-level change was a direct result of earlier work in the area of services integration by the Community Support Program.

Beginning in 1988, the first round of nine projects, administered by the National Institute of Mental Health, were required to provide, or arrange for, four essential services (outreach, case management, mental health treatment, and housing). In addition, they were required to conduct "administrative activities designed to link these services together" (Levine & Rog, 1990). These programs were among the first to attempt an evaluation of such comprehensive approaches. However, there was no cross-site evaluation and the individual level evaluations did not systematically assess the client-level impacts of these administrative (i.e., systems-level) activities (CMHS, 1994a).

In **San Diego,** the local mental healthauthority and two public housing agencies collaborated to test whether the combination of HUD Section 8 rental certificates and intensive case management would yield better client outcomes than any of three comparison groups. The collaboration between the PHAs and the mental health system was essential to the project design. The housing agencies revised their waiting lists to add a preference for project clients, agreed to consider applications from persons with histories of illegal drug use who are in treatment, and tailored the Section 8 orientation program to meet individual clients' needs. Support services are provided by the mental health agency.

A second round of five projects began in 1990. Building on the prior demonstration, and now administered by the Center for Mental Health Services, these projects were required to develop strong formal links between the community mental health, homeless services, and public housing systems in the targeted cities. Modeling the behavior expected at the local level, HUD and HHS developed a Memorandum of Understanding to jointly sponsor initiatives on behalf of homeless persons with serious mental illness and other disadvantaged populations. This agreement was then used by grantees (usually mental health centers) to forge formal agreements with their local public housing agencies to provide subsidized housing to study subjects. What began as a "system fix," to use Rog's (1997)

conceptualization, in at least two sites (Boston and San Diego) evolved into systems change as the relationship between these two systems expanded and endured.

Systems-level activities were documented as part of each individual project's process or implementation evaluation. In the San Diego project, which specifically examined the impact of these activities on housing outcomes, the results were dramatic. Those clients assigned to the group that received Section 8 certificates, a direct result of the newly created relationship between the housing authority and the mental health center, showed greater residential stability than those in the control condition (Hough et al., 1997; CMHS 1994b).

The NIAAA McKinney Demonstrations

In 1988, the National Institute on Alcoholism and Alcohol Abuse (NIAAA) funded nine demonstration grants for alcohol and drug abuse treatment of homeless individuals in the first round of McKinney funding. Increased cooperation and formal linkages among alcohol treatment, drug treatment, housing and shelter providers, and other supportive services were required. Client-level outcome data from a subset of projects that used experimental or quasi-experimental evaluation designs were analyzed to estimate intervention effectiveness. Individuals in the experimental conditions were significantly more likely to report improvement than comparison clients in the majority of sites (Orwin et al., 1994).

The experiences in designing and implementing the first NIAAA demonstration program laid the groundwork for funding a second round of 14 projects designed to evaluate the effectiveness of comprehensive approaches (e.g., case management, treatment, housing and other support services) in reducing alcohol and other drug consumption and enhancing the residential and economic stability of project participants. In keeping with the intent of the RFA, systems-level activities and outcomes received relatively less emphasis. Nevertheless, several projects elected to make systems integration an integral part of their program and others found that they had to engage in systems-level activities in order to implement their interventions.

At the time of the grant award, there were few services in **Washington, DC,** for dually diagnosed homeless population were available in the surrounding community. Community Connections set as its goal, the establishment of a treatment system that would, at a minimum, tolerate dually diagnosed clients and, as an ideal, design services specifically for this population. The program reached out to receptive service agencies and provided basic education. Agency staff were actively involved with the District's Center for Mental Health Services (DC CMHS) and sat on a committee formed to examine this issue. They addressed immediate service gaps by developing their own task forces and topic-oriented groups for participants.

Although access remained a problem, the project made several significant gains, including: (1) collaborating with a clinic willing to provide physical and dental services to clients, (2) linking to an outreach program which served clients with HIV/AIDS, (3) negotiating with DC CMHS for housing subsidies, and (4) finding resources for pregnant women (Orwin et al., 1995).

The projects experienced a number of systems-level barriers to implementation, including: (1) neighborhood resistance to project location, (2) conflicting interests with collaborating organizations, (3) budget cutbacks in multiple service areas, (4) difficulty accessing shelter and housing for program participants, and (5) the lack of technical assistance to help solve common problems as they arose (Orwin et al., 1995). The evaluation did not systematically address the impact of systems integration activities on program or client outcomes.

In 1994 with more than 5,000 persons homeless on a given day and less than half as many shelter beds, **Detroit's** homeless service system was primarily focused on crisis-oriented emergency shelter. In response to the introduction of HUD's Continuum of Care, the Mayor convened a Task Force on Homelessness bringing together representatives from state and local government, non-profit service providers, advocates, religious organizations, private foundations, the business sector, and current and formerly homeless persons. Over nine months of intensive meetings, representatives of 46 key organizations crafted a Continuum of Care plan in its report, A Home for Every Detroiter. The report, which was accepted by the Mayor and the City Council, set goals and identified major gaps in the service delivery system.

New service provider networks were organized to begin the collaborations necessary to implement the plan. In late 1995, the Detroit/Wayne County Homeless Action Network was formed uniting two separate coalitions that had focused on East and West Detroit. From a community where policy planners and service providers had worked in relative isolation, both public and private agencies have made the philosophical shift from a crisis-oriented shelter system to a more comprehensive array of outreach, assessment, and emergency, transitional and permanent housing and services (Fuchs & McAllister, 1996).

Four co-location projects were implemented at VA medical centers in **New York City, Dallas,** and **Los Angeles.** At each site, the VA designated a social worker to be responsible for (1) facilitating referrals for SSA benefits from VA clinical staff, (2) shepherding claims through the application process, and (3) helping to obtain medical records and other information required to support the application. Local SSA field offices co-located claims representatives with Health Care for the Homeless Veterans (HCHV) teams to increase understanding of the application process among VA staff and to initiate disability claims directly. Disability analysts were also designated to work directly with the HCHV teams. The Los Angeles site, the same two SSA staff members performed the tasks of both claims representative and the disability determination analyst.

ANCHOR was developed by the University of Pennsylvania with funding from HUD and HHS specifically to help local providers and government agencies plan services for homeless persons. The system includes four information modules: outreach, assessment, residential services, and service planning. Tested in 16 cities nationwide, ANCHOR became available commercially in 1998. Three cities-Boston, Anchorage and Detroit-have adopted ANCHOR after participating in extensive testing and refinement of the system. In Detroit, 35 emergency shelters were scheduled to be on-line by Summer 1998. Transitional shelters were to be added shortly thereafter.

The SSA/VA Joint Outreach Initiative

In 1991, the Social Security Administration (SSA) and the Veterans Administration (VA) began a two year demonstration of a joint initiative to increase the applications and awards for disability benefits (SSI and SSDI) among entitled homeless veterans.

An evaluation of this effort found that access to disability benefits among homeless persons with mental illness were significantly improved by co-location of staff from an income support agency with clinical staff from a specialized mental health program (Rosenheck, Frisman, & Kasprow, 1999). Veterans at the intervention sites were almost twice as likely to apply for benefits and to receive awards as those in the comparison groups. Administration costs of this integration strategy ranged from $1,700 to $3,200 per award-a small price to pay when one considers that receipt of benefits is highly related to successful housing outcomes for homeless persons (Rosenheck, Frisman & Gallup, 1995).

HUD's Continuum of Care

In 1994, the Department of Housing and Urban Development fundamentally reorganized the process by which McKinney Homeless Assistance funds were awarded. HUD homeless programs (except for the Emergency Shelter Grant program) were consolidated into a single competitive grant. This change was made explicitly to encourage systems integration in communities throughout the country. The goal was to enable localities "to fashion a comprehensive system which addresses the needs of different homeless populations and which ensures that various elements of the system...are in balance " (U.S. Department of Housing and Urban Development, 1994, p. 5).

In order for a community to apply for these funds, it must submit a Continuum of Care plan that demonstrates participation of a variety of community stakeholders, that defines a vision for combating homelessness, and that ensures a comprehensive system is under development for the delivery of outreach, transitional housing and services, and permanent housing. In addition, a Continuum of Care community must collectively decide its priorities for funding.

The HUD reorganization of its McKinney programs is one of the largest systems integration initiatives in the homeless service system arena. It affects more than 500 communities nationwide. The Continuum of Care planning process and the McKinney annual application has fundamentally changed the way in which communities address homelessness. In some communities, providers and public officials are talking and planning together for the first time. In others, the process has become more difficult and more politically charged, especially for providers and consumers representing marginalized populations.

While there is no systematic evaluation of the implementation of this public policy, there are many examples of communities where the process appears to have moved things in the right direction (Fuchs & McAllister, 1996). However in many communities the level of McKinney funding available each year forces them to make hard choices between renewing existing projects and filling the gaps that have been identified in the Continuum of Care process.

Strategic planning is just one mechanism used by communities to assess housing and service gaps in the Continuum of Care. Another mechanism being explored in cities with large homeless populations is management information systems that provide the data necessary for good planning. Implementing such a system on a city or county-wide basis takes a great deal of time and commitment at all levels across many agencies. Providers, advocates, and government agencies that use such systems do so to help them more effectively organize the delivery of services to homeless persons. Of particular concern when

implementing multi-agency management information systems is guarding the confidentiality of information on individuals in the system. It is important to know that by careful planning this issue can be, and has been, satisfactorily addressed by others (Soler & Peters, 1993).

HUD Shelter Plus Care Program

In 1992, HUD made the first of what are now hundreds of grants in more than 345 communities to provide housing and support services to homeless persons with disabilities. The Shelter Plus Care (S&C) Program (funded under the Continuum of Care process described above) is designed to integrate housing and support services by requiring that each dollar of rental assistance provided by HUD is matched by an equal or greater dollar value of support services. Local S&C programs involve a partnership including the grantee agency, one or more housing providers and a network of support service providers.

An evaluation of the program (Fosburg et al., 1997) found significant improvements in the lives of program participants in terms of engagement in needed treatment; increased income and employment, and other support services; and reduced use of emergency room, inpatient care, and jails. Although one-third of residents left within one year of entering the program, 40 percent of residents at the end of the second year of the program had been housed for a year or more.

The Shelter Plus Care program in **Alameda County,** California, represents a partnership of three key agencies: the Alameda County Housing and Community Development Program, the Alameda County Health Care Services Agency, and the Oakland Housing Authority. The three lead agencies administer the S&C program and work with 22 local housing or support service agencies to provide permanent housing with supports to formerly homeless persons with multiple disabilities, primarily alcohol or drug problems, mental illness, and/or AIDS.

In addition to multi-system collaboration, the Alameda County S&C program also features a strong commitment to involving consumers in the development and operation of the program. For example, a committee comprised of a cross-section of providers and homeless or formerly homeless consumers advises the administrative team. In another example, several of the support service agencies in this collaborative effort are consumer-run organizations. Consumers of all kinds of related services – homeless, mental health, substance abuse, and AIDS services – provide case management, peer support, outreach and engagement and other services to homeless persons eligible for S&C (Fosburg, Locke, & Holin, 1994).

HRSA's Health Care for the Homeless Program

The Health Care for the Homeless (HCH) Program is administered by the Health Resources and Services Administration's Bureau of Primary Care. Building on an earlier demonstration sponsored by the Robert Wood Johnson Foundation, 128 programs are funded nationwide to arrange for the delivery of health care, outreach, and case management to homeless individuals and families. Through formal subcontracts with 322 more community-based agencies and informal relationships with countless others, this program places a strong emphasis on advocacy for systems change, increased coordination of services across systems, and participation in multi-system coalitions where service delivery to homeless persons is the primary goal.

The Bureau supports these goals through technical assistance and information dissemination to grantees and other interested parties. In a study of HCH programs conducted in 1985, HCH programs were found to use a variety of strategies to reduce systems and organizational barriers to care for homeless persons (Cousineau, Wittenberg & Pollatsek, 1995). These strategies included collaboration with providers of housing and other support services, using mobile units to bring services to people, developing satellite

clinics in shelters and soup kitchens, providing case management and outreach services, and advocacy with policy makers at all levels.

CMHS/CSAT's Prevention of Homelessness Program.

An integrated service system may mean the difference between someone at-risk of homelessness who remains stably housed and one who repeatedly cycles into and out of homelessness. In 1997, after a one-year manualization phase, the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) began testing interventions designed to prevent homelessness among persons with serious mental illnesses and/or substance use disorders at eight sites (Rickards et al., in press).

The program focuses on three common pathways to homelessness: (1) housing loss; (2) diminished family support, and (3) misuse of financial resources. In order to demonstrate the prevention of homelessness, the target population formerly homeless or at risk for homelessness, is already engaged with the mental health and/or substance abuse treatment systems. In order to prevent homelessness, clients are linked by either a case manager or a community support specialist to services which cut across multiple systems. None of the eight sites are testing systems-level integration activities. The cross-site evaluation will focus, as do the interventions, on services-level impacts on client outcomes.

The Health Care for the Homeless Network (HCHN) in **Seattle,** Washington, is a project of the Seattle-King County Department of Public Health. HCHN has created a continuum of health and social services for homeless people by combining direct services provided by public health staff and contracts with local hospitals, community health centers and other community- based organizations. The public health department provides such direct services as, TB outreach and directly-observed therapy, immunizations, communicable disease control, parent-child health, family planning, WIC, dental screening and referral, and health education for more than 70 area shelters.

Contracted services include outreach, primary care, chemical dependency and mental health counseling, medical respite care, and assistance with enrollment and use of Medicaid managed care. As an HCHN contractor, Harborview Medical Center outreach workers and nurses provide triage, assessment, episodic care, referral and follow-up. Clients are enrolled in the Harborview system for outpatient and inpatient care. Those who need a place to recover upon release from the hospital are admitted to the HCH medical respite program and from there are discharged to emergency or transitional housing (McMurray-Avila 1997).

The CSH Health, Housing and Integrated Services Network

In 1996, the Corporation for Supported Housing began a demonstration project to develop a model managed care system for homeless adults with special needs in San Francisco and nearby Alameda County, California. The Health Housing and Integrated Services Network is a partnership that includes county health departments and public housing agencies in five counties and more than 20 non-profit organizations that provide residential and outpatient mental health and substance abuse treatment services, health care, social and vocational services, money management, peer support,

Founded in 1992, Pathways to Housing was created to serve New York **City's** street-dwelling, mentally ill homeless population. The agency specifically seeks out persons who have been turned away from other housing programs because of active substance abuse, refusal to participate in psychiatric treatment, and/or histories of violence or incarceration.

Key to the program's 85 percent success rate in keeping people in housing for one year or more is offering immediate access to scattered site housing coupled with intensive support provided by an assertive community treatment (ACT) team. With caseloads averaging about 10:1, ACT teams function as the services integrator for individual tenants linking or providing whatever the tenant needs or wants to achieve his or her long-term goals such as continuing education, job training, psychiatric and substance abuse treatment, and reconnecting with family or friends (Pathways to Housing, undated).

affordable housing and employment opportunities for people who are homeless or at risk of homelessness, mentally ill, living with HIV/AIDS or other chronic health problems, or struggling with drug or alcohol problems.

The Network's goal is not only to deliver integrated services, but to demonstrate a model for financing integrated services through the creation of a non-profit managed care provider system linked to supportive housing (Wilkins, 1996). The Network has begun to create and analyze the data necessary to establish appropriate reimbursement rates and funding mechanisms for this population and to document the cost effectiveness of housing-based service interventions as part of managed care systems. Support for this initiative is provided by the Robert Wood Johnson Foundation, the California Endowment, Rockefeller Foundation, the City of San Francisco, HUD, Medicaid reimbursements, and other public and private funders. The project is being evaluated by researchers at Vanderbilt University and others.

RWJF Homeless Families Program

In 1990, the Robert Wood Johnson Foundation and the Department of Housing and Urban Development launched a five-year program in nine cities across the nation designed to restructure the systems of health, support services and housing for homeless families. Each site received approximately $600,000 over five years to facilitate systems of care for homeless families and to demonstrate a model of services-enriched housing for a group of families. A memorandum of understanding was developed with the local public housing authority which provided 150 HUD Section 8 certificates to each project. Case management was provided or arranged by the lead agency.

Evaluators of this initiative found that the projects tended to focus on temporary or small-scale "fixes" to improve service delivery for the families they were serving (Rog & Gutman 1997; Rog et al 1997). Systems changes – enduring reformulations in the structure of a system were rare. The one exception involved changes in the role of the public housing agency. Through their participation in the program, several housing agencies increased their awareness of the needs of homeless families and they became more active participants in developing supportive housing for this population. However, the role of the Foundation and HUD appear to have been key factors in facilitating this change.

Situated within the Colorado Coalition for the Homeless, the Metro Denver Homeless Families Program is a collaboration of the City of Denver, two county governments, several public housing authorities and a large number of service providers, including the Health Care for the Homeless program. A 26-member Governance Council was streamlined and restructured over time into three independent committees – executive, operations, and policy and resources – which provide strong leadership. Project staff and the Governance Council set priorities and identified existing resources for housing and mental health and substance abuse treatment.

The group expanded its resource base, staff and the services it provides with several major grants, including the Community Development Block Grant and HUD and HHS grants for rental assistance vouchers, transitional housing, housing location services, case management, homelessness prevention and children's services. They were also able to secure an eligibility worker from the Department of Social Services to work with families as they began to look for housing. By planning and collaborating at all levels, this group was able to create together what no agency had been able to build alone (Rog, Hambrick, Holupka et al., 1994)

The ACCESS Program

The ACCESS (Access to Community Care and Effective Services and Supports) program, supported by SAMHSA's Center for Mental Health Services, was established as a five-year demonstration program to develop integrated systems of care for homeless persons with mental illness in nine states. Using a quasi-experimental design, each of nine states identified two comparable sites, one of which was randomly assigned as the- experimental site (the systems integration site) and the other one became the comparison site.

Both sites were provided funds to enhance services for the target population, particularly intensive outreach and case management services. Thus, their capacity for *services* integration was equalized. The experimental sites were provided with additional funding to support activities to improve *systems* integration. The core research question of the evaluation is whether higher levels of systems integration result in improvements in clients' functioning, quality of life, and housing outcomes (Randolph et al., 1997; Randolph 1995).

