

**SERVICES FOR HOMELESS PERSONS
WITH MENTAL ILLNESS:
COMMENTS AND STRATEGIES FOR
ALLEGHENY COUNTY**

by

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This thesis describes and assesses existing services for homeless persons with mental illness and suggests improvements. The topic of services for homeless persons with mental illness is of public health significance since the problem has been getting worse in the past few years, with people unable or unwilling to access appropriate services. Mental illness in the homeless population is looked at from a social-ecological perspective, including individual, community and policy levels. Current national programs are discussed including Medicaid, SSI, HUD, SAMHSA and ACT. The McKinney Act is discussed as one of the most important pieces of homeless policy. A more in-depth discussion of Allegheny County community capacity and services for homeless persons with mental illness is included. Housing First/Harm reduction, Operation Safety Net, Community Human Services Corporation, Health Care for the Homeless, Mental Health Courts and Police Training are discussed. Key informant interviews reveal frustrations with funding streams, lack of affordable housing and lack of appropriate job opportunities, specific to Allegheny County. An extension of this thesis to include focus groups and interviews with homeless individuals and shelter staff would reveal a more comprehensive view of homeless persons with mental illness. Suggestions for improvements in providing mental health services include, following the housing first/harm reduction model, improving quality of life through increased social supports of this population, advocacy of homeless persons with mental illness, an increase of funding streams that promote collaboration among community

agencies, more street outreach for the chronic homeless population and overall more collaboration among different agencies in Allegheny County including, government, social services, education, police and emergency services.

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PREFACE

As with most academic endeavors, this thesis progressed through the support from many people. First, I would like to thank the professionals who graciously allowed me to interview them and to be inspired by the work they do on a daily basis. I would particularly like to thank Theresa Chalich, for guiding me through an insightful internship at Bethlehem Haven and for continuing to be a lifelong mentor. Staff at the Community Human Services Corporation opened their doors and provided a wealth of knowledge to me that went beyond anything I expected. Sgt. Miller of the Pittsburgh Police is dedicated to the protection of the community and his warmth inspired me. Jim Withers and Ken Thompson are medical doctors dedicated to serving others and I am motivated by them. I would like to thank my committee members for their help and guidance in this process. I would especially like to express my gratitude to Dr. Ken Jaros, for his direction throughout my graduate career. I do not think he quite realizes the tremendous impact he had on my academic experience and my life in general. I wish to express my tremendous gratefulness and awe to my parents, William and Rita Zinno for raising me to not only respect the value of an education, but for instilling in me the values and morals to want to dedicate my life to serving marginalized people, such as homeless persons with mental illness. Their hard work and support have allowed me to arrive where I am today. And lastly, I would like to thank my fiancé, Jeremiah Ratta, for his patience, unconditional love and sustenance, not only with my academic career, but in all areas of my life.

1.0 INTRODUCTION

“To the extent that we respond to the health needs of the most vulnerable among us, we do the most to promote the health of the nation” (former Surgeon General, David Satcher, DHHS, 1999).

The purpose of this thesis is to describe and assess existing services for homeless persons with mental health problems and suggest improvements. Such services include not only specific targeted medical interventions, such as medication and psychotherapy, but also include efforts to build social support, stimulate community involvement and engagement in productive activities, because those more general efforts can lead to better mental health outcomes. Providing these types of services may allow homeless mentally ill individuals to maintain stable housing better than medication alone. The combination of mental illness and homelessness is debilitating and so complex that it is no wonder that even with programs available, the problem is still prevalent. I will therefore assess national and local services for persons who are both homeless and mentally ill and subsequently provide suggestions for progress.

Homelessness among persons with serious mental illness is an intricate and multi-faceted public health problem, both nationally and in Pittsburgh. Even the very defining of homelessness, what would seem to be a straightforward matter, becomes rather complicated. Although definitions of homelessness vary, they are used to determine who is eligible for shelter assistance, housing assistance or more chronic homeless needs. The Stewart McKinney Homeless Assistance Act of 1987 defines a homeless person as “any individual who lacks

housing, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations or an individual who is a resident in transitional housing”. Since recidivism is a problem in the homeless population, practical definitions of homelessness must account for the time frame in which a person lacks housing, distinguishing between chronic and temporary situations. According to the U.S. Department of Housing and Urban Development (HUD, 2007), a "chronically homeless person" is an individual who has been without a home for at least one year and is diagnosed with mental illness or drug or alcohol addiction. Chronically homeless individuals are so defined because of the length of time they are homeless, but also coupled with a mental health diagnosis. Mental illness can be defined collectively as all mental disorders, which are health conditions where thinking, mood or behavior are modified and associated with distress or impaired functioning (DHHS, 1999). These disorders considered to be severe and persistent mental illness can be defined through the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.

The U.S. Department of Housing and Urban Development (HUD, 2007) conducted a point-in-time estimate in January, 2005 and estimated that 754,000 people were homeless, nationally. Of this number, approximately 45% were non-sheltered homeless (street homeless). Further, approximately 25% of the homeless population suffers from a severe mental illness (National Coalition for the Homeless, 2006b). In all, it is estimated that in any year 2.3-3.5 million Americans experience homelessness, and some studies reveal that as many as a third of them suffer mental problems (Hwang, 2005). The exact numbers may vary from one research study to the next, but clearly homelessness is quite prevalent. Moreover it is quite complicated, especially when coupled with severe mental illness.

Severe mental illness in the homeless population is an important public health issue, which unfortunately appears to be getting worse. Healthy People 2010 originally set objective 18-3 to reduce the percentage of homeless adults with serious mental illness, from 25% to 19%. During the mid-course review, this objective was revised, since the percentage of homeless adults with serious mental illness actually increased. Because many homeless persons with mental illness did not receive mental health services, the new objective for Healthy People 2010 is to increase the number of homeless adults that receive mental health services, from 27% to 30%. While numerous, comprehensive publications have been released detailing what it will take to end homelessness (DHHS, 2003, ACHA, 2005, National Coalition for the Homeless, 2006b), gaps in intervention options, lack of collaboration between agencies and lack of appropriate services still exist. According to the National Resource Center on Homelessness and Mental Illness (2007), the intervention of community treatment, when utilized effectively, can decrease homelessness among people with mental illness.

The problems of homeless persons with mental illness are great, and pose a burden requiring federal assistance. These problems may exceed the capacity of local and state assistance and therefore require Federal efforts such as the McKinney Research Demonstration Programs of 1990. The results of this longitudinal research design show that “even people with the most serious mental illnesses who are homeless, once thought to be unreachable and difficult-to-serve, can be reached by the service system, can accept benefit from mental health services, and, with appropriate supports, can remain in community-based housing” (DHHS, 2003). These results confirm what many providers of homeless mental health services have long believed for themselves.

To fully understand the issue of homelessness and severe mental illness, a social-ecological approach is beneficial. This model recognizes the multi-level, interwoven relationship between an individual and his/her environment. Rather than examine a problem such as homelessness in terms of individual attributes alone, the social-ecological approach directs us to examine the other levels of the problem, including interpersonal, organizational, community and public policy levels (Glanz, Rimer & Lewis, 2002). Interventions that are multidisciplinary and multilevel tend to be the most effective for helping bring about long-term improvements in health. Taking an ecological approach implies that physical and social environments are interdependent and that multiple aspects of the person and multiple aspects of the environment influence individual and community well-being (Grzywacz & Fuqua, 2000). The framework provides an important context for the homeless individual with mental illness, such that equal emphasis is placed on the individual and their environment. In other words, full responsibility for perpetuating homelessness cannot be placed solely on the individual, but also on organizations, community and policy issues. This thesis is designed to review the current literature surrounding the issue of mental illness in the homeless population from a social-ecological perspective.

Homeless individuals' basic physical needs must be met before some mental health services can be successful. Therefore, I will also look at other factors in homelessness to provide a broader understanding of persons with mental illness who are also homeless. The issue will be reviewed from individual, interpersonal, organizational, community and policy levels to review the problem of mental illness in the homeless. As defined earlier, I will look at those individuals who are chronically homeless. Services for the general homeless population will be discussed on a national level, with a specific focus on mental health services. Rather than try to solve the issue of which comes first- homelessness or mental illness, this thesis is designed to present

views on services that are available once a person is homeless and also suffering from a mental disorder, while not ignoring risk factors that can lead to homelessness and could be prevented.

A review of the literature and overview of services was not sufficient to fully understand the issue of homeless mental illness and so key informant interviews were done to gain fuller understanding of Allegheny County homeless. Key informant interviews of community leaders provided an overview of problems and strategies surrounding the mentally ill homeless in Allegheny County. Key informant interviews helped reveal where to gather more information and identified gaps in services and collaboration efforts and also allowed for conclusions and suggestions to be drawn. A proposal of an assessment surrounding homeless and mental illness in Allegheny County was put forth, to provide a valuable viewpoint of homeless individuals themselves. Gaps in services and suggestions for providing better for the homeless are given.

2.0 THE HOMELESS INDIVIDUAL WITH MENTAL ILLNESS

Before assessing the current services for the mentally ill homeless, it is important to have an understanding of the homeless individual suffering from mental illness. Placing the individual in the context of family systems, communities and policies can help to better understand the issue of homelessness from multiple levels, which in turn helps to better assess the current services to determine if they are appropriate.

There is no doubt that mentally ill homeless individuals are among the most marginalized people in the United States. Separately homelessness and mental illness are looked upon with stigma and ignorance, but when coupled together, the effects are overwhelming. Many people choose to look the other way or pretend that homelessness and mental illness are not problems in their community. Albert Schweitzer and his concept of “Reverence for Life” have directed the lives of many in service professions to have respect for all people, including the destitute and marginalized. Schweitzer said, “Think occasionally of the suffering of which you spare yourself the sight”, which is relevant to the mentally ill homeless population and how many people choose to spare themselves the sight of working with the homeless population or pretend that homelessness is not an issue. Homelessness is indeed an issue that requires a collective solution of addressing the health matters of the homeless, but also the underlying problem of homelessness itself.

For the homeless population, mental health services for social supports and community help seem more appropriate than trying to force medication compliance and attendance in therapy. It is also not established which comes first. Does homelessness lead to poorer mental health or does a mental disorder lead to homelessness? While factors such as poverty, lack of jobs and lack of affordable housing all play a role in homelessness, there is clear evidence that the homeless population suffers higher rates of mental illness than the general population.

Understanding general risk factors for homelessness can lead to possible prevention interventions. Some risk factors for homelessness include mental illness, substance abuse, being a racial or sexual minority, being a veteran and involvement with the criminal justice system (DHHS, 2003). Those who suffer from both homelessness and mental illness will face more stigma and poorer physical health, which perpetuates the cycle.

2.1 MENTAL ILLNESS

For those with serious mental illness, the risk of becoming homeless is 10 to 20 times greater than for those in the general population (Kuno, Rothbard, Averyt & Culhane, 2000). Symptoms do not remain constant over time in many major mental health disorders. Symptoms may worsen and lessen and can be very cyclical in nature, especially if the individual cannot afford the appropriate medication or have access to counseling services. Schizophrenia, bipolar disorder and major depression are the most common forms of mental illness in the homeless population (Folsom, et al., 2005). Schizophrenia exists in 1.1% of the general population, while bipolar exists in 2.6% of the general population. On the other hand, schizophrenia and bipolar disorder make up 1/3 of the homeless population (Schizophrenia, 2007). Similarly, clinical depression,

suicidal thinking and attempts at suicide are two to five times more common in homeless individuals (Schutt, Meschede & Rierdan, 1994). These diagnoses can be hard to treat in the general population, but become virtually impossible to treat in the homeless population. The homeless have little access to psychiatric medications or the monitoring that will help them stay on their medication. Transient individuals will not be able to keep appointments for mental health services; others may never be diagnosed in the first place.

2.1.1 General vulnerability vs. specific vulnerability

Essentially, two explanations exist as reasons for homelessness in persons with mental illness. The specific vulnerability hypothesis states that mental illness is a specific vulnerability for homelessness. Reasons for homelessness are different in persons with mental illness compared to reasons in other groups. Conversely, the general vulnerability hypothesis states that reasons for homelessness are the same among persons with mental illness compared with other groups. Conditions such as poverty, stigma and lack of job opportunities are general to the whole homeless population and the source of homelessness (Mojtabai, 2005).

The specific vulnerability hypothesis suggests that more psychiatric treatment of homeless persons with mental illness is necessary. Treatment of mental illness would be necessary before housing maintenance could be achieved. On the other hand, the general vulnerability hypothesis suggests that general approaches for all homeless individuals should be provided. Thus, a person with mental illness who is homeless would be provided with housing just as the individual without mental illness. Deciding which is more appropriate could be determined based on how the individual lost their housing. If housing was lost because of their psychiatric symptoms, the specific vulnerability hypothesis would be more accurate. If housing

was lost because poverty or lack of job opportunities, rather than mental illness, the general vulnerability hypothesis would be supported. Mojtabai's (2005) study found that financial and interpersonal problems were the most common reasons that homeless individuals cited for their homelessness. Reasons for continued homelessness were the same for homeless persons with mental illness as those without mental illness.

While the general vulnerability hypothesis reminds us not to overlook the broader underlying causes of mental health problems in the homeless, we also need to address the more immediate problems of mental illness. Thus we need both hypotheses as a foundation- the general vulnerability hypothesis and specific vulnerability hypothesis. These two hypotheses match up quite well with two models on providing services to the homeless that exist today. The general vulnerability hypothesis matches up with the Housing First model, while the specific vulnerability hypothesis mostly matches up with the Continuum of Care model which will be discussed in subsequent sections. The concern with accepting the general vulnerability hypothesis lies in the lack of parity between mental health and physical health, which can turn into an unfortunate situation for a homeless individual. Homelessness should be addressed at multiple levels. At one level the homeless need to have their basic needs met, at another level they ought to have some choice of services. We need to understand that the problems of mental illness and homelessness interact to create a problem that is more than the sum of its parts.

2.2 SUBSTANCE ABUSE

Individuals who are both homeless and mentally ill may use drugs or alcohol in an attempt to forget about their problems. For those suffering from mental illness and co-occurring substance

abuse, homelessness can be more of a problem, in terms of recidivism. Montoya (2006) found that co-morbidity of mental illness and substance abuse seems to have a negative synergistic effect. Co-morbidity makes treatment outcomes uncertain and compliance less likely. Co-occurrence of mental illness and substance abuse is a significant problem, since approximately 50% of individuals with severe mental illness also suffer from substance abuse. In persons with mental illness who are homeless, this number jumps to 90%. Their symptoms appear more severe; they experience more denial and are more likely to avoid medication and other treatment (DHHS, 2003).

Co-occurrence of substance abuse with a mental disorder will put individuals at higher risk for homelessness, since many landlords will not rent to someone with substance abuse and these individuals may be at higher risk for arrest, incarceration and eviction. (DHHS, 2003). Susser and colleagues (1997) found a large prevalence of injection drug use in the mentally ill homeless over the course of their lifetime. Homeless mentally ill individuals now become more at risk for HIV or hepatitis if engaging in shared injection drug use. Susser and colleagues (1997) argue that almost no attention has been given to the homeless mentally ill population and their substance abuse and subsequent risk of HIV transmission. Clearly, homelessness can put individuals in situations where they will engage in risky behaviors and injection drug use is certainly such a situation.

Most health care professionals now recommend treatment for both disorders simultaneously when an individual has co-occurring substance abuse and a mental health disorder (DHHS, 2003). Homeless individuals are at a disadvantage in treatment options, since many do not have a fixed address and cannot afford transportation to get to treatment centers. While substance abuse treatment may be mandated if the individual gets into trouble, they may

not get the help they need for their mental health problems, at all, let alone simultaneously with substance abuse treatment.

2.3 DEMOGRAPHICS OF HOMELESSNESS

Homeless individuals are disproportionately from racial and ethnic minority groups. For instance, non-Hispanic Blacks make up approximately 11% of the general population, but make up about 40% of the U.S. homeless population (DHHS, 2003). When designing services for the mentally ill homeless population, it is important to remember that different races and ethnicities express mental health problems differently, seek help in different ways and have different ways of resolving their problems effectively. African-American or Asian groups may respond differently than whites to medications for mental illness, as well (DHHS, 2003).

Sexual minorities, especially in the youth population are at increased risk for homelessness. While gay, lesbian and bisexual youth only make up about 3-5% of the general population, they comprise approximately 20-40% of the homeless population (Buchanan, 2007). Gay, lesbian and bisexual adolescents may leave home more often, abuse substances and experience victimization more often than heterosexual youth (DHHS, 2003).

Approximately a third of homeless individuals have served in the Armed forces. Each day, about 200,000 veterans are living in shelters or in the streets. Shockingly, there are currently more Vietnam era veterans who are homeless than the number of Armed forces persons who died in that war. Approximately 45% of the veteran homeless population suffers from mental illness, 70% have alcohol and other drug abuse problems and 55% are Hispanic or African American (U.S. Department of Veterans Affairs, 2007).

People with mental illness have a higher likelihood of being arrested, even if they are committing the same crime as someone without mental illness. In fact, those with mental illness have a 64% greater risk of being arrested (DHHS, 2003). The U.S. Department of Justice reported that in 1998, 284,000 people with mental illness were in jail or prison. Many of these were homeless in the year before their arrest; approximately 20% of those in state prisons, 19% of those in federal prisons and 30% of those in local jail (DHHS, 2003). The homeless mentally ill are also in circumstances that make them more likely to engage in criminal behavior or more susceptible to violent attacks. Living in an abandoned building or on the streets makes one less safe from robberies, rape or drug use.

Individuals who have been abused are more susceptible to both mental illness and homelessness. In fact, some studies have found that between 51 and 97% of women suffering from serious mental illness have experienced physical or sexual abuse. Similarly, high rates of physical and sexual abuse in childhood are found in the homeless population. Further, once an individual is homeless, they are at risk for additional abuse on the streets and in shelters. Those with serious mental illness are especially at risk of being victimized when homeless (DHHS, 2003).

Those suffering from serious mental illness and homelessness will have less social supports than the typical individual. The homeless mentally ill have less contact and poorer relationships with their families than those who are not homeless (DHHS, 2003). These relationships may have slowly deteriorated, when family members grow tired of trying to help their relative who is experiencing severe mental illness (Lezak & Edgar, 1996). Others may think that the individual is being lazy or is unmotivated. The mentally ill homeless individual may then in turn resent family members for not understanding their plight, which can perpetuate

the cycle. Often family ties are broken. If substance abuse is involved, the mentally ill homeless individual may lose “using” friends if they themselves quit. Stigma and discrimination surrounding both mental illness and homelessness make it difficult to maintain friendships and jobs (Lezak & Edgar, 1996). Studies on social supports reveal that those who had more social support were less distressed and suicidal. Social support seems to be beneficial in itself, but also an emotional buffer for homeless individuals and may help lessen destructive tendencies as an outlet of experiencing distress (Schutt, Meschede & Rierdan, 1994).