The cross-site evaluation of the ACCESS program represents the most ambitious attempt to date to understand the mechanisms used by communities involved in a major demonstration focused on the integration of service delivery systems. It demonstrates that it is possible to move beyond a case study approach in examining systems integration strategies across multiple sites and that standardized measures can be meaningfully and reliably used. A number of descriptive and interim findings have been published thus far (Lam & Rosenheck 1997; Morrissey et al 1997; Rosenheck & Lam 1997a, b, & c; Rosenheck, Lam & Randolph 1997; Rosenheck et al, 1998). Preliminary findings specific to the implementation and impact of systems integration activities are reviewed in the next section.

Overcoming a history of "homeless wars" among providers is not first on the list of accomplishments likely to be cited by the **Wichita,** Kansas, ACCESS program. They are much more likely to talk about providing stable housing, mental health treatment and other support services to hundreds of homeless persons with serious mental illnesses over the past five years. But they would be the first to admit that they couldn't have done the second without the first. Through community-wide strategic planning focused on homelessness more generally, COMCARE, the local mental health authority and the lead agency for the Wichita ACCESS program, was able to bring local business leaders, city and county agencies and local providers to the table to meet the needs of homeless people in Wichita, including persons with serious mental illnesses.

They did it by adopting a variety of systems integration strategies, including: developing a local planning body that included city representatives, non-profit agencies, and business leaders; hiring a staff person to focus on systems integration activities; using a formal strategic planning process (repeatedly) to address problems that could not otherwise be resolved by a single provider; providing education and training for agency staff and lay persons; being willing to apportion federal, state, and local resources among providers in ways that were more rational than political; and delivering on promises to provide outreach and case management services responsive to the needs of clients and the community.

Research on Systems Integration and Homelessness: The ACCESS Evaluation

Until recently, evaluations of integration initiatives have relied largely on observations of differences between client outcomes in the experimental and the control or comparison groups. But the mechanics of systems integration-what strategies were most effective, why communities using similar strategies have different outcomes, etc.-remained subject to speculation at best.

One of the most sophisticated and promising studies of systems integration is the evaluation of the ACCESS program. Preliminary findings from this study comparing client outcomes in the nine integration and nine comparison sites are have found greater access to housing for clients in the more integrated sites (Rosenheck, et al., 1998). The ACCESS evaluation is also looking at changes in systems integration over time as well as the strategies used by communities to achieve systems integration.

The nine ACCESS systems integration sites employed between six and ten of the systems integration strategies listed in Figure 1. Three strategies were used by all nine systems integration sites:

- the creation of a paid systems integration coordinator position;
- the development of a local interagency coordinating body; and
- a formal strategic planning process.

Based on a series of structured observations over a five-year period, these three strategies appear to be key factors in the level of integration achieved by the sites. Six other strategies were used by the majority of sites: the development of interagency management information systems, pooled funding arrangements, cross-training programs, interagency agreements, co-located services and state-level interagency coordinating bodies (Cocozza, Steadman & Dennis, in press).

It is important to note that targeted funding for systems integration was not, by itself, sufficient to ensure the successful development and implementation of system integration strategies. Given competing priorities (such as the need to recruit clients and provide services) and the lack of knowledge and experience about systems integration, it became evident during the first two years of the program that sites were having difficulty developing and implementing their systems integration strategies (Randolph et al., 1997). In response, a series of technical assistance efforts, sponsored by CMHS, were held for the systems integration sites. These were followed by on-going support and assistance to the sites. This assistance helped sites revise their strategic plans, clarify their objectives and strategies, reallocate staff and resources, and focus more directly on systems integration.

The strategies used by the sites remained relatively stable over the first four years of the program. Significant technical assistance was provided to the sites between their second and third years. Some of the changes, like the establishment of a staff position to coordinate systems integration activities at all sites, reflect this assistance. Changes that occurred between the third and fourth years include greater use of pooled funding and interagency MIS/client tracking systems and the first use by any site of strategies involving the consolidation of programs/agencies and the use of special waivers. These changes seem to reflect not only a further refinement of the sites' overall plans for systems integration but also the result of activities that require both time and a well-functioning infrastructure (e.g., a coordinator and a coordinating body) to bring to fruition.

Although the comparison sites could not use grant funds to support systems integration, initiatives were sometimes underway within these communities that resulted in better systems integration. For example, in one comparison site a local elected official established a city-wide coordinating body on homelessness. In six of the nine comparison sites at least one initiative was occurring that paralleled the strategies being implemented in the systems integration sites. But systems integration activities were much more likely to be occurring at the systems integration sites than in the comparison sites. The one strategy found most often in the comparison sites was the existence of an interagency coordinating body – one of three strategies also occurring most frequently in the systems integration sites.

Although almost all experimental sites had made significant progress in implementing their systems integration strategies, no site had fully implemented all of their strategies by the fourth year of the program. Some strategies, such as developing an interagency client tracking system (or MIS) or the establishing a uniform application and eligibility criteria, have been more difficult to implement than others (e.g., establishing an interagency coordinating body, creating a systems integration coordinator position, and developing interagency agreements. In the four sites that chose to develop an interagency MIS, *none* had achieved even a moderate level of implementation by the end of the fourth year.

Making Systems Integration Work: Recommendations for Practice

There is a wealth of information and advice available to those who want to create systems change in their own localities. It ranges from syntheses of the possibilities and challenges of systems integration (c.f., Yessian, 1995; CMHS 1993; Kahn & Kamerman, 1992; Gardner, 1991; Agranoff, 1991) to guidebooks with detailed step-by-step instructions on how to implement specific aspects of systems integration (c.f., Marzke & Both 1994; U.S. Dept. of Health & Human Services 1985, undated; National Association of Area Agencies on Aging 1992; Bruner 1991; National Assembly of Voluntary Health & Social Welfare Organizations 1991; Homelessness Information Exchange 1987). Some of these are geared to formally developed projects with some funding to pursue systems integration, but, to varying degrees, these principles are relevant to more informal systems integration efforts.

- ***Leadership.*** Systems integration across multiple systems is time-consuming and difficult work requiring vision, initiative and capacity for follow-through. Without a paid staff person (or persons) whose time is dedicated to these activities, large-scale systems change is nearly impossible. The result is usually added responsibilities for already overburdened administrative staff. This finding has been reinforced by observations from other integration initiatives (Pitcoff 1998; Cocozza, Steadman & Dennis, in press).

  Second, the person charged with systems integration must be someone with enough experience and at a level high enough to interact with and to engage decision-makers in other systems. Without the capacity to bring key players to the table *and keep them there,* there is little chance for real change. Third, study after study has identified leadership as an essential element in generating and sustaining collaborative efforts. Distinguishing features include vision, entrepreneurship, political astuteness, a respect for diversity and a talent for managing complexity (Yessian 1995). As one national evaluation team put it, "Strong leaders who instill a top-down commitment to collaboration, innovation from the bottom-up, a spirit of mutual trust and collaboration, and who have a vision for achieving broader system reform that transcends the needs of individual organizations" (Lewin-ICF and MDS Associates 1992).

  Finally, for efforts that cut across multiple systems and categorical funding, some experts and researchers suggest that leadership be exerted by a central authority (Yessian 1995). This is especially important if the organizations involved do not have a history of working together well. But this is not an iron-clad rule. There are plenty of examples of an effective, trusted leader operating out of a single agency who has been able to effect multi-system, community change. The leadership qualities described above are personal more than institutional, and the people embodying them might be found at various points in a constellation of community agencies.

- ***Local Coordinating Body.*** Systems integration must involve key stakeholders who have the resources and/or the authority to create change. When addressing homelessness, this includes

business leaders, public officials, non-profit service agencies, housing agencies, local police, as well as formerly homeless persons. Without broad-based community support for the level of effort and resources required to create an integrated service system, other needs are likely to take priority. Current or former service recipients should be involved in all stages of planning and implementation.

Efforts must be made to insure that staff from different agencies develop formal and informal communication networks, learn about and take advantage of each other's areas of expertise, and develop a shared commitment to serving the target population in a comprehensive collaborative manner. More than one promising services integration effort has been disrupted by interagency conflicts, often based on long-held misunderstandings at the provider level. By establishing a forum that allows for personal relationships to develop among constituencies with competing or conflicting interests, the groundwork is laid for discussion of common goals.

- ***Strategic Planning With An Emphasis On Outcomes.*** "Failing to plan for a better system, is planning to fail" (Gardner, 1991). Without a clear sense of what communities offer and what they need to improve, service integration efforts have no direction, no means by which to evaluate their progress, and no basis on which to build the public's, or anyone else's, trust. Most of the nine systems integration sites in the ACCESS Program were floundering after a year of funding until they each undertook a formal strategic planning process in their communities (Randolph et al., 1997).

  Often overlooked, but critically important, is identifying the specific types of measures that will be used to gauge success and making the commitment to collecting the necessary data on an on-going basis. Rather than documenting program outputs, such as the number of clients served or placements made, systems integration efforts are better served by pursuing client outcome measures such as the continuous quality improvement model that has been used widely in industry and health care (Yessian, 1995). Key elements of this model are:

  - A collaborative process to identify relevant performance measures;
  - A mechanism for collecting data and presenting them in ratio formats that facilitate comparative analysis; and
  - Broad dissemination to foster a greater focus on results and on the value of current operating approaches (Yessian, 1995, p. 39).

- ***Flexible Funding/Adequate Resources/Fiscal Incentives.*** Systems integration projects must not only have a clear sense of direction, they must also have the means to get going. Without flexible funding or regulatory relief, systems integration efforts start in an extremely weak position. They find themselves almost entirely dependent on the responsiveness of specialized human service agencies that are focused on their own goals and processes and concerned about the insufficiency of their own resources.

  With some discretionary funding or the authority to waive some existing rules, new possibilities arise. Although systems integration projects still depend on the participation of these agencies, the projects can now leverage the cooperation and resources of other agencies to stimulate action (Yessian, 1995). Sometimes new funding, from a Government or private source (as in the Robert Wood Johnson Foundation initiatives and the ACCESS Program) may also provide the stimulus for change (CMHS, 1993). Other initiatives are able to "piggy back" onto larger changes that create fiscal incentives for systems change, such as managed care and welfare reform.

- ***Focus on Both Services and Systems Integration.*** Throughout this paper the emphasis has been on creating change through systems integration. But efforts that focus solely on the organizational-level without addressing the service delivery or client level are often "hollow, paper agreements" (Agranoff, 1991). Equally important are strategies that focus on the coordination of services to individual clients, such as intensive case management (see Figure 1).

  During visits to the ACCESS integration sites, case managers cite the efforts of systems integrators for educating other providers, local business leaders, and public officials about the service needs of the population; for garnering new resources and opening doors to needed services; and for increasing the visibility of the program (and therefore the cooperation of other providers). But case managers were equally clear that "they can't do it without us." If the systems integrators could not back up promises to deliver high quality and timely services to clients, other providers would have been less likely to come to the table, and more importantly, to stay there.

- ***Long-Term Commitment.*** Old ways of doing business die hard. There may be some resistance at all organizational levels, and it will take time and effort to build a system that truly delivers integrated services. As with any new initiative, a trial period should be expected during which continuing reorganization and refinement of goals may occur (CMHS, 1993).

  Given that most such efforts do not have dedicated funding for systems integration activities, it is important to remember that while large-scale systems change may be the goal, incremental change is more often than not the method by which most systems evolve. It needs to be recognized as an important interim goal in its own right (Yessian 1995).

- ***Need for Technical Assistance.*** In study after study of systems integration, the need for technical assistance arises as a key juncture in the program (c.f., Randolph et al., 1997; Rog & Guttman, 1997; Orwin, 1995; Cohen & Somers, 1990). Too often, that need is ignored because the programs do not recognize it in time, or they do not know specifically what they need or want from technical assistance, or the programs or funders wrongly assume that it is a luxury that they cannot afford.

  Where technical assistance has been available to help communities "over the hump," they are not only moved beyond an impasse, but they can be jump-started to a higher level of activity and renewed commitment. Having successfully worked through a difficult time together as a community becomes a bridge to help overcome future obstacles.

  Technical assistance can take many forms. It may be having an outside facilitator come in to lead a strategic planning session, taking key stakeholders to visit a similar effort in another city, or offering training on a topic that the group is struggling with.

Conclusion: Recommendations for Policy and Research

Successful systems integration requires a commitment by key decision-makers to an on-going planning process and the resources (financial and political) required to implement it. As the RWJF Program on Chronic Mental Illness so aptly demonstrated and as local experience with the Continuum of Care is beginning to suggest, commitment without adequate resources is not enough. Systems integration efforts cannot impact client outcomes if the resources to provide the services being integrated are not adequate to meet client needs. Because no single service system can meet the all the needs of homeless people,

efforts at systems integration are essential to maximize the potential for individuals to reach a sustained level of self-sufficiency.

There are a number of ways in which federal and state policy could encourage systems integration at the local level.

- Model the desired behavior by conducting more interdepartmental planning and joint funding of programs in order to encourage interagency coordination and integration at the local level. Offer incentives to encourage systems integration and monitor outcomes.
- Strengthen federal and state Interagency Councils on the Homeless. Empower the federal Interagency Council on the Homeless to do systems integration on the federal level. Do the same with state Interagency Councils on the Homeless.
- Issue a joint agency NOFA (Notice of Funding Availability) from HUD and HHS (or their equivalents at the state level) that requires housing and service providers to respond jointly to address the needs of homeless people.
- Provide technical assistance to communities that demonstrate a willingness to increase systems integration, Such technical assistance might range from on-site consultation to a public awareness campaign designed to educate communities about how to achieve systems integration to targeted regional forums or trainings on systems integration.

In our effort to understand the relationship between systems integration and helping homeless people, there are a number of issues that warrant further research. Research needs to be conducted in the following areas:

- The impact of the HUD Continuum of Care planning process on client outcomes and systems integration at the local level.
- The use of systems integration strategies to ensure effective discharges (and prevent homelessness) from jails, prisons, and hospitals.
- The efficacy of involving systems that have not, thus far, been the focus of systems integration efforts for homeless people—for example, the criminal justice system and.. employment and vocational services.
- The ability of systems integration to endure over time— for example, after federal funding ends or a charismatic or political leader departs.
- The cost effectiveness of systems integration efforts, presumably as they reduce duplication and produce more efficient use of resources.
- The efficacy of incentives and monitoring on the effectiveness of systems integration efforts.
- The relationship of state and federal activities to systems integration at the local level-identifying the most effective roles of each and the degree to which efforts at one level can be generalized or used at another.

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Rethinking the Prevention of Homelessness

by
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Abstract

The General Accounting Office's 1990 conclusion about the prevention of homelessness still holds: It remains "too early to tell" what works best. Eviction prevention programs show some promise but have not been rigorously evaluated and tend to exclude people at highest risk of homelessness. Several studies suggest that individuals with severe mental illness can be supported in the community, but the mixture of housing and supportive services necessary remains unclear. There is even less evidence for the usefulness of planning discharges from institutions or of programs to ameliorate domestic conflicts. However, even if expanded to reach 100 percent of their target populations and even if 100 percent successful, all of these programs together would reach only a minority of the people who become homeless each year, and targeting efforts would yield many false alarms for each future case of homelessness correctly identified. Based on evidence that subsidized housing, with or without supportive services, is sufficient to end homelessness for most families, and given the important role of subsidized housing (everywhere it has been examined) in ending homelessness among people with serious mental illnesses, we propose a shift to selected strategies of prevention, such as providing housing subsidies to those with worst-case housing needs, supporting employment and transitional assistance to poor, young people setting up households for the first time, and focusing efforts on communities from which large proportions of homeless people originate.

Lessons for Practitioners, Policy Makers, and Researchers

- Practitioners and policy makers should keep their goals clearly in mind. Morespecifically, they should remember that preventing homelessness is not identical with ending poverty, curing mental illness, promoting economic self-sufficiency, or making needy people healthy, wealthy, and wise. These are worthy goals, to be sure, but we believe that when attached to the objective of preventing homelessness or rehousing homeless people, these diffuse goals take on lives of their own and raise troubling questions of equity in the distribution of resources available to poor people.
- Every study that has looked has found that affordable, usually subsidized housing, prevents homelessness more effectively than anything else. This is true for all groups of poor people, including those with persistent and severe mental illness and/or substance abuse.
- Serious mental illness, while problematic in its own right, need not compromise an individual's ability to maintain housing; evidence regarding substance abuse is more mixed.
- Although social services are valuable for other reasons, it is not clear how much they contribute to preventing homelessness once access to subsidized housing is controlled. Studies of services that do not examine housing subsidies suggest that services are useful; studies that control for housing subsidies suggest that the intensity of services is unrelated to housing stability.
- Income supports are also related to housing stability, probably because the affordability of housing is a joint function of income and housing costs. Advocacy for entitlement income may be a key ingredient in case management.

- Some eviction prevention programs seem promising, but none have been studied rigorously. We need more research with long-term follow-up.
- Consumer choice in housing is associated with residential stability for people with mental illness and/or substance abuse problems. This suggests that a range of living options is valuable, with different degrees of social control and expectations for behavior.
- There is no evidence linking brief discharge planning efforts with reduced homelessness, although they may be useful as part of broader, more enduring services, including the provision of housing.
- Because homeless people in some cities come mainly, from a few areas of highly concentrated poverty, it makes sense to test strategies of community development that combine housing development and subsidy, market-based economic development, supported work, public employment, and social services.
- Because there is little research with long-term follow-up, it is impossible to know whether short-term interventions are sufficient to prevent homelessness. In contrast to the prevailing philosophy of time-limited benefits, in our view, it is likely that the shortcomings of the housing and labor markets require indefinite and expanded intervention by the state in both individual cases and in the aggregate. Tax expenditures on home mortgages, which benefit the well-to-do disproportionately, represent a long-term public investment in home ownership that dwarfs housing subsidies for the poor.