In our society the mentally ill and the homeless are generally shunned. People look down on and avoid mentally ill homeless because of stereotypes, fear, anger, distrust and embarrassment. This marginalization or exclusion from main stream society can lead to low self-esteem, feelings of hopelessness and isolation. It can also lead the homeless individual to avoid seeking the appropriate care he/she needs (ADS Center, 2007). Stigma can be a significant barrier for the mentally ill homeless to living in mainstream society, in the community.

2.4 RESULTS OF HOMELESSNESS

Other factors associated with homelessness occur after the individual has been homeless, as opposed to precipitating homelessness. Many homeless are in poor physical health as well. More interpersonal factors including stigma, lack of social supports and family issues or organizational and policy issues are addressed in previous or subsequent sections.

Homeless individuals have a much greater risk of death than the general population. Health conditions such as Human Immunodeficiency Virus (HIV), liver disease, renal disease, cardiovascular disease and pulmonary disease, including asthma occur to a much larger degree in

homeless adults than the general population (Hwang, 1998). Spending many hours waiting in lines or walking all day, combined with worn out, ill-fitting shoes can lead to serious foot problems in the homeless. Upper respiratory problems, diabetes, tuberculosis, lice and hypothermia are also common problems in the homeless (Włodarczyk & Prentice, 1988).

3.0 ORGANIZATIONAL AND COMMUNITY LEVEL FACTORS

Coordination and integration of services for the mentally ill homeless are critical factors in the success of a homeless individual becoming more self-sufficient and healthier, both mentally and physically. Research tells us that a particularly vulnerable time for homeless individuals to regress and therefore a critical time for intervention is when they are discharged from the hospital or jail, a shelter or inpatient clinic.

3.1 SUPPORT SERVICES AND DISCHARGE

Adequate support services are essential in preventing recidivism to homelessness following a hospital stay or imprisonment. Individuals may need help returning to the community and linking with appropriate housing, treatment and community supports (Lezak & Edgar, 1996). There is not one central community agency responsible for the coordination of supportive services and collaboration among agencies can be weak, when competition ensues. Assertive community treatment teams (ACT) have been shown to be successful in assisting individuals in getting the appropriate services (Lezak & Edgar, 1996). Assertive community treatment teams are discussed further in the section “National homeless and mental health services”.

When a homeless individual arrives in a shelter, in jail or in the hospital, staff should start the discharge process upon entry. Recent research by Bear (2007) concluded that in Allegheny

County, 22% of discharges from hospitals to shelters were considered inappropriate. Many homeless individuals find themselves staying in the shelter for the allotted amount of time and then cycling to the next shelter when housing was not obtained for them or their substance abuse or mental health symptoms are still extreme.

Dedicated staff needs to spend time on finding resources and financial help for homeless individuals so that when they leave one of these locations, they do not find themselves on the street again. Discharge planning needs to be initiated long before the individual is scheduled to be released. Discharge planning can include community visits to look at housing and establish connections with support services (Lezak & Edgar, 1996).

Especially in the jail or psychiatric hospital setting, individuals should be discharged with housing arrangements, necessary medication, a treatment plan and an appointment with a mental health practitioner. An application for public assistance should be provided or staff should help complete this process (Harvard Mental Health Letter, 2005).

3.2 DEINSTITUTIONALIZATION

Deinstitutionalization is essentially replacing long-term psychiatric hospital stays with community-based alternatives for mentally ill people. In the 40 years from 1955 to 1995, the number of occupied state hospital beds decreased from 339/100,000 to 21/100,000. The idea behind deinstitutionalization was to provide mentally ill persons with a more humane, community-based existence than a life lived in a hospital. These views were based on idealism, though, and not on research (Lamb & Bachrach, 2001). Today, many of those with severe mental illness deny their illness and therefore, their need for treatment, many because of the stigma

attached to the label of “mental patient”. They may take to using illegal drugs on the street and leading lives of crime and loneliness.

While many do not believe that deinstitutionalization has directly led to the increasing number of homeless, several of my key informant interviews revealed that they adamantly directly witnessed this with their own eyes. Two American Psychiatric Association task forces on the homeless mentally ill state that the problem is not a direct result of deinstitutionalization, but that it is a result of the manner in which it was implemented (Lamb & Bachrach, 2001).

Severely mentally ill individuals may have a hard time dealing with living situations, including landlords and they may become evicted. Many may end up on their own on the streets. Many may not keep relationships, as already discussed. If they are not in the hospital, they may discontinue their medication. Acting bizarrely or disorderly may lead to their arrest and jail time (Lamb & Bachrach, 2001). Lack of many state hospital beds, now leaves them with no place to go, little medical care and little support.

Individual, interpersonal and organizational level issues help explain the multi-dimensional nature of the problems of homeless persons with mental illness. Taking a closer look at community and policy level issues will provide a transition to looking at services currently in place at community and national levels.

3.3 LACK OF AFFORDABLE HOUSING

Most housing that is ‘affordable’ is typically in need of serious maintenance and repair, is unsafe and is not conveniently located near transportation or necessary services (Lezak & Edgar, 1996). A full time salary on minimum wage is \$10,712. In the city of Pittsburgh, \$30,815 is necessary

to fulfill the basic needs of a parent with two children, and many housing options do not exist to provide an adequate, clean safe living environment for a family of three on this wage. Even though some people may be eligible for federal assistance like supplemental security income (SSI) or section 8 exists, many people can still not afford housing. Additionally, waiting lists are so long that housing in many cases, is not available for years. There is not one housing market in the U.S. in which a person receiving SSI can afford to rent a small apartment, while still affording groceries, utilities and other basic necessities. For those who experience mental illness, an emergency such as a rise in medication costs or rent can render them homeless (DHHS, 2003).

3.4 LACK OF EMPLOYMENT OPPORTUNITIES

Employment opportunities are scarce, particularly for the homeless mentally ill. Persons with mental illness may want to work, but are unable due to their symptoms and in some cases, inability to care for themselves. Even though about 44% of homeless people work, their employment is low paying, short-term and lacking benefits. The unemployment rate for people with serious mental illness is a staggering 90% (DHHS, 2003).

4.0 NATIONAL HOMELESS POLICY AND SERVICES

The review of homeless policy is important to understand what services are available from a federal level for this population. By identifying factors that lead to homelessness and looking at available programs, gaps can then be identified and recommendations made for implementation of new programs or more coordinated care. The Stuart B. McKinney Act, Medicaid and Supplemental Security Income are federal programs that provide support and services to homeless individuals with mental illness.

4.1 STUART B. MCKINNEY ACT

Arguably the largest political influence on the issue of homelessness is the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77), which was enacted in 1987. This was the first piece of legislation to deal with homelessness at the Federal level and at present is the only comprehensive Federal homeless legislation (DHHS, 2003). This act is now known as the McKinney-Vento Act and has been amended four times in years 1988, 1990, 1992 and 1994. In the 1990 amendments, the Shelter Plus Care Program was created, which provides housing to mentally ill homeless, among other populations. (National Coalition for the Homeless, 2006a). Also in 1990, one program was renamed and is now called Projects for Assistance in Transition from Homelessness Program (PATH), which is discussed in detail under the Substance Abuse

and Mental Health Services Administration (SAMHSA) programs. The 1992 amendments consolidated two programs into the Access to Community Care and Effective Services and Support (ACCESS) program, which is also discussed further later in this paper. Unfortunately, funding associated with McKinney-Vento programs has declined significantly. In 1996 programs were cut by 27%. Overall, since 1995, U.S. budget allotment to Homeless Assistance grants has decrease by 28% (National Coalition for the Homeless, 2006a). This trend is another reason the mentally ill homeless population is in need of greater, more coordinated services

4.2 MEDICAID & SUPPLEMENTAL SECURITY INCOME

Medicaid is administered by the Department of Health and Human Services and is the largest Federal entitlement program. Medicaid grants health care for low-income, medically needy families, but also individuals who demonstrate a disability, including a mental health diagnosis. The Federal government provides guidelines to states who then administer their own programs. Part of the goal is to provide supportive services to allow people with serious mental illness or co-occurring disorders to maintain housing. Recently, Medicaid has successfully been used to finance supportive housing services (DHHS, 2005), although it varies enormously from state to state. Medicaid provides this funding since research shows that living in supportive housing greatly decreases emergency room visits and inpatient hospitalizations among the homeless, which in turn saves the health care system money.

Supplemental Security Income (SSI) may be the most essential source of income for the homeless mentally ill. Due to the dramatic rise in the number of mentally ill homeless individuals needing temporary public shelter, the guidelines have been relaxed somewhat. For

instance, recipients are now permitted to stay up to 3 months a year in an emergency shelter without forfeiting benefits (NASW, 2002). These benefits, however, are still not substantial. As of January, 2007, the monthly benefit rate for individuals is \$623.00 a month. In Pittsburgh, this is approximately the amount of money necessary for a one bedroom apartment, not including utilities, groceries, medical care, transportation and other necessities of life.

Even though mentally ill homeless individuals are considerably more likely to receive Medicaid and Supplemental Security Income, they still experience poor physical health, quality of life and victimization (Sullivan, Burnam, Koegel & Hollenberg, 2000). Medicaid and SSI benefits at such low rates may be ineffective at preventing homelessness in persons with mental illness.

National programs, such as SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) and Access to Community Care and Effective Services and Supports (ACCESS) represent attempts at the national level to decrease rates of homelessness and provide supportive services to the homeless mentally ill population. The Department of Housing and Urban Development provides various grants and administers programs to help the homeless population, including those suffering from mental illness.

4.3 SAMHSA/CMHS PROGRAMS

The Center for Mental Health Services (CMHS) is part of the Substance Abuse and Mental Health Services Administration (SAMHSA), which is a branch of the U.S. Department of Human Services. SAMHSA's vision is "A life in the community for everyone" and its mission is to build resilience and facilitate recovery, with one of its priority areas as homelessness

(DHHS, 2005). CMHS helps improve prevention, treatment and support of homeless individuals with mental illness by helping them attain services such as substance abuse treatment, primary care and legal help. The CMHS provides programs such as PATH, a demonstration program called ACCESS, and in 2003 they released a document on strategies for the mentally ill homeless. The National Resource Center on Homelessness and Mental Illness is the work of SAMSHA, which develops papers and training programs on the topic of mental illness in the homeless population.

4.3.1 Projects for assistance in transition from homelessness (PATH)

PATH is administered through the CMHS and was created under the McKinney Act Amendments of 1990. PATH gives funding to states to help deliver mental health services, through case management, outreach, assessment and training of staff. PATH is intended to support community-based services for the homeless mentally ill or for those with severe mental illness who risk becoming homeless (DHHS, 2003). In 2005, \$52 million was distributed to each state, with a minimum of \$300,000 every year to each state. In the same year, agencies reported serving over 82,000 people, of which 27% had schizophrenia and other psychotic disorders and 44% had affective disorders, like depression. Services eligible for PATH funding include outreach, screening and diagnosis, community mental health services, alcohol and drug treatment, case management and some housing services. PATH funds are over 23% of the total funding allotted by provider agencies to serve homeless individuals with mental illness (PATH, 2007)

4.4 DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT PROGRAMS

The Department of Housing and Urban Development (HUD) provides programs to support people who are homeless, including emergency shelter grants, supportive housing program (SHP), and veterans programs. HUD administers the McKinney-Vento Homeless Assistance Act programs and awards funds to develop a “Continuum of Care” (CoC) system in the community. CoC is based on the belief that homelessness is not just a lack of housing, but that physical, economic and social issues are also involved (HUD, 2007). CoC is the predominant service delivery system to address the needs of the homeless, which begins with outreach, includes treatment and transitional housing and then ends with housing (Tsemberis, Gulcur & Nakae, 2004). This model contrasts significantly with the Housing First/harm reduction model, which is discussed in the Allegheny County section of this thesis.

CoC Homeless Assistance Programs are the supportive housing program (SHP), shelter plus care program and single room occupancy program. Overall goals of the SHP program are to achieve residential permanence, increase skill levels and incomes and to obtain greater self-determination (HUD, 2007). The Shelter Plus Care Program is for homeless persons with disabilities, including serious mental illness, who are typically hard to serve. The program provides rental assistance and supportive services to the homeless in the form of grants through four programs: Tenant, Sponsor, Project, and Single Room Occupancy (SRO) assistance. SRO units are dorm-like buildings that may have been an old school or hotel and they provide homeless individuals with their own room (HUD, 2007).

Criticisms from consumers regarding the CoC arise when individuals feel that CoC presents them with a series of hurdles they must overcome before they can get housing. They see housing as their immediate need and become frustrated with rules that require treatment first.

CoC supportive housing uses the abstinence-sobriety approach and the belief that until sobriety and treatment are maintained, housing is not possible (Tsemberis et al, 2004). These homeless may prefer life on the streets where they can maintain their independence.

Reviewing the services and programs for the homeless population with mental illness provides a framework of the national structure that is in place. Services provided by SAMHSA and HUD, in addition to a national policy structure provide a foundation for services to the homeless mentally ill. The following is a description of the Assertive Community Treatment program that exists across the country and in the Pittsburgh region.

4.5 ASSERTIVE COMMUNITY TREATMENT (ACT)

ACCESS was a five-year demonstration program that started in 1993 and continued until 1998 as a demonstration program. The program was in 18 communities in 9 states, who provided more enhanced services, like case management through the use of these funds. The hypothesis was that integrated systems of care for the homeless mentally ill would improve individuals' level of functioning, quality of life and housing outcomes (DHHS, 2003). The results proved the hypothesis correct and individuals even demonstrated a decrease in mental symptoms, drug use and criminal activity. The systems integration provided positive housing results for homeless mentally ill individuals (DHHS, 2003).

ACT grew out of the ACCESS demonstration project and is widely used across the United States and through the Department of Veterans Affairs. ACT is a treatment approach that uses teams to provide community-based mental health treatment for those with severe mental illness. Teams have group members with various backgrounds, including psychiatry, nursing,

counseling and social work. Services are provided 24 hours a day 365 days a year (ACTA, 2007).

ACT is intended to decrease symptoms of illness, increase quality of life, improve functioning and help the individual live independently in the community, while lessening the burden on family. Key features of the program include treatment, rehabilitation, and support services. ACT allows individuals to spend less time in hospital treatment, and reduces symptoms while the individual lives in the community. Currently, only six states have statewide ACT programs, although 19 states have at least one ACT pilot program (NAMI, 2007). An ACT approach in Pittsburgh is seen in the Neighborhood Living Project at Western Psychiatric Institute and Clinic (WPIC).

5.0 ALLEGHENY COUNTY HOMELESS AND MENTAL HEALTH SERVICES

Most of the national homeless programs are also found in Allegheny County, but there are specific programs and coalitions in Allegheny County address the homeless issue. The following is a review of Allegheny County services and the capacity of the community to deal with such a significant public health issue.

The estimated homeless population in Pittsburgh is 2,300 individuals. Despite an array of services for the homeless, the number of homeless individuals has been increasing in Pittsburgh, particularly homeless women with children (Allegheny County Homeless Alliance, 2005). In Allegheny County, about 40% of the homeless population suffers from mental illness, which is considerably higher than the national average (DHS, 2007).

Despite community capacity in Allegheny County that consists of housing options and services for the mentally ill homeless, homelessness is still on the rise (Allegheny County Homeless Alliance, 2005). From December, 2000 to June, 2004 the number of homeless women with children, homeless men with children and homeless children overall has increased. During these same years, the number of homeless children increased 57%. The average homeless person in Allegheny County is 43 years old, the average child is 8.5 years old and approximately 21.5% had been homeless for at least one year (Allegheny County Homeless Alliance, 2005).

Obtaining a living wage and adequate housing are also issues in Pittsburgh for homeless persons with mental illness. The full-time salary on minimum wage is \$10,712 a year. In

Pittsburgh, \$30,815 is necessary to meet the basic needs of a parent with two children, (Pittsburgh Social Venture Partners, 2007).

5.1 COMMUNITY CAPACITY

The Allegheny County Department of Human Services (DHS, 2007) defines homelessness as “lacking a fixed, regular, and adequate night-time residence.” Allegheny County has a wealth of resources for the homeless including emergency shelters, street outreach and housing assistance (see Appendix A for shelter listing). Mental health services are present, but not as accessible as physical health services, in that a homeless individual may readily go to the emergency room for a physical ailment, but may be uncertain or unwilling to get help for mental issues.

Allegheny County is fortunate to have influential community leaders and community agencies dedicated to serving the homeless and mentally ill. These agencies include the Allegheny County Homeless Alliance (ACHA), U.S. Department of Housing and Urban Development (HUD), U.S. Department of Veterans Administration (VA), Health and Human Services (HHS), Pennsylvania Department of Public Welfare (DPW) and the Pennsylvania Department of Health. Overall, a network of 44 providers exists to make available housing and services to the homeless population (ACHA, 2005). Despite these best efforts, homelessness is still on the rise in Allegheny County, which leaves room for improvement.

Pittsburgh and Greater Allegheny County have used coalitions and advocacy groups for years to try to address the issue of homelessness. A national 10 year plan to end homelessness exists in 200 cities across the country. Locally, a conference convened in 2004 called “Ending Homelessness: Creating New Partnerships for Change”, sponsored by the Allegheny County

Homeless Alliance. In the conference report, the participants discussed both positive and negative events since 1995 that have impacted homelessness in Allegheny County. Positive events were the establishment of a continuum of care system, the beginning of HUD SHP and the creation of the City of Pittsburgh Police Homeless initiative. Negative events included continued down-sizing of state mental hospitals, no increase in HUD grants, turf fragmentation, an increase in homeless providers who are all competing for the same money, the economic crisis in the city and jail as a housing option. Most of these events are further elaborated in the key informant interviews. The following agencies and programs offer a sampling of services for the homeless of Allegheny County who also suffer from mental illness. These services appear to be successful in that they are utilized by the community, but gaps will be identified and suggestions made for improvement.

5.1.1 Allegheny County Act 137

Pennsylvania passed a state law in 1992 known as the Optional County Affordable Housing Trust Funds act, which is more commonly known as Act 137. This Act created housing trust funds, similar to other housing trust funds in cities all across the country. In Allegheny County, 20% of its trust fund revenue goes to the Department of Human Services to assist the homeless. Seventy-five percent of the money helps with down payment assistance and other help with housing (Philadelphia Housing Trust Fund Campaign, 2007). Revenues for Act 137 are raised by increasing fees for recording deeds and mortgages up to 100% over the prior level. The money is then used for more affordable housing needs and the homeless (Penn State, 2005).