Introduction

Anyone who has passed a person sleeping in a doorway, seen a family with their belongings heaped in a shopping cart, observed makeshift dwellings under a bridge, or visited a shelter where strangers lie warily on adjacent beds, is likely to have thought that, surely, such scenes could be prevented. In our view, homelessness in the United States could be avoided, for the most part; and yet we are not sanguine about the prospects. A lack of resources, even in the midst of the century's most sustained peace-time economic growth, is not the only obstacle, though it is the most formidable. In addition, many current efforts to prevent homelessness may not be based on sound premises. Moreover, tributes to their effectiveness are statements of faith that cannot withstand serious, scientific scrutiny.

In this essay we cast a critical eye on existing measures to prevent homelessness. By way of further introduction, we discuss the logic and basic terminology of prevention. Next, paying careful attention to the conceptual and methodological issues involved, we review research on programs that aim to prevent homelessness. We conclude that most such efforts do useful things for needy people, but they seem to have only marginal impact on the prevention of homelessness. In view of the conceptual and methodological quandaries we identify, and the empirical findings we review, we recommend that homelessness prevention be re-oriented from efforts to work with identified at-risk persons to projects aimed at increasing the supply of affordable housing, sustainable sources of livelihood, and the social capital of impoverished communities.

The Logic of Prevention

Simply put, to prevent means to keep something which would have happened from happening in fact. At a minimum, the logic of prevention requires that its critical terms be specified in detail and that we be able to tell if the effort has been successful. Thus, we must be able to define clearly what is to be prevented, we must be able to specify the intervention(s), and we must be able to establish a causal (or at least correlational) connection between intervention and the demonstrated avoidance of the undesirable phenomenon. Other things equal, the more narrowly we define what is to be prevented, the more elegant the intervention, and the more rigorous the experimental design of evaluation, the easier the task of determining effectiveness. Thus, the prototypical example is of a discrete disease entity (say, polio), preventable by vaccination (a simple, easily standardized intervention), where effectiveness can be demonstrated clearly by comparing outcomes in vaccinated and unvaccinated samples.

Alas, most unwanted phenomena are more like suicide than polio. They have ambiguous definitions (when is a suicide attempt "real" and thus to be counted as a case?); they have multiple causes; they are only somewhat responsive to a variety of interventions; and outcomes are difficult to assess by rigorous means (the determination of suicide after the fact is notoriously problematic). Moreover, most interventions are complex, difficult to standardize, and often implicated in an unwitting redefinition of the phenomenon by virtue of the rewards or penalties they distribute. (For example, a "right to shelter" provision may cause some people living in crowded or deficient housing to present themselves at shelters, thus redefining their circumstances and the nature of what we call homelessness.) Only in the most strained metaphors are social interventions anything like vaccinations.

Note, too, that prevention involves predicting the future. To determine whether an intervention is successful, we must know the likelihood that the unwanted will occur so that we may compare this with the actual outcome following intervention. Not everyone will get even an easily transmissible disease. In the case of a relatively rare phenomenon, few will be affected. Thus, to allocate resources efficiently, or to ration scarce resources, prevention programs **target** particular subjects who have been "exposed"

(in the language of disease) or who are, by some theoretically plausible or empirically determined criteria, "at risk" of being affected. An example of effective targeting is the prevention of mental retardation due to phenylketonuria. A simple, inexpensive blood test, shortly after birth, accurately identifies infants who lack the enzyme that metabolizes certain proteins. Children can be treated successfully with special diets low in the amino acids that give rise to phenyls.

Unfortunately, most unwanted phenomena are not much like phenylketonuria. There is no one factor that accurately predicts them. Rather, there are usually a number of predictive correlates, with risk increasing as the number of such risk factors (the overall burden of risk) increases. Even so, the accuracy of such prediction often is not particularly high. This results in poor targeting and consequent inefficiencies in prevention programs even when the interventions work as intended. But the example of phenylketonuria is instructive in one important respect: Although the problem is the lack of an enzyme, the effective prevention measure does not replace the enzyme but modifies the child's diet instead. We will suggest that in the case of homelessness as well, the solution may not always match the problem directly.'

Prevention programs are of three ideal types (Mrazek & Haggerty, 1994, following Gordon, 1983). Universal prevention programs are available to the entire population, although they are sometimes targeted at people who have reached a particular period of life. Such programs may be narrow and inexpensive, such as childhood immunizations to prevent measles, or quite expensive and expansive, such as old-age pensions, intended to prevent poverty among the elderly; subsidized housing programs intended to prevent homelessness; or the wholesale construction of water treatment facilities to prevent water-borne disease. As these examples suggest, prevention programs (of all types) may involve strengthening individuals (a measles vaccine) or changing the environment (water treatment).

Selected prevention programs are aimed at people at risk due to membership in some group. No individual screening is required for participation. For example, an educational program might be aimed at occupational groups at risk of repetitive motion injuries.

Indicated prevention programs are directed to people at risk because of some individual characteristic or constellation of characteristics. Individual-level screening is required. Programs to mitigate the consequences of genetic diseases are of this sort.

Ideal types are heuristic devices, of course, and distinctions among types of prevention are often fuzzy. For instance, people discharged from mental hospitals comprise a group at risk of homelessness, but also have the individual risk factor of prior mental hospitalization. A universal housing program may, in fact, be attractive only to those who are poor (an individual risk factor).

Selected and indicated strategies may be more efficient than universal measures when it is easy to identify and deliver interventions to groups of people or individuals at risk for a particular condition. The efficacy of targeting is thus of fundamental importance to the design of prevention programs, and the costs of targeting must be compared with the costs of offering programs more broadly or allowing people to select themselves for universal programs attractive only to those with high levels of perceived need.

A prevention program is at least somewhat effective if it reduces the overall incidence of a problematic condition (the number of people who newly become affected over some defined period) or its prevalence (the number of people affected at a particular point in time, or over some defined period). Showing that most people who use the program do not become affected is insufficient. Perhaps they would not have

1 Put more technically, the solution is not "isomorphic" with the problem.

been affected in any case. Perhaps the condition has been delayed, but not averted. Or perhaps some aspects of the intervention have encouraged or allowed consumers of the program to simply "jump the queue" to receive services, so that others, pushed back in the queue, are at greater risk.

Finally, programs can focus on preventing new cases of something (usually called primary prevention) or on the early identification and treatment of current cases (usually called secondary prevention). Secondary prevention efforts may reduce the prevalence of a condition, but they do not reduce its incidence.

Later in this essay we will consider whether homelessness prevention programs fulfill these logical requirements. Here, though, we need to establish the operational definition of our subject. If homelessness is the undesirable phenomenon we wish to prevent, we need to specify it, for without a definition, we will not be able to identify the subjects ("targets") of our efforts, nor will we be able to identify the presence or absence of the condition.

The simplest approach is merely to adopt the conventions of the federal government and most survey researchers (see Burt, 1996). Indeed, since the programs we will review are guided by these conventions, this is a sensible restriction for the purposes of this paper. Simply stated, people are homeless when they live without housing or take up residence in shelters. People are "at risk" of homelessness when they have lost security of tenure in any residential setting, whether a household or an institution. Typically, homelessness prevention programs are concerned with preventing shelter entry, a criterion that is amenable to relatively easy measurement and encompasses a major public cost of homelessness even if it fails to capture private burden.

Still, consider some of the important questions begged by this definition with respect to what constitutes prevention. The size of the shelter population is driven in large part by the number of beds available and policies regarding access to them; that is, admission criteria, limits on length of stay, and so forth (e.g. Culhane, Lee & Wachter, 1996). If a shelter turns applicants away, or evicts residents after some fixed period, the count of homeless people may be limited, but it is not clear that those denied access are better off even if they do not end up on the street. Indeed, subjectively they are not, for they preferred shelter to whatever other arrangements were available. Should we then say that homelessnes's'has been prevented for those who are denied shelter but find some arrangement short of literal homelessness? Similarly, if officials intentionally make entry into a shelter system aversive, so that some people who would otherwise apply for shelter decide to stay in overcrowded or deficient housing, should we say that homelessness has been prevented?[2]

Further, studies that follow the "careers" of homeless people over time show that, for single adults, "the state of homelessness appears to be more a drift between atypical living situations and the street than between normality and street life" (Sosin, Piliavin & Westerfelt, 1990:171). The atypical situations, such as staying with friends, do not appear to be sustainable. Should we say that homelessness has been prevented if people make the rounds of friends and family, constantly doubling up in precarious situations? Similarly, many homeless people with severe mental illnesses and substance abuse problems travel "institutional circuits" that include mental hospitals, prisons, or jails as well as shelters, shared or doubled-up arrangements, and the street (Baumohl, 1989; Hopper, Jost, Hay, Welber & Haugland, 1997; Milofsky, Butto, Gross & Baumohl, 1993; Snow & Anderson, 1993; Spradley, 1970; Wiseman, 1970).

[2] In 1985, worried that hotel rooms drew people out of sub-standard housing and into the shelter system, New York City made congregate shelters-where scores of families lived in a single, large room with rows of cots-the entry point to the shelter system for families. Said Mayor Koch, "We are going to, whenever we can, put people into congregate housing like the Roberto Clemente shelter-which is not something people might rush into, as opposed to seeking to go into a hotel" (Basler, 1985).

Has homelessness been prevented if people are temporarily moved from one such housing status to another?

Thus, criteria for successful prevention are established within the boundaries of the problem's definition. The operational definition of homelessness employed here is more convenient than theoretically satisfactory, but it will serve. (For a theoretical reformulation, see Hopper & Baumohl, 1994, 1996.)

Conceptual and Methodological Problems in Preventing Homelessness

The Problem of Targeting

Many studies have identified factors that reliably distinguish people who are homeless from some comparison group. Lindblom (1991: 963) suggested targeting prevention assistance based on a profile of risk factors that could "identify the lion's share of those extremely poor persons who will enter or reenter homelessness if they do not receive outside help." He also noted (1996: 188) that "only a small portion of the persons targeted by many prevention programs are actually at risk of repeated or prolonged homelessness." We know of only one study of the efficacy of targeting or forecasting the onset of homelessness (Knickman & Weitzman, 1989; Shinn, Weitzman, Stojanovic, Knickman, Jimenez, Duchon, James & Krantz 1998). This study examined 20 potential factors, including measures of demographic characteristics, persistent poverty, behavioral disorders, social ties, and housing that might distinguish between families on welfare who requested shelter in New York City from other New York City families in the public assistance caseload. Families who had used shelter previously were excluded from both groups. The authors used these factors to construct various multi-predictor models to forecast homelessness. Although 18 factors were related to homelessness, taken one at a time, the "best" multivariate model included 10 predictors. These variables made reliable contributions to the prediction of homelessness in the context of the other variables in the model.[3]

The model yielded a score summarizing risk for each family in the study. Choosing who should be eligible for a prevention program corresponds to choosing some cutoff for risk scores: Families with scores higher than the cutoff would be eligible; families with scores lower than the cutoff would not be served. A liberal cutoff score, selected to deliver prevention services to a large portion of those who would otherwise become homeless, also targets many families who would not become homeless in the absence of services ("false alarms"). A conservative cutoff yields fewer false alarms but also has a lower "hit rate;" that is, it reaches fewer of those who would become homeless without preventive efforts.

[3] Two of three demographic factors were included in the best model: race/ethnicity (African Americans were at greater risk than Latinos or others), and being pregnant or having an infant under the age of one year. (Youth was related to entering shelter when taken alone, but ceased to be significant when housing factors were entered into the equation, suggesting that youth affected homelessness primarily via access to the housing market.) Two of five measures of human capital or likelihood of remaining persistently poor were included: childhood poverty (defined as receipt of welfare benefits by the family of origin when the respondent was a child) and being married or living with a partner. Surprisingly, marriage increased risk for homelessness. Education, work history, and having been a teen mother were not predictive in the context of other variables. Two measures of disruptive social ties contributed. These were domestic violence in adulthood and family disruption in childhood (a scale that included foster care or other types of separation from the family in childhood or childhood abuse). Positive ties reflected in the respondent's personal network were not predictive in the multivariate model (and at the univariate level, homeless mothers actually had stronger networks than housed mothers; 80 percent had stayed with network members before requesting shelter). Finally, four of five housing factors (doubling up with others, lack of subsidized housing, frequent moves, and overcrowding) predicted shelter entry. Building problems did not because they were almost as severe for poor but housed families as for those who became homeless, None of the four measures of behavioral disorder (mental illness, substance abuse, health problems, or imprisonment) differentiated between homeless and housed samples in the context of other variables, so all were excluded. Note that levels of these problems are relatively low in homeless families generally.

Thus, a plot of hit rates versus false alarm rates for different predictive models is a very useful policy tool (Camasso & Jagannathan, 1995; Swets, 1973 & 1988). Shinn et al. (1998) found that the best model was able to correctly "hit" 66 percent of welfare families who requested shelter with a false alarm rate of only 10 percent.[4]

While this ratio of hits to false alarms may sound good, the population to which the false alarm rate refers is far larger than the group who will end up in shelter. At the time the data were collected, there were about 290,000 families on welfare (over the course of a year) in New York City, and about 90 percent of the approximately 10,000 families who first entered shelter over the course of the year came from the welfare caseload. Thus, to correctly reach 6,000 families (90% of 66% of 10,000), a prevention program would have to offer services to 27,000 families (10% of 290,000, less those with previous shelter experience) who would not become homeless. With respect to preventing shelter entry, over 80 percent of the services would be wasted, although such help might be valuable to families for other reasons. A more narrowly targeted prevention program that confined false alarms to 2 percent of the public assistance caseload and reached only 36 percent of those applying for shelter, would still "waste" three-fifths of its services (correctly identifying 3,600 families against 5,400 false alarms). To reach three-quarters of families applying for shelter in New York City alone, one would need to target an additional 60,000 families who would not become homeless. In addition to the problem of wasting services on those who will not become homeless, there is the problem of failing to serve those who will become homeless. Even a targeting cutoff that wastes 80 percent of the services misses 34 percent of the families who in fact become homeless.

In addition, the best predictive model included some risk factors, such as childhood disruptions or domestic violence in adulthood that might be hard to assess or verify. If access to an attractive prevention program (such as subsidized housing or valued social services) depended on such risk factors, and the prediction formula became even roughly known (as it inevitably would), the targeting effort would create incentives for people to dissemble in order to obtain services and could create an adversarial relationship between service providers, charged with certifying eligibility, and their clients. Likely, reports of the key risk factors would increase, more people would be deemed eligible for services, and the predictive power of the model would decline.

Interestingly, a model with only seven easily verified predictors did almost as well as the full model at intermediate levels of risk (65% versus 66% hits at 10% false alarms, among families on public assistance). The model included the same two demographic characteristics as the best model and all five housing variables. However, this model did less well for narrow targeting and includes one factor (race) on which it would be illegal to base access to services.

Prevention programs could be developed based on predictive models targeting other groups (such as single adults or adolescents homeless on their own), and the New York model might not apply to families in other areas (correlates of homelessness vary by locale). Still, without continuously renewed data and analysis, all such predictive models are static. This is important, because unlike the case of phenylketonuria, the correlates of homelessness shift over time, both because the phenomenon itself changes (homelessness today is not exactly like the mass dispossession of the Great Depression or the more ambiguous homelessness of post-war skid rows), and because routes to shelter residence change, thus reconfiguring the populations found there (Hopper & Baumohl, 1994, 1996). Any predictive model,

[4] In the language of signal detection, a graph of hit rates vs. false alarms is known as an ROC curve (for receiver-operating or relative operating characteristic curve). In the language of epidemiology, the hit rate, or the ability to detect true positives, is known as sensitivity. The rate of detecting true negatives, or avoiding false alarms, is known as specificity.

then, is in jeopardy of becoming rapidly outdated and progressively inefficient. Today, most of what we know about correlates of homelessness comes from studies conducted nearly a decade ago, when economic conditions, for instance, were very different; and today's knowledge may not apply in the future, when, for example, a smaller fraction of the poor is eligible for welfare support. Homelessness is a dynamic phenomenon, chased but never really captured by research.5

One general lesson can be learned from the New York experience: A prevention program aimed at people with any single characteristic, such as those being discharged from mental hospitals, is likely to target only a small portion of all who become homeless; even sophisticated multivariate models with very narrow targeting (which therefore reach a very small proportion of those who become homeless) are likely to have far more false alarms than hits. A second lesson, perhaps less general, is that in the case of New York families, targeting based primarily on their housing status did about as well as models that took into account less verifiable indicators of individual risk.

If the outcome criterion to be predicted were months in shelter (which is more closely associated with public dollars spent than is simple shelter entry), it might be possible to develop more efficient predictive models. For example, Culhane and Kuhn (1998) show that in New York, 18 percent of single adult, first-time shelter users consumed 53 percent of the total days in shelter for first-time users in their first year. In Philadelphia, 10 percent consumed 35 percent of these days. The authors describe several individual factors associated with longer stays and repeat use of shelter (age, mental health and substance abuse problems, and sometimes medical conditions), but do not tell us how efficiently these high-consumers can be identified. (Such knowledge is crucial to the practical application of such data, of course.) Further, the criterion of months in shelter is problematic for another reason: The timing of exits from shelter depends in part on resources made available to residents. For example, in Philadelphia, people with serious mental disorders exited more quickly, whereas those with less serious disorders exited more slowly than those with no assessed disorder, probably because those with the most serious disorders were eligible for specialized services (Culhane & Kuhn, 1998). For families in New York, months in shelter was positively associated with subsequent stability in housing because a long time in shelter reflected movement to the top of the queue for subsidized housing (Shinn et al., 1998).

Most actual prevention programs use simple targeting strategies. A majority of the over 400 prevention programs receiving funds from the Emergency Shelter Grants Program in fiscal year 1991 used receipt of an eviction notice (52%) and/or a utilities shut-off notice (27%) to identify clients eligible for prevention services. (A program could use more than one criterion.) Sixteen per cent targeted victims of domestic violence (Feins, Fosburg & Locke, 1994a: 116).