5.1.2 Housing First/Harm Reduction

The housing first and harm reduction model is mainly discussed in the context of chronically homeless individuals with dual diagnosis and is increasingly being adopted both nationally and in Pittsburgh. Community Human Services Corporation specifically advocates for the housing first/harm reduction model in the Pittsburgh area. It is seen as more compatible with clients' priorities and not as restrictive to individuals who cannot comply with rigid program rules. Pathways to Housing developed the Housing First model for chronically homeless individuals, on the belief that housing is a foundation for rehabilitation and individual choice. It allows consumers to identify their own needs and goals and provides them with housing regardless of if they participate in psychiatric treatment or become sober. Consumers will not suffer any consequences if they refuse clinical services. The only requirements are that individuals must give 30% of their income for rent, which is usually in the form of SSI and they must meet with a staff member at least two times a month. In addition to housing, an Assertive Community Treatment (ACT) team helps provide treatment and support. The Housing First model is based on the assumption that if persons with severe mental illness can survive on the streets they will be able to manage their own apartment housing (Tsemberis et al. 2004).

Along with housing first, a harm reduction model is also adopted, which allows homeless individuals more choice. For those suffering from dual diagnosis, this may include allowing individuals to choose to use alcohol or drugs or not and to take their medication or not. No matter which choice they make, they will not lose their housing. A recent study by Tsemberis et al. (2004) found that the Housing First approach is effective in keeping chronically homeless, dually diagnosed individuals housed. In their study, the program had an 80% retention rate and that was with individuals who all had a diagnosis of a serious mental illness. The success of the

Housing First model makes it a viable choice in servicing the homeless, but remains controversial since some individuals do not believe that persons using drugs should be given supportive services, such as housing, until they are clean of all substances.

5.1.3 Allegheny County Continuum of Care

The Continuum of Care concept has been woven through each of the programs discussed and particularly under the HUD section. This is a nationwide service delivery model for the chronically homeless population. The Continuum of Care consists of outreach efforts initially, then provides treatment, transitional housing and finally permanent supportive housing (Tsemberis, Gulcur & Nakae, 2004). The idea is to follow homeless individuals continually so that they get the services they need. This opposes the housing first model and has recently been criticized for not allowing consumers to have a say in their own care.

5.1.4 Street Outreach/Operation Safety Net

Operation Safety Net provides medical care to the street homeless of Pittsburgh. This program was created by Dr. James Withers in 1992 as one of the first full-time street medical homeless outreach programs in the country. Operation Safety Net provides training to health profession students and case management to the homeless. It makes use of a medical service van and high tech computer equipment for data entry on clients. Operation Safety Net has received numerous awards, including the Robert Wood Johnson Community Health Leadership Program Award, in 2002 and the Servitor Pacis Award, Permanent Observer of the Holy See to the United Nations and an additional 36 awards and recognitions.

5.1.5 Western Psychiatric Institute and Clinic

The Western Psychiatric Institute and Clinic (WPIC) developed a novel program in 1998 to help those with serious mental illness have supportive housing. The program is called the Neighborhood Living Project (NLP) as is part of the WPIC Homeless Continuum, along with the Buffalo Street Project and WPIC Community Services and creates collaborations to provide a continuum of services for those who are both homeless and mentally ill. The program uses the community treatment team and assertive community treatment models and accepts that individuals have a right to refuse treatment and a right to receive respect (American Psychiatric Association, 2002). NLP is funded by HUD to provide services to homeless individuals and families that are affected by mental illness.

The continuum addresses various needs, including physical and mental health problems, family and social problems and educational and vocational problems. Short-term and long-term approaches are used to guide clients through the continuum as they become increasingly stable. The continuum works with the Mayor's Task Force on Homelessness, has two psychiatrists, seven psychiatric nurses, five intensive case managers, one addiction counselor and a secretary. Employing professionals with various health backgrounds creates a multi-disciplinary atmosphere that may provide useful in the community. The WPIC Homeless Continuum has been successful at closing some gaps by partnering with other agencies and even grocery stores to provide vouchers to clients. (American Psychiatric Association, 2002). Within six months of services, 80% of clients are in more stable housing (Kupersanin, 2001).

The program adequately measures outcomes of client satisfaction, level of functioning, time spent in jail, shelter and supportive housing and quality of life. WPIC is well-known for its

research , clinical services and training programs, but now it can also be known as a pioneer in mental health services for the homeless population (American Psychiatric Association, 2002).

5.1.6 Health Care for the Homeless

The Health Care for the Homeless program in Pittsburgh is found at Alma Illery Medical Center, in the Homewood section of the city, but serves the urban population of the greater Pittsburgh area, including the Mon Valley. Health Care for the Homeless is part of a large group of community based organizations in Pittsburgh, some of which have already been mentioned in this paper. This network of organizations includes, Community Human Services Corporation, the East Liberty Family Health Center, Operation Safety Net, Program for Health Care to Underserved Populations (at the University of Pittsburgh School of Medicine), and the Salvation Army WPIC program. The activities for the Health Care for the homeless include, bridge housing, soup kitchens, drop-in centers and primary care, including podiatry, dental, pharmacy, vision and pediatrics (HRSA, 2006).

In 2002, the Health Care for the Homeless program, along with the Allegheny County Department of Human Services began a three-year grant called AIM-HIGH, which stands for Allegheny Initiative for Mental Health Integration for the Homeless (Gordon, Montlack, Freyder, Johnson, Bui & Williams, 2007). The goals were integrations of mental health and medical providers, promotion of partnerships, decreasing overlap of services and evaluation of progress and outcomes. AIM-HIGH was successful in proving that integration of medical, mental health and substance abuse services health care for the homeless is possible in an urban environment, it facilitated access to behavioral and medical health care and found that collocation of behavioral

and physical health care services in the same clinic is an effective way to integrate services to the homeless (Gordon et al, 2007).

5.1.7 Community Human Services Corporation

The Community Human Services Corporation (CHSC) provides a wealth of resources to the South Oakland community and serves as a leader in homeless services through coordination and collaboration with other agencies. CHSC provides supportive homeless outreach services, mental health residential programs, youth programs, health care and family programs. It also runs Wood Street Commons, a housing shelter program in downtown Pittsburgh. CHSC also coordinates and houses the Homeless Outreach Coordinating Committee (HOCC) meetings monthly. While conducting research for this thesis, CHSC proved to be an invaluable resource, both personally and as witnessed in the community.

5.1.8 Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is for individuals with severe, persistent mental illness, who have difficulty maintaining their most basic needs. ACT helps individuals with the necessary skills to remain living in the community and services including housing, employment, medical care, finances, substance abuse, family issues and daily living issues (HOCC, 2005). ACT includes a team of people to provide the various services whenever necessary. ACT is available 24 hours a day, 7 days a week and a person may receive services for as long as they need them, without limit. Services are assertive and individualized to help the person integrate into the community (HOCC, 2005).

In Allegheny County, Community Treatment Teams (CTT) based on the ACT model, were developed through collaboration of Community Care Behavioral Health, Allegheny County and Allegheny Health Choices, Inc. Community Care Behavioral Health and Allegheny County provide funding for CTT services, with Allegheny County providing \$2.2 million annually. Currently four ACT/CTT exist in Allegheny County, including 2 run by WPIC, 1 run by Mercy Behavioral Health and 1 by Residential Care Services (Semuels, 2005).

5.1.9 Homeless Assistance Programs

Homeless Assistance Programs (HAP) are funded through the Pennsylvania Department of Public Welfare. Allegheny County provides HAP through the Bureau of Hunger and Housing Services. HAP funds are used to help assure that homelessness can be avoided through prevention services and affordable housing; that people who are homeless will still have refuge and care; and that those who are homeless will be helped to become self-sufficient. HAP services include case-management, rental assistance, bridge housing, emergency shelter and innovative supportive housing services (PA Department of Public Welfare, 2004). Allegheny County HAP and HUD providers can be found in Appendix C.

5.1.10 Emergency Shelters

Allegheny County contains 16 emergency homeless shelters, as listed in Appendix A. Each shelter may vary in whether it serves males, females, and children and if it provides services for domestic violence issues. Shelters may also vary in how many nights they permit an individual to reside in the shelter, before they must find residence or go to another shelter. Shelters are

generally only for overnight use and are meant to provide a clean, safe place for individuals to stay, while they also receive help in solving immediate issues.

5.1.11 Safe Haven

The safe haven in Pittsburgh is called Safe Oasis and Residence (SOAR) and is the only safe haven in Allegheny County for women. SOAR offers permanent housing for women who are chronically homeless and also suffer from mental illness and is part of Bethlehem Haven, which also provides shelter and transitional housing. Unlike shelters, which limit the number of days an individual may stay, the safe haven provides unlimited stay and more flexible structure than residing in a shelter. To be admitted into the SOAR program, the individual must be a single woman, have documented mental illness and be chronically homeless, according to HUD's definition of chronic homelessness.

5.1.12 Allegheny County Mental Health Court

Mental health courts are intended to redirect offenders suffering from mental illness out of the criminal justice system and into mental health treatment systems, while making sure that the public is still safe (Ridgely, Engberg, Greenberg, Turner, DeMartini & Dembosky, 2007). In Allegheny County, the mental health court is part of the Court of Common Pleas and works in collaboration with the Allegheny County Department of Human Services, Office of Behavioral Health, Office of the Public Defender, Office of the District Attorney and Office of Probation and Parole. The mental health court has been shown to save the taxpayer money in jail costs by giving the offender community-based services, which cost less. The Allegheny County Mental

Health Court was developed in June of 2001. Since that time more than 350 participants have been processed in the system (Ridgely, et al., 2007). The mental health court used in conjunction with better police training in mental health shows signs of positively impacting the homeless community. Homeless mentally ill individuals will be diverted from jail, which many times is used as a housing option, and will hopefully receive the mental health treatment they need to better function in society.