5 In this connection, we should observe that there are several possible explanations for the persistence of homelessness during the last five years in spite of the unprecedented tight labor market. One possibility is that economic prosperity has had little effect in the lowest reaches of the income distribution from which homeless people come. Whether because the very poor have failed to secure adequate jobs due to lack of skills, lack of child care, or spatial isolation from centers of job growth, or because public assistance programs have become more restrictive, the poorest of the poor have not participated in the expansion. The latest census figures show that whereas child poverty decreased from 1995 to 1997, the proportion of children in families in extreme poverty (below half the poverty line) increased (Sherman, Amey, Duffield, Ebb & Weinstein, 1998). Also, despite the economic expansion, or perhaps because of it, the crisis in affordable housing is worse. A U.S. Department of Housing and Urban Development report (1999) notes that: 1) rents increased faster than incomes for the poorest 20 percent of American households from 1995 to 1997; 2) the number of units renting for less than $300 (adjusted for inflation) decreased by 13 percent from 1996 to 1998, leading to a loss of 950,000 such units; 3) federal support for affordable housing has been cut, leading to a drop of 65,000 in the number of HUD-assisted households from 1994 to 1998; and 4) private owners are dropping out of the HUD-assisted project-based subsidy program.

These programs are likely to reach only a small proportion of people who would otherwise become homeless. For example, among New York families requesting shelter, only 22 percent of first-time users had ever been evicted from any apartment (and many of these were informally evicted by the people with whom they were staying rather than receiving formal eviction notices from landlords), whereas 44 percent had never even had an apartment of their own for as long as a year since having children (Weitzman, Knickman & Shinn, 1990). By way of comparison, 6 percent of the public assistance caseload who had never used shelter also reported having been evicted. Because the public assistance caseload is far larger than the group of families who entered shelter, we estimate that a program that targeted welfare families facing eviction in New York would serve four or more families who would avoid entering shelter anyway for every family who would in fact enter shelter in the absence of the program, while reaching only one-fifth of the shelter population.[6]

The proportion of homeless families who have been evicted varies by time and location. Wood, Valdez, Hayashi and Shen (1990) found 34 percent with housing problems, including eviction, in Los Angeles (and many more with economic problems); Bassuk, Buckner, Weinreb, Brown, Bassuk, Dawson, and Perloff (1997) found that 26 percent of homeless families in Worcester-and 17 percent of housed poor families-had been evicted or locked out, suggesting that eviction prevention services would be far less efficient than in New York. Other studies, reviewed by Bueno, Parton, Ramirez, and Viederman (1989:8-9) reported percentages of homeless families who had been evicted ranging from 14 percent to 57 percent, with the high figures sometimes including other housing problems such as non-payment of rent. These studies did not give proportions of people evicted who ended up in shelter. Among residents of shelters that received funds from the Emergency Shelter Grant program in 1992, 14.8 percent came from rental housing and 6.7 percent from owner-occupied homes (Feins & Fosburg, 1998, Exhibit 9). It is not known how many of these people were evicted prior to entering shelter. It is possible that others who came to shelter from the streets or other locations had been evicted previously. But it seems safe to say that targeting people at risk for homelessness solely on the basis of eviction would not be very efficient.

The Problem of Effectiveness

After selecting people at risk for homelessness, based on a more or less sophisticated model, one must then determine what interventions will most readily prevent homelessness, at what cost. The best design for evaluating a prevention program is to randomly assign some proportion of people who meet some risk criteria to receive the specialized program. People who did not receive specialized services would remain free to use other services. Both groups would need to be followed for some reasonably long period of time (years rather than weeks or months) to determine meaningfully what proportion of each group became homeless. If 25 percent of the at-risk group became homeless in the absence of any intervention, and 15 percent became homeless despite the intervention, then one could argue that the

[6] The ratio, calculated for 1988 is .06 X 270,000 families on welfare with no shelter experience who ever faced eviction to .22 X .90 X 10,000 families who entered shelter, at some time after facing eviction, or about 8 to 1. Note that the percentage of shelter requesters who have ever been evicted is slightly higher (28%) if families with previous shelter histories are included, as is the percentage of families on the welfare caseload (7%) (Knickman, Weitzman, Shinn, & Marcus 1989), leading to a ratio of 7.5 to 1. Because homeless families are younger than a random sample of the public assistance caseload, and have been exposed to eviction for a shorter period, their eviction rate per unit time is relatively higher than the rate for the public assistance caseload, so a prospective study, offering services to families facing eviction might reach as few as 4 families who would avoid shelter on their own for each family who would otherwise go to shelter. The New York State Department of Social Services (1990) used the same data to calculate that 34 percent of families evicted rather than 20 percent end up in shelter. We believe that figure is too high due to two errors: in footnote 5 the report adds two percentages that refer to overlapping groups of families, so that some families are counted twice; in footnote 9 the authors compare evictions ever with shelter entries for a one-year period, getting a higher proportion than would be obtained if the time periods were the same.

intervention prevented 40 percent of the cases of homelessness that would otherwise have occurred [calculated as (.25 - .15)/.25]. Alternatively, one could measure total months homeless in the two groups and determine how many months of homelessness were prevented.

Remarkably few studies of prevention programs have anything approximating this design. Many programs have no comparison group that failed to receive prevention services, much less one that is randomly assigned, and authors make implausible assumptions about the numbers of people who would have become homeless in the absence of intervention (typically assumed to be 100%). Studies frequently have little or no follow-up to determine whether homelessness was prevented, merely postponed, or not affected at all, and often presume success rates of 100 percent for those who received services. Cost-benefit analyses derived from such studies present an illusion of specificity, but, as we will show, different and more plausible assumptions frequently lead to quite different conclusions.

The Problem of Queue-Jumping

Some observers have likened homelessness to a game of musical chairs in which the players are poor people and the chairs are the housing units they can afford (McChesney, 1990; Sclar, 1990), or in a slightly more sophisticated analogy, the chairs represent the housing poor people can purchase or otherwise occupy by drawing on their personal networks (Koegel, Burnam & Baumohl, 1996). Where there are more poor people than affordable housing units, and where personal networks are attenuated or materially impoverished, some will be left homeless when the music stops. Although individual characteristics may determine who is most vulnerable, and hence be predictive of homelessness, it is resources relative to needs that determine overall prevalence rates (Wright & Rubin, 1991; Koegel et al., 1996). Thus, while homelessness can be prevented by creating resources or reallocating them from those who are not at risk to those who are, reallocation among groups at similar levels of risk is unlikely to affect overall prevalence rates. That is, reallocation affects who gets the housing units, not how many are left homeless when the music stops.

If housing subsidies or other services effectively prevent homelessness for particular individuals, but are in short supply and must be rationed, prevention programs that offer the scarce goods risk reallocating homelessness. Program participants are less likely to become homeless, but those moved back in line or displaced from the queue may be more likely to become homeless. For example, in a sample of families in shelters in New York, two factors predicted receipt of subsidized housing: length of stay in shelter and being assigned to a relatively small, non-profit shelter rather than a congregate shelter or a welfare hotel (Shinn et al., 1988). An earlier analysis of the non-profit shelters suggested that staff did not generate new housing resources; rather, by means of persistent advocacy on behalf of their families, they garnered more than their proportional share of the subsidized housing units available (Shinn, Knickman, Ward, Petrovic & Muth, 1990; for a similar point, see Baumohl & Huebner, 1991). In essence, "months in shelter" reflected families' coming to the top of the housing queue, whereas the success of the non-profit shelters reflected queue-jumping. The overall prevalence of homelessness was not changed by this reallocation of homelessness between those lucky enough to have advocates and those who were not.

Allocation of resources poses a real dilemma for policy makers. Many cities have long waiting lists for public housing. If homeless people are put at the head of the queue, others on the verge of homelessness may be moved back and, as noted, become homeless more often than under a different dispensation. Indeed, if entering shelter is seen as the quickest, most certain route to subsidized housing, shelter entry may be promoted by queue-jumping. (See Culhane, 1992, for a more extended discussion of the perverse incentives created by preferential placements of homeless families.)

This amounts to a cautionary tale for evaluators of programs to prevent homelessness. Even a carefully designed experiment, in which a group randomly assigned to receive preventive services experiences less homelessness than a control group, may not demonstrate prevention (overall reduction in incidence or prevalence) if homelessness has merely been reallocated. At the individual level homelessness has been prevented for program participants, but at the population level, no prevention has occurred. Because overall prevalence rates are very hard to measure accurately, and are influenced by many factors unrelated to the operation of a particular program in a particular area, accurate measures of reductions in the prevalence of homelessness, and unassailable attribution of observed changes to programs, are both unlikely. Rather, we suggest that evaluators consider whether homelessness has been truly prevented or merely reallocated on whatever logical or empirical grounds are available. The reallocation hypothesis is most plausible when the evaluated program involves advocacy for or allocation of existing resources to particular groups. Still, even where the reallocation hypothesis seems persuasive, the program may show that homelessness would truly be prevented if critical resources were more widely available.

A Review of Prevention Programs

Universal Prevention Strategies

The Interagency Council on the Homeless (1994) argued for universal prevention strategies. It noted that for most people, homelessness is a manifestation of extreme poverty, and that ending homelessness will, in the long run, require combating poverty with "more opportunities for decent work, job training that leads somewhere, necessary social services, better education, and affordable housing [all as] components of comprehensive community planning and economic development" (p. 84). It argued against "institutionalizing a separate support system for the homeless population" in favor of improving access to mainstream services (p. 91). Similarly, nearly 4000 providers of homeless assistance, local officials, and homeless and formerly homeless people queried by the Interagency Council rated more affordable housing as the top priority (out of 15 options) for a federal plan to address homelessness (p. 61). (It is not clear how this sample was drawn.)

Jahiel (1992) proposed a variety of universal strategies to prevent homelessness. His recommendations embraced employment (increasing the minimum wage and using the tax system to induce businesses to pay low-income workers more), unemployment and welfare (bolstering incomes, providing vocational rehabilitation and support services such as child care), health (insurance protection for loss of income through illness or disability), education (preparation for job opportunities), and family (attacking underlying causes of family conflict). His most extensive suggestions involved housing. He would increase government support for public housing and non-profit housing corporations (including community-based corporations organized by tenants), preserve existing housing stock by strictly enforcing regulations protecting single-room occupancy hotels (SROs) and other low-income housing, improve municipal services to low-income neighborhoods, and train tenants in methods to resist displacement. He also proposed arrangements to create housing by non-profit corporations or via sweat-equity programs; methods to finance housing via limited-equity cooperatives or master-leasing of shared housing by nonprofit organizations, creation of inexpensive housing such as mobile homes or prefabricated units, and use of non-conventional housing, including SROs (pp. 327-328). Lindblom (1991) offered a similar list, coupled with indicated strategies. Efforts to combat housing discrimination against racial minorities, which remains rampant (Yinger, 1991), might begin to address the over-representation of African Americans in shelter.

Selected Prevention Strategies

Selected prevention strategies might target low-income people who have difficulty affording housing, poor people at particular life stages, or neighborhoods from which large concentrations of homeless people come.

With respect to housing affordability, the Department of Housing and Urban Development (HUD) defines worst-case households as unsubsidized renters with incomes below 50 percent of the area median who pay more than 50 percent of income for housing costs or live in seriously sub-standard housing. These households are at substantial risk of homelessness. One way to estimate the costs of preventing homelessness by attacking housing affordability directly is to calculate the difference between the amount that worst-case households can afford to pay and the actual costs of their units (including rent and utilities other than telephone). The total gap between 50 percent of the incomes of worst-case households and housing costs was $14.3 billion in 1995. If we use the HUD standard that households should pay no more than 30 percent of their income for rent and utilities, the gap between 30 percent of income and housing costs, again for worst-case households, was $22.5 billion in 1995 (figures estimated by Cushing N. Dolbeare from the 1995 American Housing Survey data, personal communication, September 7, 1998).[7] A more generous program to subsidize all households with income less than 50 percent of area median and paying over 30 percent (rather than 50%) of income for rent and utilities would cost more.

These costs are substantial, but they are a fairly small fraction of the tax expenditures that subsidize home ownership, the benefits of which accrue predominantly to wealthier members of society (Dolbeare, 1996). For example, in 1997, homeowners' tax deductions for mortgage interest alone totaled $49.1 billion. If property tax deductions, capital gains deferral, and capital gains exclusions on homes are included, homeowner deductions totaled $90.7 billion (Dolbeare, personal communication).

To put these numbers in further perspective, note that the Interagency Council on the Homeless (1994:85) observed that if the HUD budget simply had increased at the rate of inflation after 1980, budget authority in 1994 would have been $65 billion; HUD's 1994 appropriation was $26 billion. The difference would cover the cost of subsidies to all worst-case households.

There is some evidence that subsidized housing, even without other services, is likely to prevent homelessness for most families. In Philadelphia, the numbers of families admitted to shelter who had

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[7] Dolbeare points out some problems with these estimates. First, American Housing Survey (AHS) data, from which the estimates are derived, under-represent incomes, sometimes substantially, thus inflating the estimates of costs. Second, actual housing costs total something more than fair market rents, but not a great deal more. On the other hand, homeless households are excluded from the AHS data, thus deflating the estimate.

These numbers assume that renters could stay in their current units, and simply receive help with the rent. Jahiel(l992) calculated that a much smaller program to provide 840,000 units a year would cost $50 - $67 billion annually (as of 1992), on the assumption that units would need to be built or rehabilitated. In areas with low vacancy rates, more new construction may be necessary. A program to subsidize renters in existing units would, by itself, do little to ease problems of over-crowding or sub-standard building conditions. These problems are widespread, but less severe than basic affordability problems. According to AHS data for 1995, 82 percent of poor renters (representing 6 million households) spent at least 30 percent of income on rent and utilities, 59 percent spent more than half of their income, 14 percent lived in housing with moderate or severe physical problems, 10 percent lived in overcrowded housing and 6 percent lived in doubled-up circumstances (Daskal, 1998:12, 21). These percentages overlap. Note that poor renters are a smaller group than renters with incomes below 50 percent of area median.

Culhane (1992:439) makes a similar argument for Philadelphia. He observes that while closing the housing affordability gap would be much more expensive than the current shelter system, "emergency assistance and rent subsidies remain the best hope of reducing shelter demand in the long term."

been in shelter previously dropped from 50 percent in 1987 to less than 10 percent in 1990 after a policy of placing families in subsidized housing was adopted (Culhane, 1992). Similarly, Wong, Culhane, and Kuhn (1997) found a very low readmission rate (7.6%) among families discharged from shelter in New York City when they received subsidized housing. Shinn et al. (1998) found that New York City families who lived in subsidized housing were less likely to enter shelter in the first place than other families in the public assistance caseload. Further, subsidized housing was very nearly both necessary and sufficient to stabilize formerly homeless families. In a five-year follow-up of a cohort of families who entered shelter, families who received any of several forms of subsidized housing were slightly more likely to have apartments of their own than were a random sample of the public assistance caseload who had never been homeless (97% compared to 92%), and the two groups were equally likely to be stable, defined as having been in one's own apartment without a move for at least a year (80% in both groups). Very few of the formerly homeless families received any services other than subsidized housing (certainly they were not part of special case management programs), yet when they received housing subsidies they attained residential stability. On the other hand, families who did not receive subsidized housing were very unlikely to be stable at the end of five years (38% in own apartment, 18% stable).[8]

Although a variety of factors predicted which families in the public assistance caseload would enter shelter in the first place, only receipt of subsidized housing made any substantial contribution to the prediction of stability at follow-up. Among formerly homeless families, the odds of stability increased twenty fold for households who received housing subsidies, compared to those who did not. Factors that were unrelated to stability, in the context of subsidized housing, included mental illness, substance abuse, health problems, history of incarceration, education, work history, various features of the respondent's childhood (disruptive family experiences, growing up in poverty, teen pregnancy), domestic violence, and strength of personal network, although some of these factors were associated with initial shelter entry (Shinn et al., 1998). Stojanovic, Weitzman, Shinn, Labay, and Williams (1999) found that families (in the same study) who left subsidized housing did so primarily because of serious building problems or safety issues (rats, fire or other disaster, condemnation, or the building's failure to pass the Section 8 inspection).

It is important to note that in New York, families' housing subsidies (and the base rent as well) typically were paid directly to landlords. Thus, families could not delay rent payments to meet other needs. It is not clear whether families would have been as stable five years later if subsidies and base rent payments were more fungible. Lindblom (1996: 193) suggested additional advantages to voluntary programs to provide payments to landlords via an intermediary who could serve as an advocate for tenants' rights: Landlords might negotiate lower rents in exchange for the reliability of cash flow and tenants would obtain more negotiating power because numerous tenants' payments would come through one intermediary.

Less definitive additional evidence that homelessness among families is "cured" by subsidized housing comes from two other studies in which all families received such housing. A nine-city study of homeless families (chosen for long-term patterns of recurrent homelessness and need for services) offered families both subsidized housing (Section 8 certificates) and case management services. Among 601 families on

[8] Shinn et al (1998) looked for, but did not find, evidence of selection bias between those who did and did not receive subsidized housing. Only one of fifteen individual characteristics examined differentiated the two groups: families who had experienced domestic violence were a little less likely than others to receive subsidized housing, but the difference was much too small to account for the enormous association of subsidized housing with stability. The primary predictors of receipt of subsidized housing, as noted above, were length of stay in shelter (coming to the top of the queue) and being assigned by computer algorithm based on family size and size, availability, and current cost of rooms, to one of the non-profit shelters that worked to get their families housing.

whom 18 months of follow-up data were available, 88 percent remained in permanent housing. This study suggests the value of services-enriched housing and does not speak to the issue of housing without services, although no differences in housing stability were found across sites with rather different configurations of services (Rog, Holupka & McCombs-Thornton, 1995).

Weitzman and Berry (1994) set out to study whether intensive case management services reduced repeat homelessness among New York City families deemed to be at especially high risk on the basis of a set of individual and family risk factors. However, this question could not really be answered because at the end of the one-year follow-up period, the vast majority of families were housed, whether or not they had received the intensive services. Only 8 of 169 high-risk families-just under 5 percent-had returned to shelter. The type of subsidized housing received was the strongest single predictor of who would return, with families in buildings operated by the public housing authority more stable than those in an alternative City program.

Similarly, in a longitudinal study of homeless adults (including a small proportion of women with children) in Alameda County, California, participants were divided into those who attained stable housing, unstable housing, or no housing at a fifteen-month follow-up. Subsidized housing predicted both stably and unstably housed outcomes, and regular entitlement income predicted stable housing; longer histories of homelessness predicted less attainment of either sort of housed outcome; female gender and substance use disorders were associated with unstable housing. Case management services were unrelated to either type of housed outcome (Zlotnick, Robertson & Lahiff, 1999).