Cities such as San Diego have established homeless court programs at local shelters. This program helps the homeless resolve minor criminal cases and helps connect them with housing, mental health services, and employment (DHHS, 2003). Given the success of the Allegheny County Mental Health Court, it is possible to conceive that a similar homeless court will be adopted in Pittsburgh.

5.1.13 Crisis Intervention Training for Police

Recent research (Teller, Munetz, Gil & Ritter, 2006) has shown the Crisis Intervention Teams consisting of the police department, mental health professionals, family members and consumers are helpful in assisting persons with mental illness gain access to the mental health treatment system.

Crisis Intervention Team (CIT) Training for police officers dealing with mentally ill individuals has been occurring across the country, but just only recently in Pittsburgh. In fact, on Monday, June 25, 2007, the first class of officers started this week-long training. Allegheny County and the City of Pittsburgh are going through major changes currently in responding to persons with mental illness in efforts of diverting them from jail. Currently, 25-28% of those in the Allegheny County Jail suffer from mental illness (McCune, 2007).

Pittsburgh Police training allows officers to experience what many with mental illness experience. Some exercises include trying to get through a sobriety test while listening to troubling voices played in headphones. The training is provided through a partnership between the Pittsburgh Police Bureau and Allegheny County Department of Human Services and is supported by a 30 month grant of \$275,000 by the U.S. Department of Justice. Mercy Behavioral Health on the South Side has hosted the training, which is hoped to continue every other month until at least one-third to one-half of the Pittsburgh Police are trained. All officers who complete this program, which is completely voluntary, will wear a CIT badge above their name tag (McCune, 2007). Dr. Beth Nolan is active in researching the crisis intervention training for the Pittsburgh Police and was very helpful in providing information and resources for this thesis.

5.1.14 Homeless Outreach Coordinating Committee

The Homeless Outreach Coordinating Committee (HOCC) is comprised of members from various organizations including, Bethlehem Haven, WPIC, the Pittsburgh Police, the Allegheny County Office of Behavioral Health and Operation Safety Net, among many others. This committee meets once a month to coordinate services, talk about issues and to arrive at solutions. HOCC also developed a proposal for an engagement center in the city of Pittsburgh. This engagement center will target the street homeless, which make up about 5% of the homeless population in Pittsburgh (HOCC, 2005).

The engagement center intends to provide on-site support services, emergency shelter and linkages to permanent housing options. Individuals will have access to drug and alcohol services, behavioral health, a mailing address and simple use of bathrooms and showers. The

engagement center will have an emergency shelter and housing options including, safe haven, shelter plus care, housing first and HMIS linkages for available housing (HOCC, 2005).

Allegheny County has been devoted to helping the homeless from the governmental policy level to the shelter level. As a community, many people are trying to reduce the stigma surrounding the mentally ill homeless. The Allegheny County Department of Human Services is boasting a decade of progress this year and is passing out bookmarks with the Director's Action Line for more information on homelessness. The Allegheny County Library Association is participating in the One Book, One Community campaign this year, which started in Seattle, Washington. This year's book pick is The Glass Castle, by Jeannette Walls, a memoir centered on homelessness. The Library Association is hosting events to discuss and understand homelessness and poverty. Hopefully, this is one step in reducing the stigma of homeless individuals in the Pittsburgh region.

6.0 METHODS

The literature review was initiated through a search in the University of Pittsburgh Digital Library system. Databases by subject were used with the subject choices of social work and medicine. Search terms for journal articles included mental illness and homelessness, homeless programs and homeless statistics. Google scholar was also used with similar search terms. First, articles were determined to be appropriate based on title. Next, the abstract was read to determine if the article was suitable. Finally, if the article looked like a good resource, the entire article was read and the reference list of that article was used for further literature review.

The social ecological model was applied to define the problem of mental health problems and services in the homeless population. This model allowed for factors other than just the individual in leading to homelessness. Existing data was used to uncover the issues surrounding mental health problems and services in the homeless community.

Key informant interviews led to further resources in the Pittsburgh region and invitations to attend local meetings to gain more insight into programs and services for the Pittsburgh homeless community. Area health professionals were also great sources of information, providing web links to newsletters and books on the topic. Particular gratitude is owed to Karen Peterson and Theresa Chalich for their help with resources.

7.0 KEY INFORMANT INTERVIEWS

A valuable part of the methods section was conducting key informant interviews that were carried out in the spring of 2007. Key informant interviews can help reveal what data already exists on a topic, gaps in services and general thoughts on a particular issue. In this case, the interviews were extremely informative in uncovering the data that exists in Pittsburgh, on the topic of the homeless mentally ill. While key informants are identified for this thesis, summaries of the discussions are included without identifying each individual explicitly. Key informants were then able to feel more comfortable about speaking more openly on the topic. Appendix B shows the list of questions that were asked of each interviewee. Key informants also elaborated on the subject with personal knowledge and anecdotal information. Key informants represent a range of organizations in the Pittsburgh region and nationally, including Community Human Services Corporation, Bethlehem Haven, Operation Safety Net, SAMHSA and the Pittsburgh Police.

The purpose of these interviews was to recruit knowledgeable professionals with experience in working with homeless individuals with mental illness, to identify barriers to services as they see them and to outline the scope of the problem. Since only so much can be learned in a literature review, it was important to uncover what goes on in Pittsburgh city streets and in the community to truly understand homelessness and mental illness. I initially began my search of key informants with Karen Peterson, MPH who had been and still is very involved with

the Graduate School of Public Health. She suggested that I speak with Mac McMahon and Adrienne Walnoha, of Community Human Services Corporation, who both had a history of working with homeless persons with mental illness. Adrienne then also suggested that I speak with Becky LaBovick who first worked at Western Psychiatric Institute and Clinic and recently joined Community Human Services Corporation. I held face-to-face interviews with Becky and Mac and kept in touch with Adrienne via email.

I also recruited Theresa Chalich RN, MPH as a key informant since I had worked with her during my first internship at Bethlehem Haven. I knew she was very passionate about homeless issues and had spent her life serving the homeless, first in Boston and now in Pittsburgh.

Both Jim Withers,MD and Ken Thompson, MD I know personally through our work with the Pittsburgh Schweitzer Fellows Program, in which they are both advisory board members. I knew that Jim was passionate about street homeless issues and a pioneer in street outreach. Ken is very passionate about mental health issues and had recently been appointed a national position. I knew these two gentlemen would complement each other well in the interview process.

After establishing a firm relationship with Community Human Services Corporation, I was invited to the Homeless Outreach Coordinating Committee meetings, where I met Sgt. Bob Miller of the Pittsburgh Police. I started a discussion with him at the end of the meeting and he generously agreed to serve as one of the key informants for my thesis.

All individuals were initially contacted by email, since this was their main communication. Individuals could then decide if they wanted to formally meet or answer questions over email. All individuals were seen in person at some point in the process, either

formally or informally to discuss this thesis. The following sections are short biographies of each individual as well as their organization.

7.1 COMMUNITY HUMAN SERVICES CORPORATION

Mac McMahon is the director of homeless programs at the Community Human Services Corporation (CHSC). Rebecca LaBovick was recently hired as a mental health outreach nurse for CHSC. Both Mac and Rebecca were interviewed on April 25, 2007 at CHSC. Mac and Rebecca have both been working with the homeless population for over a decade. Adrienne Walnoha is the executive director of CHSC and was interviewed via email on April 18, 2007. Adrienne has been working with mentally ill individuals and homeless individuals since 1996. CHSC was chosen because of its long-standing history of service to the South Oakland and Lower Hill District Communities. Since the early 1970s, a wealth of programs have served the greater Pittsburgh area, including housing and outreach programming.

7.2 BETHLEHEM HAVEN

Theresa Chalich, RN, MPH is Coordinator for the 902 Clinic at Bethlehem Haven, which services the medical and mental health needs of the homeless population. Bethlehem Haven is a homeless women's shelter, transitional housing, recovery area and drop-in center for both males and females. The interview with Ms. Chalich was conducted on April 26, 2007 at the 902 Clinic.

Bethlehem Haven has just celebrated its 25th year of service and was also selected for interview because of its long-standing service to the homeless community.

7.3 OPERATION SAFETY NET

Jim Withers, MD is the founder and director of Operation Safety Net. He has been working with the unsheltered ‘street’ homeless population since 1992, through the creation of this medical and social program. He also practices and teaches Internal Medicine. Operation Safety Net was selected because of the innovativeness of the program, which is now a national example and because of the knowledge and dedication of Dr. Withers. The interview was conducted over several weeks in May via email and throughout our work discourse with his involvement in the Pittsburgh Schweitzer advisory board.

7.4 SAMHSA

Ken Thompson, MD is a psychiatrist and has recently been appointed as the Associate Director for Medical Affairs at the Center for Mental Health Services for SAMHSA. Dr. Thompson is dedicated to serving the community, with particular attention to mental health. He lives in Pittsburgh and knows the community well, but also provides a national viewpoint through his position at SAMHSA. He has a long history of working with both the homeless population and persons with mental illness.

7.5 PITTSBURGH POLICE

Sergeant Bob Miller has been a police officer since 1995. His recent switch to Zone 2 this year raised his awareness of the homeless population in Pittsburgh. Other Zones in Pittsburgh have little or no interaction with the homeless population. Sgt. Miller attends monthly HOCC meetings and actively attempts to form collaborations with community agencies.

7.6 COMPILATION OF INTERVIEWS/DISCUSSION

Threads of common issues and comments were woven throughout the interview process. While individuals may have different areas of expertise, the issue of homelessness and mental illness had commonalities among all respondents.