Thus, housing subsidy seems to be a very effective preventive measure, but we need more research on different populations in more geographic areas. For individuals with severe mental illness or other disabilities, who are discussed more below, additional services are likely to be necessary, but as there are no studies designed to include assignment to a no-services group, we must point out that this is a commonsensical assertion rather than a demonstrated fact. In any case, there is an important question about whether services should be linked to housing, or whether homeless individuals should make use of services in the community. Culhane (1992:438) notes that providing specialized social services, like providing housing for homeless people only, creates incentives for both policy makers and homeless people to use shelters "as a secondary welfare and housing system."

Other Approaches to Selection. Selected strategies might also target poor people at particular life stages. Studies have consistently shown that homeless families are younger than other poor families (Shinn & Weitzman, 1996). In New York, 53 percent of mothers in families in a cohort entering shelter for the first time were pregnant or had given birth within the past year (Shinn et al., 1998); as noted above, almost half had never had an apartment of their own. [Culhane and colleagues (unpublished papers cited in Culhane & Lee, 1997) found that, over a one-year period, approximately 10 percent of poor children under the age of five in Philadelphia and New York stayed in a public shelter, including 16 percent of poor African-American children.] The cost of starting out in a new apartment (moving costs, first month's rent, security deposit, furnishings) may be prohibitive even for individuals or families who could afford to maintain the housing. A program of loans or assistance directed at first-time renters might permit more young people to make the transition to independent housing, particularly if such a program included work. (We are not aware of any research on such a program.) Assistance to pregnant women and new mothers, beginning with full funding of WIC (the Women, Infant, and Children Food and Nutrition Information Program), might also help young women weather the transition to parenthood.

Another approach would select individuals on the basis of the neighborhoods in which they live. Culhane, Lee, and Wachter (1996) showed that in Philadelphia and New York, between three-fifths and

two-thirds of families entering shelter over an extended period came from identifiable clusters of census tracts. The prior addresses of homeless families were more concentrated than the addresses of families in poverty in these cities. In Washington DC, poverty and homelessness were more equally concentrated (Culhane & Lee, 1997). In Philadelphia and New York, rates of shelter admission were strongly related to an area's rates of poor, African-American, and female-headed households with young children and with rates of particularly bad housing conditions. In Washington, rates of female-headed households, female-headed households with preschool children, and unemployed persons were important.

Of course, many of these factors, considered as individual characteristics, also predict entry into shelter, and their design (using census data to characterize neighborhoods with high rates of shelter entry) did not permit the authors to determine to what extent neighborhood characteristics predicted shelter entry above and beyond individual characteristics. The neighborhoods identified were also reasonably large, comprising, in New York, much of the South Bronx, Harlem, and a broad swath of Brooklyn, including Bedford Stuyvesant and East New York. Figures in the article do not permit calculation of the proportions of families in these high-risk areas that entered shelter. Nevertheless, the same types of strategies considered under the rubric of universal prevention could usefully be applied as selected prevention strategies to specific neighborhoods most in need, as judged by the incidence of shelter entry in those neighborhoods. If prevention efforts such as community development, housing construction or rehabilitation, efforts to maintain existing housing stock, job development and training programs, and child care services that permit young mothers to take jobs, are directed at neighborhoods, it is clear that locating services in high-risk neighborhoods makes enormous sense (both from the perspective of preventing homelessness and on other grounds).

Culhane and Lee (1997) noted that families in Washington who requested shelter were put on a waiting list and had to enter shelter to gain access to other services. They suggested that neighborhood-based services brought to families before they enter or even apply for shelter (via indicated strategies triggered by individual needs assessment within the target neighborhoods) might also avert shelter entry for many. We are not aware of any research on the consequences of either selected or indicated neighborhood-based prevention strategies for homelessness, but they are surely worthy of exploration. Those involved in community development initiatives should examine their impact on homelessness.

Indicated Prevention Strategies

Despite the Interagency Council's emphasis on universal strategies to alleviate poverty and provide affordable housing, it also advocated indicated prevention methods to 1) "prevent foreclosure or eviction;" 2) "ameliorate domestic conflicts to forestall potentially violent resolutions;" 3) "provide supportive services for physically and/or emotionally disabled individuals;" and 4) "plan for soon-to-be-released inmates in prisons and hospital patients." Surprisingly, without any documentation in an otherwise well-referenced report, the Council suggested that these approaches "are significantly less costly strategies than providing emergency food and shelter for homeless individuals and families" (1994:50-5 1). Below, we review the evidence for each of these strategies.

Eviction Prevention. Most programs to prevent evictions or foreclosures on mortgages are aimed at families, although single people also get evicted. Typically, these programs offer some combination of cash grants or loans, counsel on budgeting and finances, legal services, mediation or negotiation between residents and landlords or mortgage holders, and advocacy. Often the same agencies also provide secondary prevention services to those already homeless. For example, prevention programs funded by the Emergency Shelter Grants Program (ESG) in Fiscal Year 1991 offered back rent and utility payments (82% of providers), mediation for disputes between landlords and tenants (41%) and legal services for

indigent tenants (20%) who faced evictions or utility cutoffs. Many providers also offered payments or loans to families facing foreclosure on their own homes (40%), and security deposits or first month's rent to obtain new housing for people about to be displaced (or, presumably, for people in shelters or shared housing with nowhere to go) (78%). Finally, 25 percent of providers offered referrals and counseling, although it is not clear to what group of clients (Feins et al., 1994a: 114).

An evaluation report suggests that "across the entire program, it appears that roughly 205,000 clients and 65,000 families have regained or retained permanent housing through the intervention of the ESG-funded providers" at a cost of about $200 in ESG funds per case (Feins et al., 1994a:186), although the authors also note (p. 206) that it was beyond the scope of the study to assess directly the impact of homelessness prevention activities. The data thus represent agency reports of activities, in one-quarter of cases without any follow-up of the individuals or families helped (Feins, Fosburg & Locke, 1994c:A-91). It is unclear whether any of the agencies corrected their counts for people who later entered shelter or were lost to follow-up, or for those who would have become or remained housed in the absence of intervention. Further, cost estimates may be understated because they include only ESG funds even though the authors suggest that other funds must have been used as well (p. 182).

If these figures are even approximately correct, this is a collection of extraordinarily promising and cost-effective prevention programs, but without more rigorous experimental evaluations, it is hard to credit the results. Descriptions and case studies of individual programs funded under the ESG provide little data on the outcomes of prevention efforts (Feins, Fosburg & Locke, 1994b.)

Schwartz, Devance-Manzini, and Fagan (1991) provided brief descriptions of over 50 state and local efforts to prevent homelessness and longer case studies of seven selected because they were relatively large, established, and well-documented (p. 2). One of the more detailed studies is of a program in Connecticut that provided landlord-tenant mediation and payments of back rent for up to the lesser of two months or $1200 to (then) AFDC families threatened with eviction for non-payment of rent and whose housing was deemed to be habitable, permanent, and affordable. Households were screened and referred to the program by the Department of Human Resources. About half of the cases resulted in mediated agreements between landlords and tenants; surprisingly, in many cases, no financial help from the program was needed. The primary reason for failure, and referral back to the Department of Human Resources, was the client's inability to afford the current rent and secure the tenancy even if back rent were paid (p. 19). The program provided impressive cost-effectiveness figures: In New Haven, the average back rent payment was $960 per family, compared to $7000 for sheltering a family for the allowable maximum of 100 days. In Hartford, 46 families were served at an average payment of $477, compared to $10,514 in shelter costs for 100 days.

Unfortunately, these figures are based on assumptions that we deem implausible. First, the costs of administering the program and mediation were ignored, although in the first months of the program they were substantially higher than the costs of rent payments (p. 15), and the cost of screening families was left out. If we assume that costs of administration and mediation were reduced to equal the costs of back-rent payments after the program was in operation for some time, the estimated costs per family would still need to be doubled. Next, the program assumes that all families who were threatened with eviction would have been evicted, all would have gone to shelter in the absence of the program, and all would have stayed in shelter the maximum of 100 days. As an alternative assumption, if half of those threatened would have been evicted, and half of those evicted would have gone to shelter for 100 days, the cost per shelter episode prevented (including mediation costs) would rise to $3816 in Hartford and $7680 in New Haven, leading to no savings in the latter city. Further, if the average shelter stay were 30 days rather than the maximum of 100 days in Hartford, savings in that city would also evaporate. The

authors' calculation also assumes that 100 percent of households who came to a mediated agreement with landlords were prevented from entering shelter. This may be plausible, because 6-month follow-ups were conducted-but the data were not reported.

Thus we see that even simple cost-benefit analyses depend heavily on assumptions that should be put to an empirical test. A more sophisticated analysis might also consider other costs to families who lose their homes and enter shelter (loss of belongings, difficulty in maintaining jobs), costs for stabilizing families after shelter, and benefits to others, such as landlords, when tenancies are secured. All of these factors would enhance the cost effectiveness of the program. In sum, at first glance, the Connecticut program looks promising, but a more rigorous analysis is necessary to determine if it is really cost-effective.

Programs in New Jersey and Maryland provided financial help without extensive mediation or counseling. The New Jersey program gave one-time payments to poor households who could document imminent homelessness or who had already lost housing due to a crisis beyond their control but would be able to afford the housing after the assistance ceased (Schwartz et al., 1991:46). Most payments were to renters, but homeowners facing foreclosure also were eligible for loans. The Maryland program provided rent supplements for up to a year to poor households judged able to return to long-term self-sufficiency in that time. Although "no formal follow-up of clients [was] required or conducted," local administering agencies reported that over one-third of households helped had attained self-sufficiency, and 80-85 percent had attained housing self-sufficiency, although they might receive other entitlements (p. 3 1). It is not clear what proportion of households were at risk for homelessness or what proportion might have become homeless even with the program.

The New Jersey program conducted one inexpensive follow-up by mailing surveys to 5000 landlords of tenants who had been helped; of those who responded, 72 percent reported that the tenants still resided in the housing or had moved to new situations in good standing with their landlords (p. 84). Thus, 28 percent might be deemed failures. The authors further report that the program cost an average of $1350 per renter household, and that an average stay in shelter in New Jersey lasts 3.5 to 5 months at an average cost of $1500 per month (p. 5 1) or about four times as much. Again, the cost-benefit calculations required assumptions that could not be tested by evidence. If, in the absence of the 'program, the failure rate (those leaving in bad standing with landlords) were at least 78 percent rather than 28 percent, and if half of the failures wound up in shelter for an average length of stay, the program would be cost-effective. If the failure rate in the absence of intervention were lower, or the proportion who in fact went to shelter were lower, the program would cease to be cost-effective in the sense of trading program for shelter costs. As in Connecticut, appraising other benefits to tenants and landlords could also alter conclusions.

The HOPE program in Pennsylvania, Ohio, Kentucky, Texas, and Colorado (Schwartz et al., 1991) to prevent mortgage foreclosures provided good evidence that homelessness prevention has benefits to the community that go beyond benefits to people whose homelessness is averted. To households with delinquent mortgages, the program provided intensive financial counseling and support, negotiation with creditors, and various additional resources such as job training, loans, and help obtaining benefits such as energy assistance. Mortgage lenders and utility companies, which stand to benefit when homeowners can pay their bills, provided most of the financing for the program. One utility company estimated that it recouped $9 that would previously have been written off as bad debt for each dollar invested (p. 71). Other programs, discussed more briefly by Schwartz et al. (1991) and Bueno et al. (1989) engaged in novel strategies such as counseling for landlords as well as tenants, coordination among community services, information on entitlements, eviction hotlines, housing clearinghouses and referral networks,

and matching services for people who wished to share housing-but offered little evidence of effectiveness.

Even the most sophisticated studies of eviction prevention and rental assistance programs (McIntire, Layzer & Weisberg, 1992; New York State Department of Social Services, 1990) leave much to be desired. In New York, most services were provided to clients on the verge of eviction, and involved mainly legal representation, often combined with advocacy to get clients public benefits. A smaller proportion of programs offered tenant education, counseling, case management, mediation, and tenant organizing. The New York study considered the proportion of households that would avoid eviction in the absence of intervention, and the proportion of cases where evictions were actually averted. It also considered the proportion of evictions that would result in use of shelter, although we believe the figure to be an over-estimate (see footnote 6). Unfortunately, as the report was written after the programs had barely started, the basic evaluation data used were agencies' projections of the total number of clients to be served once the programs became fully operational and estimates of the proportion of closed cases in which eviction would have been prevented or forestalled. In spite of the sophistication of the design, the absence of real program data leads us to discount the estimated cost savings of $4 in shelter costs for every dollar of public investment.

The Washington State study of homelessness prevention and rental assistance programs (McIntire et al., 1992) was one of the few to have short-term follow-up data—at least for four of eleven program sites. The prevention program was aimed at people on the verge of displacement; the rental assistance program served people without housing. Both were cheaper than shelter use (which would have been 2.5 to 2.75 times as much). The authors used the follow-up data to estimate conservatively that 20 percent of those helped might still have gone to shelter, and adjusted cost rates accordingly, but acknowledged that it was difficult to tell how many families would have used shelter without help (p. 86). They suggested that the rate was higher, and hence cost savings may have been greater, for families in the rental assistance program, about half of whom came from shelters or the streets, than for families in the prevention program. Both programs tended to provide case management and sometimes job training services in addition to short-term help with rent or mortgages, and efforts to secure permanent subsidized housing.

In sum, programs to prevent evictions or foreclosures may be of substantial benefit to borne households at risk of homelessness and to the communities in which they live. The few studies with follow-up data found that a substantial portion of those who were helped remained housed, at least for the period of assistance, and often appeared to be reasonably stable at the end of that period. But calculation of specific costs and benefits requires data about the extent to which clients of the programs avoid homelessness over the long run and the extent to which they would have become homeless in the absence of the programs. These are rarely collected.

Further, many programs husband their resources by "creaming." That is, they target families deemed most likely to succeed. Many programs serve only households that have sustained sudden losses of income, who can prove they will be able to maintain their residence after receiving help, or who can demonstrate that they are likely to be self-sufficient in the future (see also Lindblom, 1991). Many of the households most likely to become homeless in the absence of the intervention are thus ineligible for current programs. More broadly-based housing subsidies to households with worst-case housing situations would reach a far larger group of those at risk, albeit at greater cost.

Finally, programs to prevent eviction and foreclosure, even if widespread and successful, would reach only a minority of families-those whose homelessness arises from eviction-and would rarely reach

single individuals. This limited reach is not a reason to avoid such programs, but suggests that broader action is necessary.

Programs to Ameliorate Domestic Conflicts. Studies consistently find high rates of physical and sexual abuse in childhood, foster care and other out-of-home placements, and/or other family disruptions in the backgrounds of both single individuals and families who enter shelter (Bassuk et al., 1997; Bassuk & Rosenberg, 1988; D'Ercole & Struening, 1990; McChesney, 1987; New York City Commission on the Homeless, 1992; Rog, McCombs-Thornton, Gilbert-Mongelli, Brito & Holupka, 1995; Roman & Wolfe, 1995; Shinn, Knickman & Weitzman, 1991; Sosin, Colson & Grossman, 1988; Susser, Struening & Conover, 1987; Wood et al., 1990). Most studies also find higher rates of domestic violence among homeless than among other poor families (Shinn et al., 1991; Wood et al., 1990), but two studies with more detailed questions (Browne & Bassuk, 1997; Goodman, 1991) found no difference: Rates in both homeless and housed groups were extraordinarily high.

Despite the high rates of family problems and violence in the backgrounds of people who become homeless, it is not clear what a program "to ameliorate domestic conflicts to forestall potentially violent resolutions" (Interagency Council on the Homeless, 199450) would look like. Universal strategies to prevent domestic violence and child abuse (by changing norms of acceptable behavior, punishing perpetrators, and providing support and education to parents) and strategies to reduce the need for and increase the quality of foster care would, if successful, reduce these risk factors for homelessness. However, in the cases of child abuse and foster care placement, benefits for the prevention of homelessness would accrue over a very long time. Moreover, as we will note with respect to mental illness and substance abuse, the vast majority of abused and placed children do not become homeless. Designers of indicated interventions for families experiencing domestic conflicts that have not yet become violent face an almost insurmountably difficult task of identifying families to which such interventions would apply. Although programs such as marriage counseling for newlyweds or couples experiencing marital difficulties might well be useful on other grounds, it is quite a stretch to recommend such programs because of their potential to prevent homelessness.

It is even less clear that indicated interventions are advisable to stabilize households already experiencing domestic violence. Service providers report that women are reluctant to leave men who abuse them, in part because of their economic dependence on the men. The need, therefore, is for more, not fewer, shelters, psychological services to traumatized mothers and children, and housing and other resources to help families set up new households. Efforts to get women to stay with perpetrators of violence in order to avoid homelessness would likely lead to injuries and deaths. In a word, they would be misguided. We know of no studies of programs to ameliorate domestic violence as a strategy to prevent homelessness in either the short or the long term, and would hope that anyone who sets one up would look carefully at possible negative consequences.

The fact that childhood abuse and out of home placements, childhood poverty, and adult domestic violence did not detract from the long-term stability of formerly homeless families in New York (once receipt of subsidized housing was accounted for), suggests that these factors may contribute to homelessness largely by restricting housing support of an informal kind. Similarly, the impoverished social ties found in many, but not all, studies of homelessness (see Shinn et al., 1991, for a review) may be important because personal network members can provide or subsidize housing. If housing can be secured by other means (e.g., a government subsidy), it may not be necessary to address underlying problems in relationships or the attenuation of social ties in order to prevent homelessness, though such interventions may be perfectly desirable for other reasons.

Thus, although domestic violence and childhood disruptions may predict homelessness, the best preventive effort may still be access to subsidized housing. Unfortunately, in New York, women who reported domestic violence were somewhat less likely than other women to receive subsidized housing (Shinn et al., 19983. It is unclear whether batterers pursued women into shelters, whether women returned voluntarily to men who abused them, or whether there was some other reason for this pattern.

Supportive Services For Impaired or Disabled Individuals. Popular treatments of homelessness usually emphasize the contributions of one or several major impairments, but the analysts are not over-burdened by their knowledge of epidemiology (Baumohl, 1993). Once the biases of cross-sectional samples, lifetime diagnostic measurements, and other methodological problems are cut away, it is clear that only a minority of homeless single individuals have suffered recently from a major mental disorder, a substance use disorder, or a physical impairment that rises to the level of a work disability-and rates among homeless families are even lower (Koegel et al., 1996; Lehman & Cordray, 1993). Even more important for our purposes, although those with serious impairments are over-represented among homeless people, only a tiny fraction of all people with major physical impairments, mental disorders and/or substance use disorders ever become homeless (Federal Task Force on Homelessness and Severe Mental Illness, 1992; Institute of Medicine, 1990). Thus, although supportive services for people with serious impairments are valuable in their own right, they should generally be justified on grounds other than the prevention of homelessness. From this admittedly narrow perspective, most such services will be wasted.

Among mentally ill individuals, it is not even clear that the most important variables predicting homelessness indicate a lack of supportive services. A project in San Diego examined the relative role of housing subsidies and intensive services for homeless people with severe and chronic mental illness (schizophrenia, bipolar disorder, or major depression). Participants were randomly assigned, in a 2 X 2 design, to access versus no access to Section 8 certificates and to traditional versus comprehensive case management (Hurlburt, Wood & Hough, 1996). Results indicated an enormous effect produced by access to Section 8 certificates. Almost 60 percent of participants with access to the certificates achieved stability in independent housing at the end of the study, compared with 3 1 percent of participants without access. There was no effect for type of case management on housing outcomes, although all participants received services. Similarly, in the study by Zlotnick et al. (1999) cited above, in' which subsidized housing and regular income from entitlements predicted housing stability, but case management did not, about half of the respondents had substance use disorders or dual diagnoses.

A Chicago study of a random sample of both homeless and domiciled individuals with a history of psychiatric hospitalization who obtained their main meal of the day in a free meal program, found that access to material resources was more important than individual characteristics or relationships with the mental health system in predicting homelessness. Income from employment, receipt of Social Security income, and income from welfare all were associated with lower levels of homelessness in a multivariate model. No measure of mental health symptoms or previous hospitalization was significant by itself or in the multivariate model. (Symptoms of alcoholism were measured and not predictive, but symptoms of abuse of other substances were not assessed.) Those currently receiving outpatient treatment were somewhat less likely to be homeless when economic variables were not considered, but outpatient treatment dropped out of the model in the presence of measures of income (Sosin & Grossman, 1991).[9]

[9] All studies we know of that include income or housing variables in predictive models of homelessness among people with mental illness find that they are important, but not all studies include them. For example, in two case control studies in New York of homelessness among men and women with schizophrenia, the most important predictor of homelessness was lack of adequate support from the family. Homelessness was also more likely among those who abused substances and those with co-occurring anti-social personality disorder, and for men, but not women, those without a long-term therapist. (The authors note

These studies suggest that the prevention of homelessness among individuals with serious disabilities, like its prevention among people not so afflicted, should focus on access to subsidized housing and/or to income that allows the individual to rent housing on the open market. Indeed, risk factors for homelessness and protective factors against it among people with serious mental illness [see Lezak & Edgar (1996)] may be significant primarily because they affect a person's access to housing. For example, the difficulty that many people with serious mental illness have in developing and maintaining relationships may reduce the likelihood of obtaining housing and other resources from members of personal networks. If so, two interventions are possible. One could try to attack the problem by bolstering individuals' relationships with families and friends; but a more direct (and arguably more therapeutic) strategy might simply be to provide the housing and other resources that might otherwise come from family and friends. The best protective strategy (housing or income) may not be identical to the risk (attenuated relationships) it counteracts.

Lezak and Edgar (1996) also identified a number of structural risk factors for homelessness which could be altered by changing social policy. These include inadequate discharge planning (see next section), lack of funding and integration for community-based treatment and support services (including community-based crisis alternatives and integrated treatment for mental illness and substance abuse), insufficient disability benefits, and lack of affordable housing or attention to consumer preferences in housing. We focus on the last two, which relate to the need for affordable housing and sustainable sources of income among poor people generally.

Income. Whereas only a small fraction of seriously impaired people become homeless, the low value of Supplemental Security Income (SSI) and General Assistance (GA) benefits virtually guarantees that those who rely on them will have worst-case housing needs. SSI is a means-tested program for disabled, blind, and elderly people with insufficient work histories to qualify for Social Security Disability Insurance, for which basic (non-clinical) eligibility is established through a history of payroll deductions. SSI is thus a welfare program,,and in 1990, SSI checks represented only 23 percent of median income, a figure that doubtless is lower in 1999. McCabe, Edgar, Mancuso, King, Ross, and Emery (1993) compared SSI benefit levels to the fair market rent in each county or standard metropolitan statistical area in the United States. On average, renting an efficiency apartment required 66 percent of the SSI check, and renting a one-bedroom required 80 percent. In 9 percent of counties, fair market rent for a one-bedroom apartment exceeded the entire SSI benefit. In the intervening years, the purchasing power of SSI recipients seeking housing in the open market likely has eroded further, as rents almost certainly have risen much faster than benefits.

Federal SSI benefits (sometimes supplemented meagerly by a state) amounted in 1998 to $494 per month for an individual living alone and $741 for a couple living together. These are small amounts of money, to be sure, but they are princely sums by comparison to the benefit levels of General Assistance programs. GA is a generic name for state and local programs that provide ongoing or time-limited assistance to low-income persons who do not qualify for Temporary Assistance for Needy Families (what was AFDC) or SSI-or who are awaiting an eligibility decision by these or other income maintenance programs. Many states do not have GA programs, or GA is operated in only some local jurisdictions; eligibility rules and benefits levels vary dramatically from state to state, or in some states, notably California and Wisconsin, from county to county. Still, as Greenberg and Baumohl (1996:74) point out,

that the lack of a therapist may have been a consequence rather than a cause of homelessness.) However, descriptive statistics reported by the authors suggest that income (from family for both men and women and from entitlements for men) may also have been important, but for reasons unexplained, it was not included in the predictive models (Caton, Shrout, Eagle, Opler, Felix & Dominguez, 1994; Caton, Shrout, Dominguez, Eagle, Opler & Coumos, 1995).

"GA programs share one fundamental characteristic: low benefit levels." In 1992, the maximum GA cash benefit for a single adult (the typical recipient), reported by states with uniform statewide programs, ranged from lows of $27 per month in South Carolina and $80 per month in Missouri to highs of $384 per month in Massachusetts and $407 per month in Hawai'i (Burke, 1995:78). Since 1992, GA benefits in many states have declined, eligibility restrictions have been added, some jurisdictions within states have ceased benefits, and the state of Michigan abandoned its GA program altogether (Urban Institute, 1996). In Michigan, 20,000 former GA recipients were evicted following termination of the GA program (Halter, 1996:108).

The miserliness of GA programs, even where they exist, is a major reason why the ranks of the homeless are dominated by unmarried people or couples without children (Burt, 1992: Greenberg & Baumohl, 1996).[10] GA also has particular relevance for impaired people, for many GA recipients suffer with acute and chronic problems that, while making 'them realistically unemployable, do not meet the stringent Social Security standard of disability (Halter, 1996). Moreover, some impairments, notably substance abuse (since January 1997), do not qualify as the basis for a Social Security disability claim (Baumohl, 1997; Greenberg & Baumohl, 1996).

Housing and Consumer Preferences. Even if modestly augmented by food stamps and Medicaid (which is far from usual), SSI benefit levels simply will not support the configurations of housing and support services desired by impaired consumers and related to residential stability. Tanzman (1993), reviewing studies of mental health consumers' preferences for housing and support services, found that consumers consistently reported that they wanted to live in their own house or apartment. They preferred to live alone or with a spouse or romantic partner, not with other mental health consumers. They wanted staff support that was available, on call, at any time of the day or night, but did not want to live with staff. Finally, they emphasized the importance of material supports, including income, money for deposits on housing, and ongoing financial resources or subsidies for telephones and transportation.

Srebnik, Livingston, Gordon and King (1995) examined the importance of choice in housing among consumers of ten supported housing demonstration projects in five states. Although most consumers had little choice, those who had more, and perceived less influence by others over their choices, were more satisfied and had greater residential stability.

Finally, Carling (1993) reviewed over 4000 journal articles and book chapters on the success of housing programs for people with severe mental illness, including some studies of success in averting homelessness. He concluded that "a comprehensive outreach approach that offers health and mental health services and focuses on the perspectives and demands of clients, work options, and supported housing has been reported to be effective in helping most people overcome homelessness" (p. 440). He questioned the assumption of mental health professionals that people with major mental illnesses need to live in residential programs before living independently, with supports.[11] Comparing individuals with mental illness to poor people, those who are elderly or homeless, and those with developmental

10 Whatever the deficiencies of the old AFDC program, its benefits, combined with off-book employment (Edin and Lein, 1997), kept many families out of shelters.

11 This assumption is not made only about those with major mental disorders. The Greater Philadelphia Urban Affairs Coalition's (1998) "blueprint to end homelessness" recommends (p. 28) that all "clients entering the homeless system . . . would only apply for Section 8 when they are established in an appropriate case management program at a residential facility, and in conjunction with progress made in that program." Only "an experimental pilot program" would provide direct access to Section 8, but even this would be encumbered by case management provisions and the use of an expert screening committee to determine the person's "readiness for Section 8 living" (p. 29). Based on the evidence reviewed here, we think such coercive provisions are wasteful and unwarranted.

disabilities, he suggested that housing needs are similar for each group and that housing problems are less closely related to disability than to economic and social factors such as poverty, shortage of affordable housing, and discrimination. Supports, choices, and control were critical in determining whether people remained in housing, but professionals and consumers in all these groups disagreed about specific needs for housing and supports. Carling judged the supported housing approach, in which assertive community treatment is coupled with independent housing, to be particularly promising for stabilizing mentally ill individuals in the community, although he observed that additional research is needed. Recent evidence for the utility of this approach comes from a study by Tsemberis (1999), who placed mentally ill and dually diagnosed homeless people directly from the streets, drop-in centers, or shelters in their own apartments, with supportive services under consumer control. Participants had higher residential stability than a non-equivalent comparison group in the usual system of graduated residential treatment, involving transitional housing, community residences and supervised SRO hotels, even though moves within the treatment system were not counted against the stability outcome.

In a recent review of clinical research demonstration projects undertaken with Stewart B. McKinney Homeless Assistance Act Funds in five cities, the authors concluded that programs offering a range of housing alternatives, when coupled with case management services, could effectively engage and stably house homeless individuals with severe mental illness (Shem, Felton, Hough, Lehman, Goldfinger, Valencia, Dennis, Straw & Wood, 1997). The experimental manipulation in these studies involved the type and intensity of services offered. Across five cities, between 74 and 88 percent of the experimental groups were in community housing at the final follow-up (which ranged from 12 to 24 months). Excluding data from a sub-study of a street sample in one city, across four cities with data, 78 percent of those in community housing were deemed stable; that is, they had not moved in the last follow-up period. Results were very similar across the diverse interventions. Just as interesting, from 60 percent to 80 percent of the control groups who received less intensive services were also housed in the community. Thus, as noted previously for homeless families, the intensive services made less difference than might have been expected.

Together, these studies and reviews suggest that selected prevention strategies that provided housing subsidies and/or substantially greater welfare benefits to all with worst-case housing needs would be of critical value to people with severe mental illness and those with other impairments as well. In the case of individuals with severe mental illness and/or substance use disorder, aggressive and integrated mental health and substance abuse treatment, combined with housing subsidies and money management services, would seem to be a useful package.

Additional Strategies. Lezak and Edgar (1996) also gave brief descriptions of a variety of specific state prevention programs for people with severe mental illness. These included programs to integrate treatments for people with co-occurring mental illness and substance use disorders, to offer support and training for community living, to enhance discharge planning, to provide crisis services and temporary housing, to increase flexibility in services and funding, to provide comprehensive, integrated systems of care, to create linkages between public housing and mental health agencies, to provide housing options that respond to consumer preferences, to provide culturally competent care, to increase affordable housing options, to provide state rent supplements [described as "one of the most straightforward, effective ways to enable people to afford housing and avoid homelessness" (p. 23)], to supplement SSI grants, to continue rent payments during hospitalization, to develop housing expertise among mental health staff, to reduce the stigma of mental illness, and to support families of people with serious mental illnesses. Additional strategies for the primary and secondary prevention of homelessness among people with severe mental illness and/or substance abuse are currently being evaluated as part of a cooperative agreement funded by the Center for Mental Health Services and the Center for Substance Abuse

Treatment (Rickards, Leginski, Randolph, Oakley, Herrel & Gallagher, in press). Strategies include various models for providing housing and services, interventions in which a representative payee helps a consumer to manage money, and family education and respite care. So far, only baseline data have been collected.

Individually and collectively, these strategies represent creative approaches to enhancing quality of life and preventing homelessness among people with severe mental illnesses. Unfortunately, Lezak and Edgar (1996) provide no evidence that any of them actually prevent homelessness. (There "is a need to dedicate more resources to gathering solid data," they observe on page 26.) As is inevitably the case with such syntheses, proposals about what ought to work reflect logical relationships among activities that are extracted from commonsense or some theoretical perspective on good casework. Judged on their own terms, they make sense-but they remain essentially untested.

Discharge Planning. Discharge planning is often recommended as a strategy to prevent homelessness among people being released from institutions. As noted above, a substantial minority of homeless individuals follow institutional circuits, including mental hospitals, jails, and shelters as well as informal housing arrangements and the street, and a smaller minority of both single individuals and parents in families often have foster care placements in their backgrounds. Belcher (1997) documented the costs and problems associated with homeless mentally ill individuals who are repeat users of services and who approach emergency rooms for care. For example, homeless mentally ill people are far more likely than domiciled mentally ill people to enter the criminal justice system and to commit violent crimes (Martell, Rosner & Harmon, 1995; Michaels, Zoloth, Alcabes, Braslow & Safyer, 1992). However, Lindblom (1991) pointed out that relatively few people go directly from institutions to the streets, and there is no evidence that substantial numbers of youths "age out" of foster care with no place to go. Feins and Fosburg (1998, exhibit 9) found that only 14 percent of people in shelters funded by the Emergency Shelter Grants program came from another institution where discharge might have been planned (5.3% prisons or jails, 5.6% detoxification or substance abuse programs, 2% psychiatric facilities, 1.4% residential treatment programs). We have already discussed the limited role of longer-term, supportive services for individuals with severe mental illness in the prevention of homelessness. Discharge planning could be seen as one stage in this process (Lezak & Edgar, 1996) for the subset of mentally ill individuals being discharged from institutions, but there appears to be less research on this aspect of services than on many others.

Belcher (1997) proposes a Community Rehabilitation Program for use at discharge from mental hospitals, with a central role for clinical case managers. The program embodies good casework practice, but the idea that it will prevent homelessness is an article of faith. Indeed, Belcher observes that we know little about the effectiveness of particular interventions. He, too, calls for more research. The Working Conference on Discharge Planning (undated) identified some 30 key components of discharge planning processes, some with as many as four sub-components, organized in the general area of rules and responsibilities, elements of a discharge plan, collaboration and partnerships, and funding. The one we see as incontrovertible recommends research and program evaluation to identify effective services and systems. The role of different plan elements in the prevention of homelessness remains to be demonstrated. Surprisingly, although the plan suggests a starting point for discharge planning (when individuals first enter institutions) it is silent about its duration after people leave. Given the persistent and recurring nature of serious mental illnesses, it seems likely to us that discharge planning may be a good first step, but that more enduring services, especially ongoing housing subsidies, will be necessary to prevent homelessness in the long run.

We are not aware of any experimental evaluations of the efficacy of discharge planning programs per se in preventing homelessness. The study of homeless and domiciled mentally ill individuals in Chicago described above (Sosin & Grossman, 1991) is one of the few to specifically examine the association of discharge planning with homelessness. Among people with histories of psychiatric hospitalization, there was no difference between homeless and domiciled individuals in the percent who had living arrangements made for them at last discharge from the hospital, the percent for whom arrangements involved living with family members, or the percent referred to outpatient treatment at discharge. This was true even before the powerful economic variables were included in the model. Thus, discharge planning, admittedly of a less comprehensive type than proposed by the Working Conference on Discharge Planning, had little impact on homelessness in this sample.

In New York, a study of a "critical time" intervention that was part of the Stewart B. McKinney Demonstration Program mentioned above showed that intensive services offered in the first nine months after men left a psychiatric program in a shelter was associated with a substantial reduction in nights homeless (from 91 to 30) over the 18-month follow-up period (Susser, Valencia, Conover, Felix, Tsai & Wyatt, 1997). The duration of this intervention is substantially longer than what is usually meant by discharge planning. An earlier technical report (Center for Mental Health Services, 1994) noted that housing problems were critical for men in the study, but did not describe the extent to which the intervention helped men to secure stable housing.

In Hines, Illinois, homeless, addicted veterans were assigned to a 12-month case-management program, beginning with approximately three months of residential care, or customary care, beginning with a three-week hospital stay. Differences between the two groups on literal homelessness were substantial at the first three-month follow-up, when many of the experimental group, but none of the comparison group, were still in residential treatment. However, differences diminished thereafter, and reversed direction at the 24-month follow-up (Conrad, Hultman, Pope, Lyons, Baxter, Daghestani, Lisiecki, Elbaum, McCarthy & Manheim, 1998). The authors concluded that "case management needs to be continuous, community-based, and intensive to maintain and/or increase the gains achieved in residential care" (p. 52).

In sum, although discharge planning programs make sense on logical grounds, at least as part of longer-term programs for people with persistent problems, we are unaware of empirical studies of their ability to prevent homelessness, and suspect that more enduring interventions are necessary.

Conclusion: Rethinking the Prevention of Homelessness

In 1990, the General Accounting Office (GAO, 1990) reviewed what was known about indicated programs to prevent homelessness and concluded that their effectiveness could not be determined because too few collected the necessary follow-up data. Now, nine years later, the same conclusion holds: While a few programs may be promising, none are even near proven. If indicated strategies are to be pursued in the future, we must have more rigorous evaluation designs, including random assignment to treatment and, most important, long-term follow-up of both those in the treatment group and controls. When programs are unable to meet the demand for services, we see no ethical objection to allocating services by lottery among those eligible.