7.6.1 Lack of collaboration and communication

Common complaints were the lack of collaboration among agencies, while also the acceptance of the fact that collaboration is all but impossible when funding streams naturally create silos and competition among agencies. Even with an attempt at collaboration, communication is never perfect. Agencies need to have more information sharing and networking. Staff turnover was cited as a barrier to forming and maintaining collaborative relationships between agencies. Coordination and the County's Continuum of Care are part of the ten year plan to end homelessness, but do not seem to be as effective in practice as on paper. Even when agencies

and coalitions are formed, a big issue appears to be that discussions revolve around programming and not about consumers.

7.6.2 Street Outreach

Outreach to homeless with mental health needs was repeatedly discussed as being important. More successful outcomes could happen if services, including mental health services, were taken straight to the street or shelter. A homeless individual will most likely not have bus fare or energy to get to a program, especially if it is not located centrally to the city. Programs housed in buildings need to be welcoming and provide non-traditional hours of service. Some described a sense of going backwards in terms of outpatient engagement teams and housing issues.

7.6.3 Barriers

Time was a constant issue, in terms of being able to provide services and get payment. People also repeatedly said that barriers of time and funding silos among agencies do not support collaboration between agencies. Funding issues and frustrations were common in the interviews. Funding seems to be too inflexible, with too many restrictions and lack of integration. One interviewee commented that “One size fits all doesn’t work”. Even though the basic needs of the mentally ill homeless remain the same, funding priorities change and this creates problems for consumers. Other funding issues surrounded HUD funding and the fact that even if the housing dollars stay the same, the supportive services component drops and agencies need to find other sources of funding.

While interviewees feel that there are adequate mental health services, these services need to be taken more directly to the streets for the ‘hardcore’ homeless and the homeless need to be aware that these services exist. Stigma surrounding mental health issues is prevalent in all populations of society, which also is a barrier for the homeless to receive mental health services. A general frustration existed about society’s rejections of those persons with mental illness who are homeless. Lack of concern among citizens and the ‘not in my backyard attitude’ perpetuate stigma and do not help in the provision of services to this population. There is a sense that many people in society look at the homeless as ‘those people’ and that the homeless should be punished to straighten them out.

7.6.4 Key issues leading to homelessness

Some key informants revealed poverty as the biggest issue facing the homeless, but other issues vary in magnitude from person to person. Lack of affordable housing, including Housing First/Harm Reduction, low SSI benefits, non-treatment of health and mental health issues, and legal issues were all issues associated with homelessness. Others cited safety as a big issue the homeless must face. Substance abuse can lead to overdose, with no one close by to help. Homeless individuals may be more likely to be struck by a car or murdered than people not living on the streets. Better, more creative job opportunities would allow those with poor legal backgrounds or few skills to maintain a livelihood and self-sufficiency.

As reported by these key informants, there is also a lack of consistency with the Pittsburgh Police regarding homelessness. Certain zones are known to be more insensitive to the homeless, while others seem to have great mental health training. Consistency within the whole force would be beneficial. Police officers should be trained to realize that not every situation

requires an arrest and they should be equipped with information about where they can send the individual for help. Homeless individuals with mental illness may not be aware of services available. Police and outreach teams can provide information and direct individuals to appropriate services.

Overall, most interviewees expressed disturbance over the double standard that homeless individuals face. Several examples were described. One was the double standard in which college students or other 'acceptable' individuals are permitted to approach your car window for donations, but homeless individuals are not permitted to panhandle and are shunned by many individuals. Another example was landlords not wanting to house homeless individuals who may abuse alcohol or other drugs, yet the businessman who is an alcoholic is tolerated. Some of the individuals interviewed expressed real frustration and hurt over the double standard in society and the stigma that the homeless must continually face every day of their lives.

7.6.5 Changes among the Pittsburgh homeless

Most informants agreed that awareness exists of the connection between mental health and homelessness, but that solid efforts have only been gradual and are still inefficient, especially for the street homeless population. In cases where services are provided, they may be too high threshold, with unaccommodating hours and inappropriate geographic locations. So while services may be increasing, they may not be appropriate for the population. In some ways it seems that we still have a long way to go in delivering effective homeless services for those with mental illness, particularly in street outreach.

Key informant interviews and the literature review revealed the prevalence and accessibility of services from researcher and professional viewpoints. If enough time were

available, Institutional Review Board (IRB) submission would have been made to gain approval to do a formal assessment in homeless shelters. While key informant interviews were beneficial and informative, engaging with clients receiving services would have provided more insight into the problem of mental illness in the homeless population. As one key informant pointed out, the best way to tackle the issues of homelessness is to actually talk one-on-one with homeless individuals who suffer from mental illness. The following is a proposal for a homeless assessment and more in depth evaluation could have allowed for deeper understanding of the issue and then more targeted suggestions to be made.

8.0 HOMELESS ASSESSMENT

Appendix D is a proposed assessment of the issues surrounding the homeless with severe mental illness. With sufficient time and funding the proposed assessment could take place and would reveal the views of homeless individuals themselves and shelter staff.

While the literature review and key informant interviews revealed information on services for the homeless mentally ill, it is vital to hear from the individuals themselves to better provide services. It is imperative that service design planning include members of the homeless community themselves, particularly those that suffer from serious mental illness. Staff members that serve the homeless should also be involved in designing appropriate programs and services for the mentally ill homeless population.

Community involvement is very important in the assessment process. The HealthierUS approach of the CDC now calls for formal assessment of community needs and assets, whereas before it only called for planning, delivery and evaluation (Gilmore & Campbell, 2005).

Needs assessments can vary in how much contact exists between the researcher and members of the community, from no contact with participants to contact with the agency or community to combined techniques (Marti-Costa & Serrano-Garcia, 2001). For an assessment of homeless shelters and homeless individuals, it is important to have contact with members of the population to gain insight and establish a relationship that suggests that the researchers have

a commitment to helping the homeless. As with any assessment, it will be a good idea to first conduct a pilot test of the following questions to determine if they are valid.

The assessment would include individual interviews of homeless individuals. Individual interviews could be conducted in the shelter setting or on the streets. Shelter staff would be interviewed in the shelter. Focus groups for both shelter staff and homeless individuals would be conducted in the shelter itself, with special attention to privacy so that individuals could feel they could say anything. Incentives would be given to homeless individuals, such as gift cards or cash to encourage them and thank them for participating in the survey or focus group. Results from the assessment would then be used to increase the effectiveness of shelters in Allegheny County and to determine other services that would benefit homeless individuals with mental illness.

In addition to the value of a homeless assessment, it is important to be clear about the types of evaluations that should be performed to regularly improve homeless services to those with mental illness.

8.1 EVALUATION

8.1.1 Process

Client and staff satisfaction at shelters, outreach, hospitals and psychiatric centers needs to constantly be measured. Assessing satisfaction during the course of a program is important to ensure that clients are getting the services they need, but also to make sure that staff are not experiencing high stress and burnout. Each agency that provides mental health services to the

homeless population needs to consistently and continually evaluate their programs. They need to look at satisfaction and immediate outcomes and make necessary changes during the program. Many agencies wait until a program is finished and evaluate outcomes to see determine successfulness of the program. Evaluating during the program allows changes to be made to increase success.

8.1.2 Outcome

Key issues to include in client evaluation are health status (mental and physical), cost-effectiveness, number of homeless housed, employment, substance use, involvement in the criminal justice system, social supports and quality of life (DHHS, 2003). System level evaluation of organizations and integration of services is also important.

9.0 DISCUSSION

Initially it appeared that mental illness in the homeless could be looked at as a distinct public health problem. Yet the problems faced by the mentally ill homeless are complex and inherently multidimensional. Therefore, we must take a social ecological perspective. Thinking in terms of the housing first model, perhaps by providing the homeless with basic needs first, mental health symptoms will lessen and quality of life will improve. It is also important to look at this issue from the perspective of Maslow's Hierarchy of Needs, depicted in the following chart.



Maslow's Hierarchy of Needs
Abraham Maslow, *Motivation and Personality*, 2nd ed., Harper & Row, 1970

Although there is no doubt that mental illness is a large problem in the homeless population, particularly in Allegheny County, it is also clear that fundamental physiological needs and safety needs should be met first, before any other progress can be made. Also, when we are talking about mental health needs, it is important to not just think about medication and psychotherapy. Social supports, engagement in the community and fulfilling activities will all lead to better mental health in the homeless population and perhaps the ability to maintain adequate housing.

While we must meet the basic needs of homeless persons with mental illness, we must also advocate for mental health parity. Homelessness can actually be seen as a sign that public

mental health systems are in trouble. In fact, even with adjusting for inflation, states spend 30% less on mental health care than in 1955 (Harvard Mental Health Letter, 2005). For a vulnerable population like the homeless, this lack of mental health parity is even more prevalent, regardless of the fact that basics needs must be met.

10.0 CONCLUSIONS & SUGGESTIONS

While it is clear that many people and agencies attempt to help the homeless mentally ill population, the resources and services are still lacking. Several key suggestions are provided here. The first involves an extension of this thesis to include interviewing and conducting focus groups with homeless individuals with mental illness. Homeless individuals should also be involved in planning processes both locally and nationally. Next, there should be more flexible guidelines with benefits such as SSI, which for many individuals are their only sustenance. Access to housing needs to be less rigid, both in terms of funding allocated for housing and in landlords' expectations. Many landlords in housing programs for the homeless ask for drug testing. This is a double standard, since those professionals who engage in drug use don't need to be tested in order to obtain their housing.