The GAO report did not consider the effectiveness of targeting, but if the goal of prevention is to reduce the incidence or prevalence of homelessness rather than merely to provide useful services to poor people under a politically convenient rubric, targeting is a critical issue. We believe that indicated strategies

(e.g., eviction and foreclosure prevention, supportive services for seriously mentally ill people and substance abusers, and discharge planning) will collectively reach only a minority of people who become homeless. Even if they were expanded to reach 100 percent of their intended targets, and were also 100 percent successful in averting the homelessness of those served, they would still prevent fewer than half the annual cases of homelessness. Of course, if an intervention can prevent even a small number of cases of homelessness in an efficient, cost-effective manner, it is a worthy undertaking. But we should at least consider whether broader selected strategies can do better.

Inefficiency is a serious problem with indicated programs. This is because homelessness (even narrowly defined) is not like phenylketonuria: Whereas the latter is an individual, durable, biological trait, the former is the often passing, frequently recurring, complex product of shifting structural influences on individual lives. Homelessness is more the outcome of circumstance-more the product of social contingency-than the predictable fate of certain sorts of poor people. Given this, it should not surprise that individual correlates of homelessness, even when bundled, are inefficient predictors of future homelessness. Indeed, the evidence suggests that it will never be possible to target services sensitively enough to avoid missing a substantial proportion of people who will become homeless or specifically enough to avoid serving several people who will not become homeless for every one who will. To the extent that prevention services are rationed on the basis of individual characteristics, they inevitably will be burdened with the expensive, invidious, and scientifically dubious chore of sorting poor people. Further research on targeting might prove us wrong, but the efficiency of targeting must be demonstrated, not assumed.

Two problems noted by way of introduction are even more fundamental to the practical application of targeting strategies. First, because correlates of homelessness change over time and vary by location, the data on which scientific targeting relies would need to be periodically renewed in the areas to which they are applied. This would be costly, though it would keep a small army of epidemiologists off the street. More troublesome, however, is the inevitable disclosure of targeting criteria to those to whom they apply. A good advocate would do no less, after all, and if a public benefit were at stake, the contents of eligibility criteria would not be protected by law. This would result in relentless manipulation and counter-manipulation between clients and providers, with antagonism and scientific futility as the results.[12]

In view of this assessment, why should we persist with indicated programs heralded as homelessness prevention? There is an old debate about whether material aid and other help for poor people should be narrowly targeted or embedded in universal programs. The argument for targeting emphasizes the tendency of universal programs to "squander" resources on the most privileged; the counter-argument asserts that targeted programs are politically fragile because they alienate middle-income voters (Skocpol, 1991; Wilson, 1987). This larger debate need not concern us here, but there is an analogous question in the prevention of homelessness: Should homeless or "at-risk" poor people get privileged access to resources? The question is important because this is surely what occurs all over the country in the process of queue-forming, whether for subsidized housing in New York City or access to scarce, publicly-funded methadone maintenance slots in San Francisco,

Such preferences reflect moral judgments about relative suffering and culpability, and the relative success of advocates for one group of disadvantaged people or another, but these considerations aside, do

[12] The Social Security Administration's experience with adjudicating disability claims is perhaps the best example of the travails of an agency attempting to defend eligibility boundaries against desperate claimants often well-rehearsed by lay advocates and lawyers [see, in general, Mashaw (1983) and Stone (1984)].

they contribute to the efficient prevention of homelessness? In some part, the queue-jumping phenomenon makes such a question difficult to answer because it confounds the efficacy of indicated targeting. Moreover, agency staff sometimes have strong incentives to stretch the official definition of homelessness or risk for it-that is, to widen their nets-and such collusion further complicates the matter. Thus, the street-level politics of categorical distinction and resource rationing (Lipsky, 1980) make it difficult, though not impossible, to rigorously evaluate indicated homelessness prevention activities. We believe that most such programs probably prevent some homelessness, but what they do, for the most part, is help some poor people manage their deprivation a little better.

Broader, arguably more equitable approaches to the prevention of homelessness are essentially speculative, largely untried, and in their own ways, difficult to evaluate. On the surface, at least, they seem expensive, and no more efficient than the indicated programs we have criticized. Even so, the evidence to date suggests, above all, that the most effective levers for homelessness prevention are instruments of housing and income. Writ large in the form of housing, employment, income maintenance, and tax policy, such broad programs would affect the many rather than the few and lift vagrant boats on the flood tide. A selected strategy like subsidies for households with worst-case housing needs [akin to what Skocpol (1991) calls "targeting within universalism"] would not solve the problem of eligibility thresholds that arises in all programs that are not absolutely universal, but it would reach a high proportion of those who become homeless, and would, we believe, markedly decrease homelessness.

Such an approach seems especially urgent in view of HUD data which show that the crisis in affordable housing is worsening even during this period of roaring economic expansion (see footnote 6). Now, in particular, efforts to prevent homelessness must focus on making housing affordable to poor people. Only once this goal is attained does it make sense to consider other objectives. In our opinion, we need at this point to study the impact of saturating several geographically dispersed communities with new Section 8 certificates available to those with worst-case housing needs. (Such projects might be combined with empowerment zones.)

But Section 8 certificate holders need income as well as housing. In the wake of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and the 'collapse of General Assistance, we ought to test selected employment strategies modeled on the Job Corps but modified to include single parents and those with impairments that do not reach the level of a work disability as evaluated by the Social Security Administration. Such programs would address the failures of General Assistance and the homelessness of poor, young parents whose transition from adolescence to adulthood, from family of origin to independent household, historically was aided by welfare and, in recent years, seems to have incorporated frequent (if sometimes brief) shelter utilization.

If universal strategies, or selected strategies directed at abjectly poor people or those with worst-case housing needs, were employed nationwide, evaluation of their discrete contributions to homelessness prevention would be difficult. If they were applied in particular states or communities, evaluation might be possible using time series designs to compare prevalence rates of homelessness in locales with the programs to those without in nearby states or communities subject to the same general economic or social trends. These are the demonstration projects we recommend.

To compare variations on such approaches, housing subsidies and income subsidies, supported work, and public employment could be combined in some places with social services (including representative payee or rent voucher provisions) for substance abusers and people with a serious mental illness. Both services and participants' access to housing and income supports need to be carefully specified, however.

As suggested earlier, there is some evidence that direct rent payment may be an important predictor of long-term stability in housing and thus it warrants a separate experimental condition. More generally, it is critical to specify what is meant, precisely, by references to "case management." In the Alameda County study cited above, among homeless adults with major mental illnesses and/or substance use disorder, those with case managers had four to nine times the odds of receiving entitlement income (Zlotnick & Robertson, 1996). In other studies, case management seems to have included social brokerage and advocacy in connection with housing and entitlements, but as its content is essentially unspecified, case management is treated like the proverbial black box. To the extent that it provides access to housing and income, many studies that find significant contributions of case management to housing stability may have obscured the most critical elements of its success.

Finally, Culhane et al.'s (1996) findings on the neighborhoods from which shelter dwellers come suggest the relevance of selected prevention programs that both provide services to individuals and families and utilize community development and community organization methods to enhance the financial, human, and social capital of such immiserated areas.[13] Such programs deserve a test. We do not share Culhane et al.'s faith in the utility of indicated prevention measures within such a selected strategy, but we may be wrong, and certainly there is every reason to believe that community development is vitally necessary if prevention programs are to rise above the mere reallocation of homelessness.

13 Social capital is defined in a variety of ways, but however defined, it is not a characteristic of individuals but of collectivities, whether personal networks or geographically bounded communities. As the late James S. Coleman (1988:S98) phrased it: "Unlike other forms of capital [human and financial], social capital inheres in the structure of relations between actors and among actors. It is not lodged either in the actors themselves or in physical implements of production." Put another way, social capital "refers to the stocks of social trust, norms, and [formal and informal] networks that people can draw upon in order to solve common problems" (Lang and Homburg, 1998:4). Social capital, then, is implicated in the distribution of material resources, knowledge, and the specific and diffuse, formal and informal, influences gathered under the rubric of social control. Social capital is the lifeblood of communities that are both supportive and restraining; it promotes individual well-being and tolerable social order.

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Appendix A

Agenda

U.S. Department of Housing and Urban Development
U.S. Department of Health and Human Services

National Symposium on Homelessness Research
What Works?

Holiday Inn Rosslyn
1900 N. Fort Meyer Drive
Arlington, VA
October 29-30, 1998

FINAL AGENDA

Thursday, October 29.1998

8:30 - 9:00 Registration and Continental Breakfast

9:00 - 9:30 **Welcome and Overview** (Rosslyn Ballroom)

Xavier de Souza Briggs
Deputy Assistant Secretary for Research, Evaluation and Monitoring
U.S. Department of Housing and Urban Development
Washington, DC

Margaret A. Hamburg
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Washington, DC

Ann O'Hara
Symposium Facilitator
Technical Assistance Collaborative
Boston, MA

9:30 - 10:30 **What Do We Know? Demographics, Needs, and Special Populations**

Introductions:
Mary Ellen O'Connell
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Washington, DC

Presenters (20 minutes each):

Martha Burt
The Urban Institute
Washington, DC

Robert Rosenheck
Northeast Program Evaluation Center
West Haven, CT

Facilitated Discussion (20 minutes):
Ann O'Hara

10:30 - 1050 BREAK

1050 - 12:30 **What Do We Know About Addressing Homelessness?**

Introductions:
James Hoben
Office of Policy Development and Research
U.S. Department of Housing and Urban Development
Washington, DC

Presentations (20 minutes each):

Prevention
Mary Beth Shinn
New York University
New York, NY

Outreach and Engagement
Jaime Page
Health Care for the Homeless Project
Honolulu, HI

Emergency Shelter and Services
Linda Fosburg
Abt Associates, Inc.
Cambridge, MA

Transitional Housing and Services
Susan Barrow
New York State Psychiatric Institute
New York, NY

Facilitated Discussion (20 minutes):
Ann O'Hara

12:30 - 1:30 LUNCH (on your own)

1:30 - 2:40 **What Do We Know About Addressing Homelessness?**

Concurrent Discussion Groups (select one)

A. Prevention (Rosslyn Ballroom)

Respondents (10 minutes each):
Philip Mangano
Massachusetts Housing and Shelter Alliance
Boston, MA

Eric Lindblom
Campaign for Tobacco-Free Kids
Washington, DC

Ruth Schwartz
Shelter Partnership, Inc.
Los Angeles, CA

Facilitated Discussion (40 minutes):
James Hoben

B. Outreach and Engagement (Shenandoah A)

Respondents (10 minutes each):
Julie Lam
Northeast Program Evaluation Center
West Haven, CT

Elizabeth Patterson
The Shepherd's Table
Alexandria, VA

Steve Baron
Baltimore Mental Health Systems
Baltimore, MD

Facilitated Discussion (40 minutes):
Walter Leginski
Center for Mental Health Services
Department of Health and Human Services
Rockville, MD

C. Emergency Shelter and Services (Shenandoah B)

Respondents (10 minutes each):

Sr. Mary Scullion
Project H.O.M.E.
Philadelphia, PA

Terri Bishop
Community for Creative Non-Violence
Washington, DC

Barbara Poppe
Community Shelter Board
Columbus, OH

Facilitated Discussion (40 minutes):

Mark Johnston
Office of Special Needs Assistance Programs
U.S. Department of Housing and Urban Development
Washington, DC

D. Transitional Housing and Services (Dogwood)

Respondents (10 minutes each):

Cynthia Wilson
Arlington/Alexandria Coalition for the Homeless
Arlington, VA

Greg Owen
Wilder Research Center
St. Paul, MN

Sue Watlov Phillips
Elim Transitional Housing
Minneapolis, MN

Facilitated Discussion (40 minutes):

Jean Whaley
Office of Special Needs Assistance Programs
U.S. Department of Housing and Urban Development
Washington, DC

2:40 - 3:00 BREAK

3:00 - 4: 15 **What Do We Know About Providing Services To People Who Are Homeless?**

Introductions:
Mary Ellen O'Connell

Presentations (20 minutes each):

Case Management
Gary Morse
Community Alternatives
St. Louis, MO

Clinical Interventions
Lillian Gelberg
University of California Los Angeles
Los Angeles, CA

William Breakey
Johns Hopkins University
Baltimore, MD

Systems Integration
Deborah Dennis
Policy Research Associates, Inc.
Delmar, NY

Facilitated Questions from Floor (15 minutes):
Ann O'Hara

4: 15 - 5:30 **What Do We Know About Providing Services To People Who Are Homeless?**

Concurrent Group Discussions

A. Case Management (Dogwood)

Respondents (10 minutes each):
G.G. Greenhouse
Alameda County Health Care for the Homeless
Oakland, CA

Phyllis Soloman
University of Pennsylvania
Philadelphia, PA

Nora Stark
Compass Health Care
Tucson, AZ

Facilitated Discussion (40 minutes):
Mary Ellen O'Connell

B. Clinical Interventions (Shenandoah A&B)

Respondents (10 minutes each):
Laura Gillis
Health Care for the Homeless
Baltimore, MD

Jacki McKinney
Work Group on Women, Violence, and Mental Health
Philadelphia, PA

Ed Hendrickson
Arlington County Mental Health, Mental Retardation'and Substance Abuse Services
Arlington, VA

Facilitated Discussion (40 minutes):
Jean Hochron
Health Resources and Services Administration
U.S. Department of Health and Human Services
Bethesda, MD

C. Systems Integration (Rosslyn Ballroom)

Respondents (10 minutes each):
Margaret Reese
UNITY for the Homeless
New Orleans. LA

Vicki Wieselthier
St. Louis Mental Health Center
St. Louis, MO

Mary Ann Gleason
National Coalition for the Homeless
Washington, DC

Facilitated Discussion (40 minutes):
Fran Randolph
Center for Mental Health Services
U.S. Department of Health and Human Services
Rockville, MD

6:00 - 7:30 RECEPTION – Sponsored by Freddie Mac

Special Thanks to the staff at Abt Associates and Policy Research Associates, especially Linda Fosburg and Deborah Dennis, who organized the Symposium for HUD and HHS.

We also wish to acknowledge the Arlington/Alexandria Coalition for the Homeless which is a co-sponsor of the Symposium under a grant provided by the Freddie Mac Foundation.

Friday, October 30, 1998

8:00 - 8:30 Continental Breakfast

8:30 - **9:00** **Recap of Previous Day**

Ann O'Hara

9:oo - 10:20 **What Do We Know About Reconnecting People To Permanent Housing and Employment?**

Introductions:
James Hoben

Presenter (20 minutes):
Debra J. Rog
Vanderbilt University
Washington, DC

Respondents (10 minutes each):
Jim Wright
Tulane University
New Orleans, LA

Eric Payne Butler
Pine Street Inn
Boston, MA

Gerald Turner
Arlington/Alexandria Coalition for the Homeless
Arlington, VA

Facilitated Discussion (30 minutes):
Ann O'Hara

10:20 - 10:40 BREAK

10:40 - **12:OO** **What Do We Know About Meeting the Needs of Specific Subgroups Among Those Who Are Homeless?**

Four discussion groups will be led by expert facilitators. Experts will provide 5-10 minutes of introductory remarks, then open discussion to the group.

A. Families/Domestic Violence (Rosslyn Ballroom)
Amy Salomon
The Better Homes Fund
Newton Center, MA

B. Youth (Shenandoah B)
Gretchen Noll
National Network for Youth
Washington, DC

C. Veterans (Shenandoah C)
Linda Boone
National Coalition for Homeless Veterans
Washington, DC

D. Adults with Health Issues I (Shenandoah A)
Fred Osher
University of Maryland
Baltimore, MD

E. Adults with Health Issues II (Dogwood)
James O'Connell
Health Care for the Homeless Program
Boston, MA

12:oo - l:oo LUNCH

1 :oo - 2:20 **What Do We Know About Accountability and Outcomes?** . .

Introductions:
George Ferguson
Interagency Council on the Homeless
Washington, DC

Presenter (20 minutes):
Dennis Culhane
University of Pennsylvania
Philadelphia, PA

Respondents (10 minutes each):
Paul Koegel
RAND
Santa Monica, CA

Donna Haig Friedman
University of Massachusetts
Boston, MA

William Phillips
Rensselaerville Institute
Rensselaerville, NY

Facilitated Discussion (30 minutes):
Ann O'Hara

2:20 - 2:40 BREAK

2:40 - 4:30 **Where Do We Go From Here?**

Moderator:
Kim Hopper
Nathan Kline Institute for Psychiatric Research
Orangeburg, NY

Panelists:
Harreld Adams
Los Angeles Homeless Services Authority
Los Angeles, CA

Brenda Ferrell
Central Massachusetts Housing Alliance
Worcester, MA

Maria Foscarinas
National Law Center on Homelessness and Poverty
Washington, DC

Julie Hales
Michigan State Housing Development Authority
Lansing, MI

Vivian Frelix Hart
City of San Jose Homeless Services
San Jose, CA

Paul Koegel
RAND
Santa Monica, CA

Heidi Nelson
Chicago Health Outreach
Chicago, IL

Nan Roman
National Alliance to End Homelessness
Washington, DC

4:30 ▪ 4:45 **Closing Remarks/Next Steps**

Fred Karnas, Jr.
Deputy Assistant Secretary for Economic Development
Office of Community Planning and Development
U.S. Department of Housing and Urban Development
Washington, DC

Marsha Martin
Special Assistant to the Secretary
Office of the Secretary
U.S. Department of Health and Human Services
Washington, DC

Appendix B

Biographies

U.S. Department of Housing and Urban Development
U.S. Department of Health and Human Services

National Symposium on Homelessness Research
What Works?

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Holiday Inn Rosslyn
Arlington, VA
October 29-30, 1998

FACULTY BIOGRAPHIES

Susan Barrow is an anthropologist who works as a research scientist at the New York State Psychiatric Institute in New York City. She has been doing research on homelessness since 1979. Her work has combined qualitative methods in studies of service interventions and housing programs for psychiatrically disabled men and women as well as other homeless adults staying in shelters or on the streets or other public places. Recent studies have focused on low demand transitional housing and on alternative approaches to permanent housing.

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Ellen Bassuk is Associate Professor of Psychiatry at Harvard Medical School. She is co-founder and president of The Better Homes Fund, a non-profit organization started in 1988 by Better Homes and Gardens magazine to help homeless families and their children nationwide. Its purpose is to reduce family homelessness by developing and helping to implement preventive, comprehensive, and long-term policies and programs. Dr. Bassuk has published many articles, monographs and books and has completed some of the seminal research about homeless families and children. She is currently the principal investigator of an epidemiologic longitudinal study, investigating the risks of family homelessness and its impact on children. Dr. Bassuk received her B.A. from Brandeis University, her M.D. from Tufts Medical School and completed a residency in psychiatry at Beth Israel Hospital. She served as director of Hospital's Continuing Care Clinic and Psychiatric Emergency Services. Dr. Bassuk was also a Fellow at The Bunting Institute, Radcliffe College. She received an honorary Doctorate of Public Service from Northeastern University in 1993. Dr. Bassuk just completed a 3-year editorship at the American Journal of Orthopsychiatry.

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Jim Baumohl holds a doctorate in social welfare from the University of California, Berkeley, and has been a professor at Bryn Mawr College since 1990. Between 1986 and 1990, he taught at McGill E-mail: barrows@pi.cpmc.columbia.eduUniversity in Montreal, Quebec. Before turning to full-time academic work in 1986, Jim Baumohl had been a streetworker, a welfare rights advocate, a shelter director, and a tenant organizer, among other things for 15 years.

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William Breakey completed his medical and psychiatric training in Belfast, Northern Ireland. Subsequently, he held faculty positions at Cornell, Punjab University in India, and the University of Oregon Health Sciences Center. In 1976, he joined the faculty of the Johns Hopkins University School of Medicine in Baltimore, where he is currently a professor in the Department of Psychiatry and Behavioral Sciences. His extensive work in community psychiatry and services for persons with severe and persistent mental illness has included a special emphasis on homeless people. His research focus has been primarily on the epidemiology of psychiatric disorders among persons who are homeless, and the evaluation of programs for persons with serious mental illness. Dr. Breakey has published widely on topics relating to homelessness and has participated on APA and other national committees and task forces. He recently served as chair of the Mental Health Section of the American Public Health Association.

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Martha Burt has been involved with research on homelessness, emergency assistance, and hunger since 1985. In 1992 she completed a book, ***Over the Edge,*** analyzing the causes of homelessness in the 1980s. She has recently focused on the impact of federal and state policy changes on the well-being of children and youth, on homelessness, on hunger among the elderly, on services integration projects for at-risk youth, and on service issues related to domestic violence. She directed the first national probability-based study of the urban homeless (1987), resulting in one book and other publications. She was involved in planning the second such study (National Survey of Homeless Assistance Providers and Clients, 1995-96), and is currently completing a report on its results. She helped to develop and disseminate different ways to count and describe homeless children and adults; has examined state policies, legislation, funding and programs to serve the homeless and to prevent homelessness; has written about rural homelessness; evaluated the effectiveness of the Emergency Food and Shelter Program funded through the Federal Emergency Management Administration; and has worked with European researchers on homeless measurement.

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Joseph J. Cocozza is Vice President for Research with Policy Research Associates, Inc. (PRA). Since joining PRA in 1990, Dr. Cocozza has worked on a number of projects including a national survey of pre-trial forensic evaluations, a multi-site study of welfare reform, and an assessment of comprehensive approaches to children and family services. As part of his long-standing interest in mental health services for juvenile offenders, he edited a comprehensive review of existing research in the monograph, Responding to the Mental Health Needs of Youth in the Juvenile Justice System, and has evaluated the changes occurring in a number of states that are attempting to improve their services to these youth. For the past three years, Dr. Cocozza has directed a new national effort, The National GAINS Center for People with Co-occurring Disorders in the Justice System, focused on improving and better coordinating the systems responsible for people with co-occurring mental health and substance abuse disorders who come in contact with the justice system. Over the past year, the Center has undertaken a number of initiatives aimed specifically at youth involved with the juvenile justice system. Currently, Dr. Cocozza is also directing the Coordinating Center for the federally supported, 14 site, Women and Violence Study for women with co-occurring disorders and histories of violence/trauma, and has lead responsibility for PRA's involvement in the national evaluation of the Center for Mental Health Services' ACCESS Demonstration Program for integrating services for homeless persons with mental illness. Prior to joining PRA, he spent seven years as Executive Director of the New York State Council on Children and Families (CCF) where he had earlier served as its Director of Research. As head of CCF, a state agency charged with improving the provision and coordination of services for children and families, Dr. Cocozza worked with the Governor's Office, budget and legislative officials, state commissioners and local officials and providers to analyze and develop major state initiatives aimed at promoting more effective and better integrated services. Dr. Cocozza had held a number of policy-oriented research, academic and administrative positions over his career including work over a five year period with the New York State Office of Mental Health. Dr. Cocozza received his doctorate in Sociology in 1975 and has authored a number of professional publications and reports.

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Dennis Culhane's primary area of research is homelessness and housing distress. His current work includes studies of the impact of homelessness on utilization of Medicaid services, public hospitals, state psychiatric hospitals, jails, prisons, and behavioral health treatment, in New York City, and studies of the dynamics of public shelter use in New York and Philadelphia. He recently completed the development of a management information system for tracking utilization of homeless services for HUD and HHS. He also recently completed studies of housing and neighborhood factors related to the distribution of homeless persons' prior addresses in New York, Philadelphia and Washington, D.C. He is currently leading an effort to integrate property, neighborhood, and human services data from Philadelphia into a geographic information system to support policy analysis and program planning and evaluation.

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David Eldridge is a Ph.D. candidate in Social Welfare at the University of Pennsylvania. His proposed dissertation is entitled, "Paying the Rent: Tenancy, Landlord-Tenant Law, and Housing Justice", and is a multi-method analysis of the conflict between landlords and tenants in the context of legal disputes and housing economics. His major research interests are housing, homelessness, and fair housing.

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Sally Erickson has more than fifteen years social service, managerial, public relations, and special events experience in non-profits and the private sector in Los Angeles, Seattle and Honolulu. For the last three years, she has served as a Project Director for Mental Help Hawaii in the development and startup of Safe Haven Honolulu. She received her MSW in 1997 from the University of Hawaii at Manoa.

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Judith Feins has over 20 years' experience in housing research and policy analysis, the evaluation of federal and local programs, and management of research studies. A senior associate at Abt Associates in Cambridge, MA and a political scientist by training, she came to the study of housing programs for homeless families and individuals through her interest in improving the living conditions of low-income people in the United States. Dr. Feins' current primary research focus is housing mobility--helping low-income families to leave the concentrated-poverty neighborhoods in which so many live and move to areas of opportunity, where work is available and the quality of schools and public services is better. She directs the project to assist HUD with long-term tracking and monitoring of the Moving to Opportunity Demonstration program and is helping sites around the country to improve their Regional Opportunity Counseling programs. She holds a doctorate in Political Science from the University of Chicago.

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Linda Fosburg is a senior associate at Abt Associates in Cambridge, MA, with 24 years of experience in managing and conducting research for HUD and other clients. Skilled in both qualitative and quantitative research methodologies, she has directed projects in a wide variety of fields including homelessness, housing, education, banking and financial services, employee satisfaction, health, nutrition and publishing. She has had lead responsibility for three national evaluations of homeless programs funded by HUD and HHS: the 1987-1990 NIMH McKinney Demonstration Program for Homeless Persons with Mental Illness, the HUD Emergency Shelter Grant Program evaluation, and the HUD Shelter Plus Care Evaluation. She holds a Ph.D. in Counselor Education and Educational Research from the University of Florida.

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Lillian Gelberg is Associate Professor of Family Medicine in the UCLA School of Medicine. Dr. Gelberg is a health services researcher who conducts community-based research on the health of homeless and impoverished adults in Los Angeles County. She has studied homeless adults living in shelters and outdoor areas, and the health and use of health services among homeless and low-income housed patients. She also has studied change in health status and use of health services among homeless adults; delays in onset of treatment for tuberculosis patients; health status, contraception use, access to care, and patient satisfaction among homeless women in shelters and food programs; structures and processes that predict access to care in medical facilities providing care to impoverished women; and satisfaction of patients treated in ambulatory settings in public health care clinics. Dr. Gelberg is an alumna of the Robert Wood Johnson Foundation Clinical Scholars Program and is currently a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar. She has received the Association for Health Services Research 1995 Young Investigator Award and the 1997 Article of the Year Award. Dr. Gelberg graduated with an M.D. from Harvard Medical School and completed her internship and residency at Montefiore Hospital in The Bronx, N.Y. She earned an M.S.P.H. in health services research from the UCLA School of Public Health. She has been a member of the UCLA School of Medicine faculty since 1986.

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Nicole Glasser is a public education specialist with the Massachusetts Department of Mental Health in Boston, MA, where she has worked since 1994. She is a journalist who has written on many issues related to mental health, including her personal experiences in recovery from mental illness, homelessness and substance abuse. Her articles have appeared in *Connections,* a magazine for and by persons with disabilities, and *Spare Change,* a newspaper of the streets in Massachusetts. She is a member of the City of Boston's Consumer Involvement Committee which advises the City's Emergency Shelter Commission and the Office of Neighborhood Development. The Committee, composed of consumers with experienced with homelessness and mental illness, was formed to provide input into the allocation of a $100,000 trust left to the Boston Foundation and targeted to homeless persons with serious mental illness.

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C. Scott Holupka is a Research Associate at the Washington Office of the Vanderbilt University center for Mental Health Policy where he has worked on a number of projects involving homelessness, supportive housing, and social service systems. Current and recent research efforts include the development of a cost study of supportive housing for people living with HIV/AIDS: participating in the coordinating center for a multi-site study of housing approaches for persons with serious mental illness; an evaluation of the Corporation for Supportive Housing for The Pew Charitable Trusts, The Ford Foundation, and The Robert Wood Johnson Foundation; and an evaluation of a supportive housing employment initiative. Dr. Holupka has also been involved in the evaluation of the Homeless Families Program, a nine city demonstration developed and jointly sponsored by The Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development. Prior to joining Vanderbilt, Dr. Holupka was part of a research team that evaluated the Lafayette Courts Family Development Center, a pilot social service program in Baltimore. In addition to his evaluation activities, other areas of interest include urban development and community change.

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Marsha McMurray-Avila works for the National Health Care for the Homeless Council as a Program Coordinator for activities related to training, education and research in the field of homeless health care. She is the author of *Organizing Health Services for Homeless People: A Practical Guide* (1997), a reference for communities or groups interested in creating or improving health care services for homeless people, and has co-authored several articles related to various aspects of homelessness and health. Beginning in 1985, Marsha worked for Albuquerque Health Care for the Homeless, serving as

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Gary Morse is the founder and president of Community Alternatives in St. Louis, MO, a managed behavioral health care agency formed specifically to meet the needs of persons with serious mental illness, including those who are homeless. As a researcher and clinical psychologist, Gary has worked in the field of services for homeless persons since 1983. He is the author of several book chapters, journal articles, and major research reports on homeless issues. He was one of the first NIMH-funded researchers to study the relationship of homelessness and mental illness and the efficacy of service and treatment modalities for the homeless mentally ill population. Bridging the worlds of both clinical practice and research, Gary is an expert on case management and outreach to homeless persons.

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Jaimie Page is the project coordinator of Kalihi-Palama Center's Health Care for the Homeless Project (HCHP). HCHP provides comprehensive services to more than 2,000 homeless persons each year on the island of Oahu. Jaimie was an integral member of the task force that designed and planned Safe Haven Honolulu, a collaborative project of HCHP. She was clinic coordinator for Safe Haven's first two years before moving on to her current position. Jaimie received her bachelor's degree is social work from San Diego State University in 1989 and her master's degree in social work from the University of Hawaii in 1991. She has ten years experience working with homeless persons in San Diego, Salt Lake City, and Hawaii in outreach, case management, clinical and administrative areas.

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Debra Rog is a research fellow with the Vanderbilt University's Institute for public policy studies, and director of the Washington office of the Center for Mental Health Policy. She has nearly 20 years of experience in program evaluation and applied research and has directed numerous multisite evaluations, and research projects. Dr. Rog has to her credit numerous publications on evaluation methodology, housing, homelessness, poverty, mental health, and program and policy development. and is co-editor of the Applied Social Research Methods Series and the recently published *Handbook of Applied Social Research Methods.* Currently, she is on the Board of Directors of the American Evaluation Association, and a member of the American Psychological Association and the American Public Health Association. She completed an appointment on the Advisory Committee of Women's Services for the U.S. Substance Abuse and Mental Health Services Administration, and has been recognized. for her evaluation work by the National Institute of Mental Health, the American Evaluation Association, the Eastern Evaluation Research Society, and the Knowledge Utilization Society.

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Amy Salomon, a political scientist, has over fifteen years of experience in research and evaluation, technical assistance and policy and program development. Her work has focused on disenfranchised populations including homeless families, minority elders, people with disabilities, and families with incomes under 125% of poverty. Dr. Salomon is currently executive director at the Better Homes Fund in Newton Center, MA. She has also served as director of programs and evaluation, as well as project manager for the Worcester Family Research Project, and NIMH-funded study of homeless mothers and children in Worcester, MA. Dr. Salomon has focused most recently on the interface between homelessness and family violence; the prevalence of violence in the lives of welfare recipients;, and the impact of violence on welfare use and women's capacity to maintain work over time. Dr. Salomon currently teaches a Community Medicine Clerkship on Homelessness at the University of Massachusetts Medical School and has co-taught a course on Poverty, Homelessness and Women at Harvard Divinity School.

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Marybeth (Beth) Shinn is professor of psychology and chair of the psychology department at New York University. She has conducted several studies of homelessness including a five-year longitudinal study of homeless and poor housed families in New York City funded by the National Institute of Mental Health. Dr. Shinn is a recipient of the award for Distinguished Contributions to Theory and Research from the Society for Community Research and Action. She received her Ph.D. in social and community psychology from the University of Michigan in 1978.

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Henry J. Steadman, Ph.D., is President of Policy Research Associates, Inc. Previously, Dr. Steadman ran a nationally known research bureau for 17 years for the New York State Office of Mental Health. His work has resulted in six books, over 100 journal articles in a wide range of professional journals, 18 chapters, and numerous reports. Among Dr. Steadman's major current projects are: (1) the National GAINS Center for Persons with Co-occurring Disorders in the Justice System; (2) the John D. and Catherine T. MacArthur Foundation Violence Risk Assessment Study; (3) the National Resource Center on Homelessness and Mental Illness under contract to the Center for Mental Health Services; and (4) the Women and Violence Coordinating Center funded by SAMHSA. Dr. Steadman received his B.A. degree and his M.A. degree in Sociology from Boston College and his Ph.D. in Sociology at the University of North Carolina at Chapel Hill. In 1987, Dr. Steadman received the Amicus Award from the American Academy of Psychiatry and the Law. He also received the Philippe Pine1 Award from the International Academy of Law and Mental Health in 1988, the Saleem A. Shah Award in 1994 from the State Mental Health Forensic Directors, the 1998 Distinguished Contribution to Forensic Psychology from the American Academy of Forensic Psychology, and the 1999 Isaac Ray Award from the American Psychiatric Association for his outstanding contributions to the psychiatric aspects of jurisprudence.

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Paul Toro is Associate Professor of Psychology and Director of the Research Group on Homelessness and Poverty at Wayne State University in Detroit, Michigan. He has published over 50 articles and other works. His research on homelessness has involved homeless adults, families, and youth and has included studies comparing homeless with matched housed groups, following homeless people in longitudinal designs, evaluating interventions, assessing public opinion, and making international comparisons. He has also conducted research on mutual-help groups, social support, and prevention programs.

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Carol Wilkins is the Director of the Health, Housing and Integrated Services Network, a collaborative which currently includes more than 30 non-profit and local government agencies which offer affordable housing and an array of services to homeless and disabled adults in three counties in the San Francisco Bay Area. She has more than 15 years of experience in public finance, services and policy work, including work with the State Legislature's Office of the Legislative Analyst, the State Assembly Ways and Means Committee, as Deputy Mayor for Finance in San Francisco, and as Finance Director for the San Francisco Housing Authority. She has substantial experience managing complex, multifaceted, multidisciplinary programs serving vulnerable populations. She is the author of the 1996 article, "Building a model managed care system for homeless adults with special needs: the Health, Housing and Integrated Services Network" in ***Current Issues in Public Health.***

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Rita Zimmer is Founder, President, and CEO of Women In Need, Inc. (WIN), an agency established in 1983 to provide services to homeless and underprivileged women and children. Concerned about the lack of adequate social services for this population, Zimmer and a like-minded group of colleagues decided to take action, opening WIN's first shelter on Valentine's Day in 1983. WIN has grown from one shelter and a soup kitchen with a budget of $15,000 in 1983, to an organization with multiple residences and programs, 175 staff, more than 300 volunteers, and an $8.5 million budget in 1997. Today, WIN's services are based in Manhattan, the Bronx, Brooklyn, and Queens. Programs include transitional residences; employment and educational training; alcohol and substance abuse treatment; children's services; family support services; HIV prevention education; and aftercare services. From the beginning, WIN's focus has been not only on the delivery of services, but on program evaluation and research as well. All programs are designed with the goal of enabling the women and their families to realize self-determination. WIN and Rita Zimmer have won 14 awards in the past fourteen years. Among them are the Joseph Webber Award presented by United Way for being on of the six best managed social service agencies in New York City; the Brooke Russell Astor award to Zimmer, "in recognition of her outstanding commitment and contribution to improving the quality of life in New York;" and the Robin Hood Foundation Heroes Award, in recognition of WIN's "heroic work to serve poor New Yorkers." Rita Zimmer graduated from Ricker College in Maine and received an MPH from New York University. She is active on several boards, committees, and advisory groups whose missions are to promote the well-being and empowerment of poor and addicted women and their families.

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Appendix C

Participant List

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U.S. Department of Health and Human Services

National Symposium on Homelessness Research
What Works?

Holiday Inn Rosslyn
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October 29-30, 1998

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