Funding cutbacks need to be stopped and the funding streams should be given out, such that collaboration among providers is encouraged. More outreach to the street homeless, specifically to help them with mental health needs and not just physical health needs would be beneficial in helping to lessen one of the risks of homelessness in the first place.

As a society, we need to be less discriminating against both homeless individuals and persons with mental illness, and especially those individuals suffering from both conditions. The question needs to be asked, is it fair for a community to place middle-class values on homeless individuals? Do homeless individuals want housing? If a homeless individual is living on the streets with all the friends they have, which make up their entire support system, do we expect

them to move into housing? Homeless persons with mental illness may not even feel that their mental illness is a factor in their homelessness. They may feel like economic problems (lack of affordable housing and little job opportunities) and social problems (lack of family support) are the reason for their homelessness. It does appear that stigma, poverty, lack of job opportunities and affordable housing are the source of homelessness, as revealed in the literature and in key informant interviews. Education of the general public could help decrease stigma of this population.

The Housing First model appears to be a feasible way to provide services to the mentally ill homeless population. While still controversial, its success has been shown and it provides a model in which homeless individuals can still maintain a say in their own care. Providing ownership, choices and ability to set their own goals in treatment still gives individuals a sense of independence and autonomy.

In addition to extending this thesis to involve interviews and focus groups with homeless persons with mental illness, I propose the following solutions to closing the gap in services to the homeless. First, the creation of funding streams that more naturally allow for collaboration among agencies. Currently, funding streams are allocated in silos, such that each agency needs to complete its task and collaboration may hinder this work or foster competition of funds. Second, more street outreach needs to be done, with more information giving about mental health services that are available to the homeless. We need to respect the homeless and meet them where they are physically. If their home is under a bridge, we need to reach out to them to provide services and cannot expect them to secure the transportation to reach services themselves. If they chose to get services on their own homeless persons need to be provided with accurate information about the available services. Third, advocacy of homeless persons

with mental illness needs to be done. The stigma and discrimination that this population faces need to be lessened and communities need to have reverence for all individuals and at the same time not ignore that the problem exists. Lastly, more creative options in terms of jobs, housing and funding need to be accomplished. For homeless individuals with criminal backgrounds, job and housing opportunities may be limited. Those with mental health issues may have a hard time finding a job that matches their skills. SSI and other public assistance are generally not sufficient for a homeless person with mental illness to maintain housing and basic needs. Benefits should be more generous and more opportunities in terms of jobs need to exist for this special population. Housing vouchers could be provided to reduce homelessness. An increase in the minimum wage would more accurately fit the living wage and the ability to afford housing and basic necessities.

Overall, improving mental health would consist of improving quality of life through increasing social supports, providing appropriate housing and helping homeless individuals achieve independence. Societal changes are necessary to reduce stigma of homeless persons with mental illness. Individual and interpersonal changes are also necessary to foster collaboration among agencies providing care to the mentally ill homeless. Agencies should be meeting together at least on a monthly basis in person to discuss strategies. To be more effective, agencies should be communicating through email or telephone about certain cases where agencies could all work together to provide an individual with the help they need. If we could all think more often of the suffering which we normally spare ourselves the sight, as Schweitzer posited, we could perhaps relieve that suffering of homeless persons with mental illness, rather than pretending that suffering does not exist.

APPENDIX A

LIST OF ALLEGHENY COUNTY HOMELESS SHELTERS

Shelter	Men	Women	Men with children	Women with children	Couples with children	# Beds
Allegheny Valley Council of Churches				yes	yes	14
Alle Kiski Hope Center		yes		yes		7
Bethlehem Haven		yes				28
Community Human Services Corporation						
East End Cooperative Ministry	yes					24
Family Links	yes	yes		yes		18
Orr Compassionate Care Center						
Mercy/ Operation Safety Net						
Light of Life Ministries	yes					34
Northside Common Ministries	yes					25
Primary Care Health Services		yes		yes		20
Salvation Army Family Crisis Center		yes	yes	yes	yes	35
Womanspace East, Inc.		yes		yes		8
Womanspace		yes		yes		24
Women's Center and Shelter		yes		yes		34
YMCA McKeesport	yes	yes				25

APPENDIX B

KEY INFORMANT INTERVIEWS

- 1) What is your history in working with the homeless? Working with persons with mental illness?
- 2) How do you feel the homeless issue has changed over the years in Pittsburgh, with particular attention to mental health?
- 3) Do you think that there is appropriate coordination of care among all agencies (in Allegheny County) that provide services to the homeless population?
- 4) What do you do to coordinate care with others? What do you see as barriers or resources to doing this and do you think it is valuable to do so?
- 5) Who do you think would be a good partner in what you do? How would you go about building partnerships?
- 6) Do you feel that adequate mental health services exist for the homeless of Pittsburgh? Which ones? Do you feel that homeless individuals are aware of these services?
- 7) What do you think is the biggest issue facing the homeless today- adequate housing? Health problems? Lack of family/social supports? Something else?
- 8) What do you feel are the biggest policy issues for the homeless population today?

9) What kind of help do you receive from funding sources? What kind of funding would you need to provide more services? Is there a particular area of funding that you think is lacking?

What issues surround being able to secure funding?

10) What advice do you have for a new professional dedicated to serving the mentally ill homeless?

---Open-ended comments on experience and overall feelings on this issue?

APPENDIX C

LIST OF HUD/HAP CONTRACTED PROVIDERS IN ALLEGHENY COUNTY

-Please refer to www.county.allegheny.pa.us/uploadedFiles/DHS/About_DHS/Publications/Resource_Guides/CSHAPHUDDirectory.pdf for an in depth look at each program, including what types of programs they offer and which population they specifically serve in terms of gender and age.

- Action Housing
- Adagio Health- Bridge Housing
- Allegheny Valley Council of Churches
- Alle-Kiski Hope Center
- Auberle
- Bethlehem Haven
- Bridge to Independence
- Community Human Services
- East End Cooperative Ministry
- Familylinks
- First Step Recovery Homes
- Goodwill Industries
- Health Care for the Homeless
- HEARTH
- Hosanna House
- House of the Crossroads
- Light of Life ministries
- Mercy/Operation Safety Net
- Michael's Place/ St. Vincent DePaul Society
- Miryam's
- North Side Common Ministries
- Parental Stress Center
- Pittsburgh AIDS Task Force
- Primary Care Health Services

- Salvation Army Family Crisis Center
- Salvation Army Harbor Light Center
- Sisters Place Inc.
- Sojourner House
- Strength, Inc.
- University of Pittsburgh Medical Center/ Matilda Theiss
- University of Pittsburgh Medical Center/ WPIC
- Urban League of Pittsburgh
- Veterans Place of Washington Blvd, Inc.
- Veterans Leadership Program of Western PA
- Womansplace East, Inc. / Womansplace
- Women's Center and Shelter
- YMCA/YWCA of McKeesport
- YWCA of Greater Pittsburgh

APPENDIX D

HOMELESS ASSESSMENT PROPOSAL

Surveys

Homeless individuals

1) What do you feel are the 3 most important issues you face being homeless?

1. _____

2. _____

3. _____

2) Do you feel that there are places for you to go to get the help you need?

_____ Yes

_____ No

3) Do you feel you have enough health and mental health services available to you?

Yes_____

No_____

If "Yes", which services are of the most help to you?

1. _____

2. _____

3. _____

If "No", which services would you like to have available?

4) What issues or circumstances led you to become homeless?

5. How satisfied are you (on a scale of 1 to 10, with 10 being the highest) with the comfort of the shelter in terms of temperature?

Comfort in terms of sleeping arrangements?

Comfort in terms of personal space?

6. How satisfied are you in how the shelter staff has interacted with you, on a scale of 1 to 10?

7. What could staff do to better help you with your needs?

8. Do you feel that the shelter is a safe place for you?

___ Yes ___ No On a scale from 1 to 10, how safe is the shelter? _____

Shelter staff

1. How are individuals received into the shelter and how is their need documented?

2. What is your funding source(s)? What are your funding requirements?

3. What do you see as the major problems for the homeless in the Pittsburgh area? What do you wish could be done and what do you think can be done?

4. Do you feel there is an appropriate number of staff in your facility to appropriately serve the homeless?

Focus Groups

Using focus groups will include developing an interview guide, enlisting a well-trained, experienced moderator, determining the number and composition of groups, selecting participants and arranging the facilities (Gilmore & Campbell, 2005). Audio or video tape can be used to create transcripts. The following are some simple questions that can be the start of a general discussion in each group. After respondents start providing answers and generating a discussion, the facilitator would ask further questions based on their responses. The following are proposed question for homeless individuals and staff.

Homeless Individuals

1. What health and mental health services are you aware of that you could use?
2. On a scale of 1 to 10, with 10 being the best, how would you rate the care you receive when residing in a shelter? Why did you rate it a ___? What changes would have to occur for you to increase your rating?
3. What specifically would allow you to receive the help you need?

Shelter staff

1. What is the staff/client ratio in your shelter?

2. What is the extent of staff training and what is the turnover rate?
3. On a scale of 1 to 10, with 10 being the highest, how would you rate overall staff morale? Why did you rate it a ___? What changes would have to occur for you to increase your rating, i.e. to increase staff morale?
4. What kind of documentation do you use and to whom are you accountable in your reporting?
5. How is client satisfaction determined and how are your programs evaluated in general?
6. What types of follow-up care are in place for clients, specifically for mental health services?
7. How does your shelter collaborate with other services or agencies to coordinate overall efforts?

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